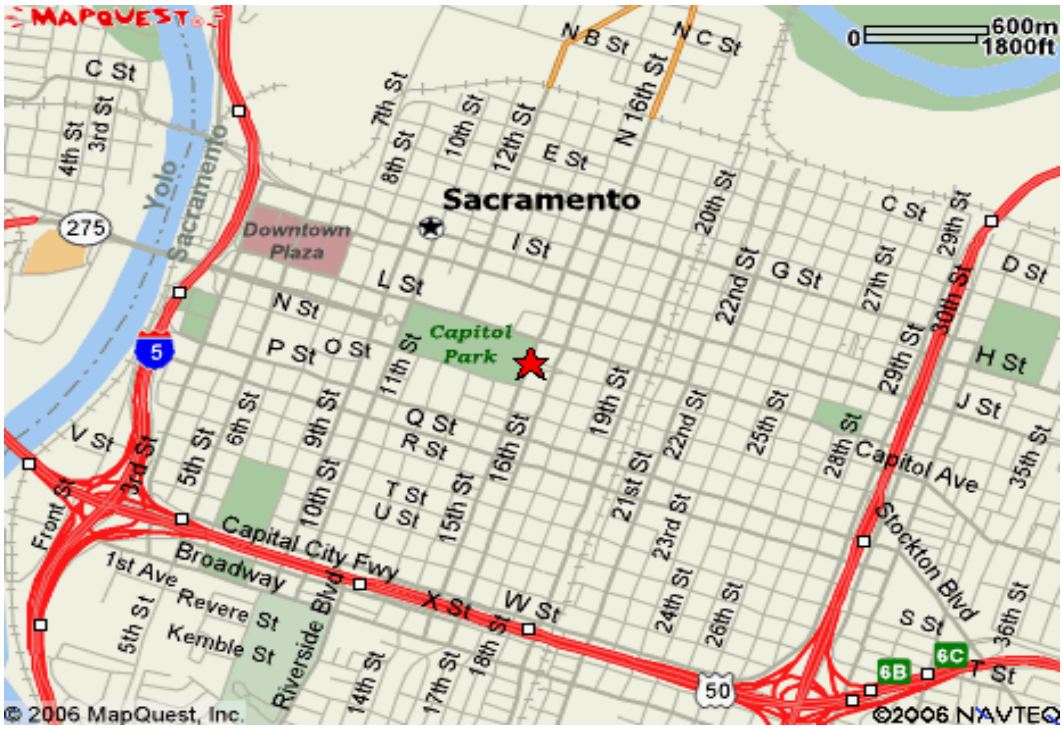
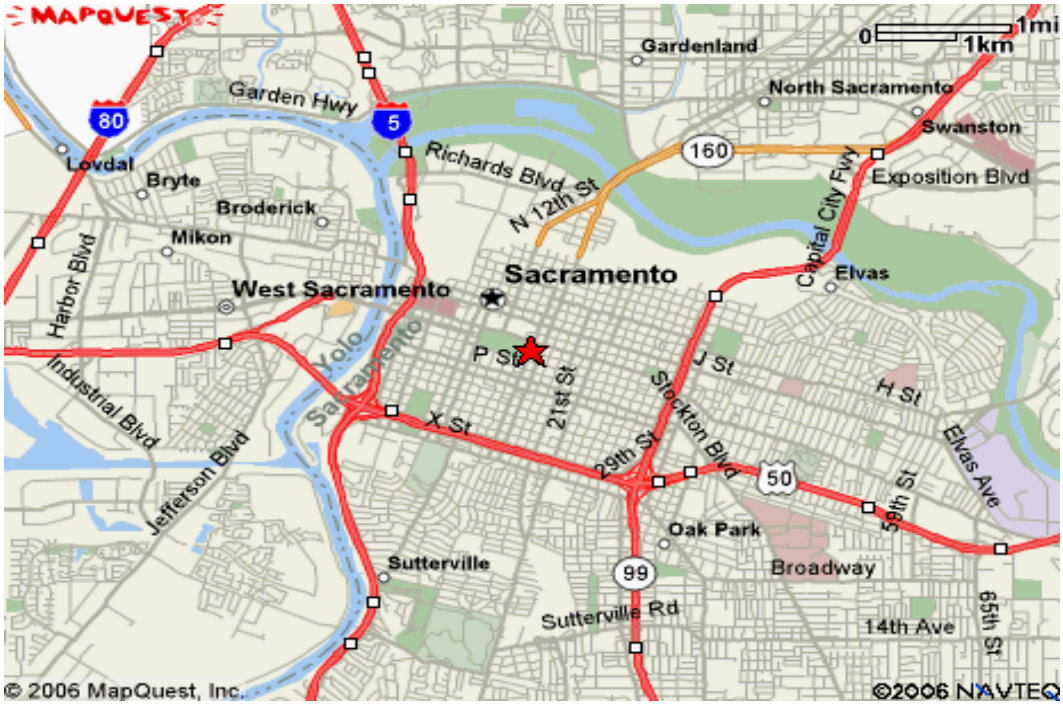
Appendix 1

Sacramento Maps (Location of DHCS)





Appendix 2
Formula for Adjudication Audit

Definitions

n = Number of claims in sample

xy dx

x, y, d = $\sum_{i=1}^{n} x_i$, $\sum_{i=1}^{n} y_i$, $\sum_{i=1}^{n} d_i$ for the corresponding totals found in the sample

d/x = *p* = Discrepancy found in the sample expressed as a proportion of the total Contractor payments found in the sample

P = Actual discrepancy in the universe expressed as a proportion of the total contract payments

r = |P - *p*| = Absolute precision of *p*

$$Sp = \sqrt{\frac{n\sum_{n-1}^{n}(d_i)^2 - \left(\sum_{i=1}^{n} d_i\right)^2}{x^2(n-1)}}$$ = Standard error of *p*

t = Normal deviation corresponding to desired two-sided confidence level. For a 95 percent two-sided confidence level, t = 1.96.

The absolute precision of *p* may be stated at any confidence level by *p* ± t • S*p*. The midpoint of this confidence interval is *p*, which represents that estimated dollar amount found to be in discrepancy for the purpose of implementing RFP requirements and for other State purposes.

Appendix 3
Formula for Processing Audit

Attribute sampling will be used during the Processing Audit to ascertain what proportion of line items contain one or more processing errors (automated or manual).

Definitions

N = Total number of line items in the universe

A = Total number of line items in the universe that contain one or more processing errors

P = A/N = Proportion of all line items in the universe that contain one or more processing errors

n = Total number of line items in the sample

a = Total number of line items in the sample that contain one or more processing errors

p = a/n = Proportion of all line items in the sample that contain one or more processing errors. Also, the sample estimate of P

d = |p - P| = absolute precision of p

$$Sp = \sqrt{\left(\frac{N-n}{N}\right)\left(\frac{p(1-p)}{n}\right)} = \sqrt{\left(\frac{N-n}{N}\right)\left(\frac{p \bullet q}{n}\right)} = \text{Standard error of p}$$

Where q=(1-p), which is the proportion of line items in the sample containing no processing errors

This formula is reduced to

$$Sp = \sqrt{\left(\frac{p \bullet q}{n}\right)}$$

when n is small compared to N (normally five percent or less of N, since $\frac{N-n}{N}$ becomes close to 1).

t = Normal deviation corresponding to a two-sided confidence level. For example, t = 1.96 for a 95 percent two-sided confidence level, and t = 1.645 for a 90 percent two-sided confidence level.

This, 95 percent confidence limits of p would be p ± 1.96 • Sp, and 90 percent confidence limits of p would be p ± 1.645 • Sp.

Appendix 4
Glossary of Terms

ACCOUNTS RECEIVABLE (A/R):
An accounting system for recording activity pertaining to obligations incurred, payment made to providers within the Claims Processing Subsystem, which incorporates both manual and automated procedures. It reports current financial balances on individual providers and a history of transactions. Examples of A/R activity are:

1. Additional payments to providers who have been underpaid;
2. Recovery of payments to providers in accordance with approved procedures;
3. Advance (interim) payments to providers; and
4. Returned provider checks.

ACTIVITY RECORD:
A claim service line from an input document that has additional information not contained on the original document (e.g., the Claim Control Number (CCN); a history of the Data Control Center (DCC); error codes; suspense codes; identifiers of persons assigning suspense or denial conditions).

ADDENDUM, CONTRACT:
An addition or change made to the contract before the contract is signed into effect. The fiscal intermediary (FI) contract will include addenda added to the Request for Proposal (RFP).

ADJUDICATED CLAIM SERVICE LINE (ACSL):
The ACSL consists of all claim service lines included in this contract and any other health claims added to this contract adjudicated for all claim categories (approved for payment or denied) with exceptions (Payment Provisions, Adjudicated Claim Service Line Subsection) ACSL is a term whereby the reference is limited to Contractor payment.

ADJUDICATED ELAPSED TIME (AET):
Total time elapsing in a single work session between the retrieval of the electronic facsimile of a pended document and the final adjudication routing.

ADJUDICATION STATUS:
The status of a claim during claims processing. The status may be approved, suspended, or denied.

ADJUDICATION:
A term, which refers to the final resolution of a claim or Treatment Authorization Request (TAR) in claims processing.

ADJUSTMENT, ACSL:
A single annual adjustment made to the payment for administrative services to reconcile the prospective ACSL volume range payment to the actual ACSL volume for work performed.

ADJUSTMENT, AUDIT:
Post-payment adjustment made by DHCS to the amount payable to a provider, based on an examination of dental and/or financial data of the provider.

Appendix 4
Glossary of Terms

ADJUSTMENT, CLAIMS PROCESSING:
A transaction that changes information on a previously adjudicated claim/Notice of Action/Authorization (NOA); e.g., payment amount, units of service, or other change to history. May be a debit, credit, or void adjustment.

ADJUDICATION CODE:
A code specific to a claim service line reflecting the reason for modification or denial.

ADMINISTRATIVE BULLETIN:
Bulletins released to potential bidders to answer questions that clarify RFP provisions.

ADVANCE PLANNING DOCUMENT:
A written plan of action which requests federal financial participation in the cost of determining the need for, feasibility, and cost factors as well as acquisition of automated data processing equipment and services. (Federal Register/Vol. 73, No. 46/Friday, March 7, 2008/Proposed Rules; also http://www.state-itc.org/ntc2006/accessible/NTC2006-Wetterhan-APD/textmostly/slide4.html)

AFFILIATE:
A company's parent companies and subsidiaries, and companies that are also owned or controlled by the company's parent companies. A parent company is one that owns or controls another, which is the subsidiary company.

AGED HISTORY:
Claim history that is over thirty-six (36) months old (also referred to as Purged History), which includes all history records, including once-in-a-lifetime procedures and other records needed for service limitations.

AGED HISTORY REPORTS:
Claims payment history records that are 37 through 72 months old.

AID:
Cash assistance, food stamps, Medi-Cal, or other health care programs.

ALLOWABLE COST:
Medi-Cal reimbursement rates to providers for services, as defined by regulation in Title 22 in the section related to Rates of Payment.

APPLICANT:
All individuals seeking public assistance, including persons being added to an existing case and any other individual(s) whose income or resources are considered in determining the amount of benefits. The term applicant also applies to persons or entities seeking to become providers in the Medi-Cal program.

ASSUMPTION:
Refers to the Contractor’s assumption of claims and TAR processing. For example, the Contractor’s assumption of CD-MMIS Operations.

Appendix 4
Glossary of Terms

ASSUMPTION OF OPERATIONS:
The first day of the first operational period of the contract. Corresponds to the Assumption of Claims Processing.

AUDIT:
1. The examination and verification of the Contractor's operation subject to the terms of this contract.
2. Validation checks made by the Contractor of a TAR, claim, or claim service lines against previously adjudicated claims or TARs, including claims or claim service lines adjudicated at the same time as the current claim (see AUDIT-COMPUTER).

AUDIT-COMPUTER:
An automated examination of data on the claim/TAR/NOA in which the data is compared during the process to applicable historical records and to other data on the claim, etc., for the purpose of determining claim/TAR and charge validity.

AUTOMATED ELIGIBILITY VERIFICATION SYSTEM:
An automated telephone voice response system that allows providers to verify a recipient's eligibility, SOC, and medical services transactions for Medi-Cal and County Medical Service Program (CMSP) recipients by using a touch-tone telephone. Providers are able to make inquiries regarding recipient eligibility by entering the beneficiary identification number from the face of the Benefits Identification Card (BIC). Responses to provider inquiries are generated using recorded voice messages.

BENEFICIARY:
A person who has been determined eligible for public assistance, e.g., cash assistance, Medi-Cal, food stamps, California Children's Services (CCS), Genetic or Genetically Handicapped Persons Program (GHPP), or CMSP. This term is used interchangeably with "recipient."

BENEFICIARY REIMBURSEMENT PLAN:
The court approved implementation plan (i.e., Conlan) for processing beneficiary reimbursement claims.

BENEFIT:
Health or dental care services available to Medi-Cal, CMSP, Child Health and Disability Prevention Program (CHDP), Children's Treatment Program (CTP), CCS, and GHPP beneficiaries.

BENEFITS IDENTIFICATION CARD:
A plastic card issued by DHCS to each Medi-Cal recipient. Possession of a BIC is not proof of Medi-Cal eligibility because it is a permanent form of identification and is retained by the recipient even if he or she is not eligible for the current month. The dental provider must verify eligibility of a beneficiary using the BIC at the time of services through the Medi-Cal Automated Eligibility Verification System (AEVS). The BIC contains magnetic strip similar to that on a credit card and is designed to slide through a Point-of-Service (POS) machine, giving the dental office automatic access to patient eligibility information by viewing the AEVS read-out on the POS device.

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Glossary of Terms

BENEFICIARY ID BIO NUMBER:
The fourteen (14) digit identification number assigned to each Medi-Cal recipient by the county welfare department. The BID number consists of a two (2) digit county code, two (2) digit alphanumeric aid code, seven (7) digit alphanumeric serial/case number, one (1) digit alphanumeric Family Budget Unit (FBU), and a two (2) digit alphanumeric person number. All claims history for a recipient, prior to the date of implementation of the Social Security Number (SSN) as primary ID enhancement, is filed under the first beneficiary ID number known to the claims processing system. Subsequent beneficiary ID numbers are cross-referenced to this initial ID or to the Permanent ID. See also “RECIPIENT ID” and “PERMANENT ID”

BENEFICIARY TOLL-FREE OPERATIONS:
Contractor employees whose sole purpose is to perform work responsibilities that are exclusively dedicated to telephone activities generated by beneficiary inquiries/complaints as defined in this RFP.

BID:
Document containing Cost Proposal Bid Sheets submitted by Proposer after their Narrative Proposal has been determined acceptable.

BIDDER:
See PROPOSER

BI-MONTHLY:
Every other month or once every two (2) months.

BI-WEEKLY:
Every other week or once every two (2) weeks.

BOARD OF DENTAL EXAMINERS:
The entity within the State Department of Consumer Affairs which is responsible for the licensing, regulation, and discipline of dentists.

BOTTOM LINE PRICING:
Bottom line pricing compares the total paid by Medicare on all of the lines on a crossover claim to the total of the Medi-Cal allowed amounts for all of the lines on the claim. The Medi-Cal Program pays any difference.

BUSINESS DAY:
Any day that the Contractor or Department is open for business.

BUSINESS FUNCTIONALITY:
Business goals and advantages that need to be enabled by technology.

BUSINESS IMPACT ANALYSIS:
An examination which identifies the business processes which are most critical to DHCS’s business recovery.

BUSINESS REQUIREMENTS:
A specification of what the business wants, the purpose of initializing a specific project, what the needed achievements will be, and the quality measures.

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Glossary of Terms

BUY-IN:
An activity of the DHCS Third Party Liability Branch (TPL), which coordinates and controls Medi-Cal payment of Medicare Part A and Part B premiums for eligible Medi-Cal beneficiaries.

CALIFORNIA CHILDREN'S SERVICES (CCS):
The program, which provides specialized medical and dental services to financially and medically eligible children under the age of twenty-one (21) years who have severe medically handicapping conditions. The CCS program covers diagnostic, treatment, and therapy services.

CALIFORNIA CONSUMER PRICE INDEX (CPI):
A measure of the average change over time in the prices paid by urban consumers in California for a fixed market basket of goods and services. The CPI provides a way to compare what this market basket of goods and services presently costs with what the same market basket will cost, over a period of time.

CALIFORNIA DENTAL MEDICAID MANAGEMENT INFORMATION SYSTEM (CD-MMIS):
The certified California Dental Medicaid Management Information System developed under federal guidelines for development and operation of California's Dental Medicaid processing and information retrieval. As a federally certified system, the CD-MMIS receives ninety percent (90%) federal funding for development and seventy-five percent (75%) federal funding for systems operation costs (administrative) and fifty percent (50%) federal funding for claims payments on most federal/state covered services. The CD-MMIS processes dental claims.

CALIFORNIA ELIGIBILITY VERIFICATION AND CLAIMS MANAGEMENT SYSTEM:
A non-mainframe system that includes on-line, real time processing of eligibility verification, share of cost, medical services, and pharmacy claims transactions using a POS device, Eligibility Verification System (AEVS), Claim Eligibility Real Time System (CERTS), Internet, or through approved user-developed/modified systems

CALIFORNIA MEDI-CAL MANAGEMENT INFORMATION SYSTEM:
The certified California Medicaid Management Information System (CA-MMIS) developed under federal guidelines for the development and operation of California's Medicaid processing and information retrieval. As a federally certified system, the CA-MMIS receives ninety percent (90%) federal funding for development, seventy-five percent (75%) federal funding for systems operation, and fifty percent (50%) for claims payments on most federal/state covered services. The CA-MMIS processes all Medi-Cal claims for services other than claims for dental services that are processed on CD-MMIS.

CALIFORNIA POINT OF SERVICE (POS):
The Department's on-line, real-time pharmacy claims adjudication system, operated and maintained by the Department's Fiscal Intermediary Contractor.

CAP:
A method of health resource allocation in which a predetermined limit is set on the amount of health expenditures. See also "CAPITATION FEE."

CAPITATED SERVICE:
A service covered by a managed health care plan (HCP), thus not payable by fee-for-service (FFS). Providers must bill the HCP for reimbursement of capitated services. Duplicate FFS payment of capitated services is avoided via CD-MMIS edits and audits.

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CAPITATION FEE:
A single, fixed monthly amount paid to a provider or a managed care health plan. A fixed rate is paid per beneficiary, to cover a specified package of services, regardless of actual utilization. Also referred to as "CAPITATION RATE"

CASUALTY INSURANCE:
Auto, commercial, product, homeowner, and a variety of other insurance programs that generally have medical, dental and liability coverage. Federal law mandates DHCS to seek recovery from the liable third party when Medi-Cal monies are paid for medical or dental services that are covered by casualty insurance.

CATASTROPHIC INSURANCE COVERAGE:
Health insurance, which provides protection against the high cost of treating severe or lengthy illnesses or disabilities. Generally such policies cover all or a specified percentage of medical or dental expenses above an amount that is the responsibility of the insured. If appropriate, DHCS will set up an Accounts Receivable before recovering funds when Medi-Cal pays for dental/medical services covered by casualty insurance.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS):
Formerly the Health Care Financing Administration (HCFA). The federal government program that monitors the State health care programs.

CERTIFICATION FOR MEDI-CAL RECIPIENT ELIGIBILITY:
The determination by the county welfare department, the State, or the Social Security Administration, verified by DHCS, that a person is eligible for Medi-Cal and either 1) has no Share of Cost (SOC), 2) has met his/her SOC, or 3) has an SOC which is less than the cost of long term care at the Medi-Cal rate.

CERTIFICATION, FEDERAL FINANCIAL PARTICIPATION:
Certification must be approved by CMS, for a Dental Medicaid Management Information System before receiving increased federal financial participation.

CERTS:
See "CLAIMS AND ELIGIBILITY REAL TIME SYSTEM"

CHANGE ORDER:
The document and/or the process used by the State for funding additional responsibilities not inherent to the original or amended contracts. Change Orders are billed separately to the contract. This is a contract change resulting in changes to Contractor responsibilities and an adjustment to Contractor payment. A Change Order is distinguished from a contract amendment in that it is within the scope of the contract and is not a fundamental change to the nature of the contract, and does not require Contractor approval to implement.

CHARGES:
The price assigned by the provider to a service rendered. Charges under different conditions may be construed as actual, allowable, customary, prevailing, reasonable, and/or usual, depending on the reimbursement situation involved. Charges are to be distinguished from the actual cost of providing services and from the amount allowed by Medi-Cal.

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CHECKWRITE:
The function performed by the Contractor of printing, issuing, and mailing checks to providers.

CHILD HEALTH AND DISABILITY PREVENTION (CHDP):
The program provides health care assessments and screening of children under age twenty-one (21) for potentially handicapping conditions, and refers those needing additional services for diagnosis and treatment. This program is the California implementation of the federal Early and Periodic Screening & Diagnosis and Treatment Program (EPSDT) for Medi-Cal beneficiaries. The program also provides health care assessments for children under nineteen (19) years of age who are at or under two hundred percent (200%) of the Federal Income Guidelines.

CHILDREN'S TREATMENT PROGRAM (CTP):
Treatment mandate which provides dental treatment for children under nineteen (19) years old who meet CTP eligibility requirements. CTP eligibility requirements are as follows: 1) not covered by private health insurance; is Medi-Cal eligible without share of cost, CCS, or any other publicly funded program; and 3) resides in specific CMSP counties. The CTP mandate states that counties which receive Proposition 99 funds for uncompensated care "shall provide, or arrange and pay for, medically necessary follow-up treatment, including necessary follow-up dental services and prescription drugs, for any condition detected as part of a Child Health and Disability Prevention screen for a child eligible for services" under the CHDP program. The legislation, which appropriated funds for this program, allows CMSP counties to contract back to the State to administer their CTP mandates.

CLAIM:
A billing made on a claim form, computer media, or on a Notice of Authorization (NOA) returned by the provider with dates of services. Reference to a claim refers to the entire document.

CLAIM CONTROL NUMBER:
The unique number assigned to each claim to identify it throughout processing.

CLAIM DETAIL REPORTS (CDR):
Claims payment history records that are one (1) through seventy-two (72) months old.

CLAIM/FORM:
Approved form used by a provider to request payment for non-prior authorized services rendered to Medi-Cal beneficiaries. The form includes all detail service lines (See "NOTICE OF AUTHORIZATION").

CLAIM INQUIRY FORM:
The form submitted by the provider to the fiscal intermediary to inquire about the status of a document in the system, request an adjustment of a previously paid claim, or to request a reconsideration of a denied claim or claim line.

CLAIMS AND ELIGIBILITY REAL TIME SYSTEM:
State-provided software, which allows providers to submit on-line eligibility, SOC, Medi-Services, pharmacy claims, and HCFA 1500 claims transactions.

CLAIM PACKET:
A six (6) page packet, to be filled out by the beneficiary, to request reimbursement for out of pocket expenses for medical or dental services rendered.

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CLAIM SERVICE LINE:
A logical detail service line on a claim/TAR form or on a returned NOA that requests payment and contains a service code, a service description, a service fee and a service date.

CLAIM SCHEDULE:
Hard copy document (State Standard Form 218) which accompanies the payment tables and substantiates the dollar amounts represented.

CLAIM TYPE:
Classification of a claim for billing purposes by origin or type of service provided to a recipient.

CLIENT INDEX NUMBER:
A permanent and unique nine-character number that is assigned to every health services recipient via the daily MEDS batch update process. Once assigned, the Client Index Number never changes.

CLINICAL SCREENING DENTIST:
A dentist hired by the Contractor to reexamine Medi-Cal recipients and present their findings/observations in the form of “second opinions”.

CO-INSURANCE:
A cost-sharing requirement under a health insurance policy that provides that the insured will assume a percentage of the costs of covered services. The policy provides that the insurer will reimburse a specified percentage of all or certain services above any deductible. The insured is then liable for the remaining percentage of costs until the maximum amount stipulated under the insurance policy is reached. Medicare requires a co-insurance under Part B and for specified services under Part A.

COMPUTER MEDIA CLAIM/DOCUMENT (CMC):
Claims processing documents sent to and from the Fiscal Intermediary Contractor in machine-readable format on electronic media. CMCs include documents that are on magnetic tape/tape cartridge, diskette, or data transmitted over telephone lines.

COMPUTER OUTPUT MICROFILM:
Computer-generated micrographic images on either microfilm or microfiche.

CONLAN v BONTA/CONLAN v SHEWRY:
Lawsuit initiated in 1997 with a resulting court order requiring the Department to reimburse Medi-Cal beneficiaries for their covered out of pocket medical or dental expenses incurred with dates of service between June 27, 1997 and November 16, 2006. The court order was implemented November 16, 2006 and included a deadline for submitting claims as of November 16, 2007. The claims for services that were provided on or after November 17, 2006, must be submitted within one (1) year after the date of service or within ninety (90) days of the issuance of the Medi-Cal card (BIC), whichever is longest.

CONTEXT DIAGRAM:
Generalized tool to clarify the relationship of the CD-MMIS operations to external entities by delineating the domain of the system. It shows net inputs and outputs, but omits the details of the process within. Context diagrams may be expanded to serve as an "entity diagram" as well,

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i.e., to depict what documents or information is used, who is involved, and what is produced or accompanied.

CONTRACT CLOSEOUT:
This is the third and last phase of Runout, the first through the 5th business day of month nine during the Runout period. During contract closeout, all remaining residual claims/NOAs, etc., transfer to the successor Contractor, along with all contract records, accounts receivable and residual inventory. Final reconciliation and termination of the current contract occur by the last day of this phase (last day of month 17 of Runout).

CONTRACT EFFECTIVE DATE:
The date upon which the terms of the contract go into force. Defined as the later of the Agreement Start Date and the Agreement Approved Date on the DGS-approved Standard Agreement (STD 213) that defines the fiscal intermediary contract.

CONTRACT MANAGER:
Same as Contracting Officer (see below).

CONTRACT OFFICER:
Same as Contracting Officer (see below).

CONTRACT OPERATIONS PURE PREMIUM PERIOD:
Period in which the Contractor receives a prepaid monthly Pure Premium Payment from the Department to provide insured dental benefit coverage to eligible Medi-Cal beneficiaries.

CONTRACT REQUIREMENT:
Any service, deliverable or other duty the Contractor is required to provide or perform under the terms of the contract.

CONTRACTING OFFICER:
The DHCS official that is responsible for managing the contract. The Contracting Officer can mean the Contracting Officer or his/her designee.

CONTRACTOR:
The fiscal intermediary that processes and adjudicates TARs and claims for Medi-Cal Dental Services on behalf of the State.

CONTRACTOR COST:
The actual cost or expenses incurred by the Contractor to perform any task as part of the contract. Certain Contractor bid prices are required to be based upon Contractor costs.

CONTRACTOR REPRESENTATIVE:
The appointed or designated Contractor Representative is responsible for managing the Contractor's operation.

CONTRACTOR WORKDAY:
Any day the Contractor is open for business.

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COORDINATION OF BENEFITS:
The process of utilizing third party liability resources to ensure that the Medi-Cal program is the payer of last resort. This is accomplished by operating a cost avoidance method of paying claims, when the existence of Medicare or private dental coverage is known at the time the claim is processed, or the method of post payment recovery of the cost of services, if the coverage is identified retroactively.

CO-PAYMENT:
A type of cost sharing whereby insured or covered persons pay a specified flat amount per service or type of service with the insurer paying the rest. Co-payment is incurred at the time of the service and is collected by the provider. Currently, co-payment for Medi-Cal services is not mandatory.

CORRESPONDENCE REFERENCE NUMBER:
A control number assigned to all incoming provider correspondence, claims inquiry forms, appeals, high priority mail, and telephone calls. Assignment of a CRN initiates the controlling of correspondence from date of receipt to the closing of the case and generation of a response letter.

COST:
1. As it relates to providers, the expense incurred in delivery of dental care services; “cost” is distinguished from “charges.”
2. As it relates to the Contractor, the expense or actual cost incurred by the Contractor to perform any task as part of the contract (see CONTRACTOR COST).

COST AVOIDANCE:
A program requirement to bill the other health coverage and receive payment or proof of denial before submitting claims to Medi-Cal. It is the process of utilizing other coverage before billing Medi-Cal (42 CFR section 433.139).

COST CONTAINMENT INNOVATIONS:
Items brought to the attention of DHCS by the Contractor that result in savings in Medi-Cal program expenditures and which the Contractor shares a portion of the savings. These items consist of: 1) ideas that increase DHCS control over the expenditure of program dollars and result in savings in Medi-Cal program expenditures; 2) the identification of fraud that results in program expenditures being reduced (i.e., the estimated dollars that would have been paid in the event the fraud had not been detected).

COST REDUCTION CHANGE PROPOSALS:
The Contractor is encouraged to submit proposals that reduce the operations cost of the CD-MMIS FI Contract. If approved, a Contractor-initiated proposal will result in a shared savings between the Contractor and DHCS.

COUNTY MEDICAL SERVICES PROGRAM:
In 1982, legislation was passed to transfer the Medically Indigent Adult (MIA) population, which was eligible under State-only Medi-Cal, to the counties. Those counties with a population of three hundred thousand (300,000) or less (as of the 1980 census) have the option, annually, to contract back with DHCS to administer their MIA program. Of the fifty-eight (58) counties, forty-three (43) are eligible to contract back; however, only thirty-two (32) of the forty-three (43) eligible counties currently contract back with the State.

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The contract-back MIA program administered by the State is known as the County Medical Services Program (CMSP), and the noncontract-back MIA program administered by the counties is known as the Medically Indigent Services Program (MISP). The MIA program is supported out of the State General Fund.

CMSP beneficiaries, individuals who are twenty-one (21) through sixty-four (64) years of age and who are not linked to Medi-Cal, are eligible for many of the same services as a Medi-Cal beneficiary with the exception of pregnancy-related services; long term care; acupuncture; chiropractic; and faith healing. CMSP uses the Medi-Cal Provider Master File and has all dental claims adjudicated through the DHCS Medi-Cal Dental FI.

COUNTY ORGANIZED HEALTH SYSTEM:
A local agency, with representation from providers, beneficiaries, local government, and other interested parties, created by the county Board of Supervisors to contract with the Medi-Cal program. Beneficiaries are given a wide choice of providers within the COHS network; however, they cannot obtain Medi-Cal services under the traditional FFS system, except in limited circumstances.

CROSSOVER BENEFICIARY:
A person who is entitled to coverage under both the Medicare and the Medi-Cal programs.

CROSSOVER CLAIM:
A bill for services rendered to a crossover beneficiary. Medicare is billed first and pays for covered services less co-insurance and deductible or denies non-covered services. Medi-Cal may then be billed and pays the residual up to Medi-Cal allowable amount for Medi-Cal covered services. The provider must re-bill Medi-Cal using Medi-Cal claim forms.

CUSTOMER INFORMATION CONTROL SYSTEM:
Software monitor that interfaces between the application software and the on-line database.

CUSTOMER RELATIONSHIP MANAGEMENT SYSTEM:
A technology-based information system that uses established databases to capture, track, and trend customer information from start to finish. Provider Services staff members use different components of CRM to perform their daily work.

DATA CONTROL CENTER:
A unique identifiable manual or computerized station to which or from which documents may be routed during the adjudication process.

DATA ELEMENT DICTIONARY:
A database or file containing: a) database descriptions, both schema and subschema, and b) a system/collection of programs. Basically, it is a central storage facility for data definitions, programs/modules, documentation, and run-time information. CD-MMIS uses the product Integrated Data Dictionary (IDD). Refers to a collection of records, elements, sets, or areas

DATA ENTRY:
Method of entering data or information into the CD-MMIS from claim documents. Examples include: Optical Character Recognition (OCR), key-to-disc, tape-to tape, or via modem.

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DATA PROCESSING AUDIT:
Examination of the control within the Information Technology infrastructure by collecting and evaluating evidence of the information systems, practices, and operations to determine if the information systems are safeguarding assets, maintaining data integrity, and operating effectively and efficiently to achieve goals and/or objectives

DAY:
The word "day" in the contract shall be a calendar day unless otherwise specified. (See also STATE WORKDAY or BUSINESS DAY)

DEDICATED STAFF:
Staff that is solely assigned to perform work under a specified provision of the contract. Dedicated staff shall be strictly maintained at a level no less than that required in the RFP or proposed in the technical proposal, whichever is greater and shall be guaranteed at that level for the life of the contract. Dedicated staff and any changes thereto, shall be identified by name, in writing, and may not be committed by the Contractor to work activities outside the areas of the contract section designating them as dedicated staff without prior written approval of the Contracting Officer. The functions of these dedicated staff shall be adjusted based upon the work requirements of the Department.

DEDUCTIBLE:
The amount of loss or expense that must be incurred by an insured or otherwise covered individual before an insurer will assume any liability for all or part of the remaining cost of covered services. Deductibles are usually tied to some reference period over which they may be incurred, e.g., one hundred dollars ($100) per calendar year, benefit period, or period of illness.

DELIVERABLES:
The specific product the Contractor is required to submit upon completion of a task or subtask. When the deliverable is intangible, documentation must be provided demonstrating completion.

DELTA DENTAL PLAN OF CALIFORNIA (DELTA):
The current Fiscal Intermediary for the Medi-Cal Dental Program.

DENTI-CAL:
Term that is commonly used to refer to the Medi-Cal Dental Program. This program provides TAR/claim processing services, check issuance, utilization review, and control of dental claims for Medi-Cal recipients on a fee-for-service basis.

DENTAL OPERATING INSTRUCTION LETTER (DOIL):
Document used to notify the Contractor of changes and clarifications to program policy, including instruction to the Contractor regarding changes required and language to be utilized by the Contractor in issuing provider bulletins or manual updates.

DENTAL REIMBURSEMENT STATE HEARING:
A State Hearing related to the denial of either a beneficiary or provider request for reimbursement.

DENTAL SCOPE STATE HEARING:
A State Hearing related to the denial of a request for a dental service.

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DENY:
To determine in document processing, that a requested or billed service(s) is not allowable or payable because it does not meet Medi-Cal requirements for authorization or payment.

DEPARTMENT:
In the contract, refers to the State of California Department of Health Care Services (DHCS) and interchangeable with DHCS.

DEPARTMENT OF HEALTH AND HUMAN SERVICES:
The federal agency responsible for management of the Medicaid program.

DEPARTMENT OF HEALTH CARE SERVICES:
The single state agency responsible for administration of the Medi-Cal, CMSP, CCS, GHPP, and CHDP programs. It also has responsibility for other health-related programs administered through DHCS. The Department acts for the State of California as the contract entity. Department/State actions are taken by the Contracting Officer or his or her designee. In the contract, Department and DHCS are interchangeable.

DETAILED DESIGN SPECIFICATIONS:
Those documents that contain the technical description of the configuration, components and operation of CD-MMIS.

DHCS PROGRAMS:
All programs currently administered by the Department of Health Services, or potentially to be administered by the Department under the contract resulting from this RFP and/or system change documents such as SDNs. These programs include those under which billing is made to the Medi-Cal FI for all Medi-Cal dental provider types currently billed to the CD-MMIS. Further, this includes such programs as CMSP, CHDP, CHDTP, CCS, and GHPP.

DISALLOW:
Private insurance companies and government programs may not pay (may disallow) certain costs claimed by providers. Under private insurance, the patient may be responsible for picking up the difference. (Medi-Cal does not permit the provider to bill the patient except for recipient liability as defined by the State)

DISASTER:
A sudden calamitous event bringing great damage, loss, or destruction.

DISKETTE:
For purposes of the contract, a diskette, either three and one half inches (3 ½“) or compact disk (CD) in a density specified by the Department, for use on PCs.

DISPUTE:
A controversy arising under the contract between the Department and the Contractor regarding the Contracting Officer's determinations concerning the terms and conditions and contractual obligations embodied in the contract.

DOCUMENT CONTROL NUMBER:
A unique number assigned to each claim/TAR, used to identify the claim throughout processing. The number includes the Julian date of receipt by the Contractor.

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DOWNTIME:
The period of time that CD-MMIS is unavailable or "inhibited" to a State user or a State user terminal.

EARLY, PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM (EPSDT):
A federal program that has been expanded by the State and is delivered through the State CHDP Program. This program screens children under age twenty-one (21) and refers those needing diagnosis and treatment for services. In about 1996 the EPSDT program became much larger in scope to embrace all treatment services for children under the age of twenty-one (21), even if such needed treatments are not specific in the State Plan.

EDIT:
An examination in the claims processing subsystem of data on a document performed to ensure application of program policy. Edits include examination for such things as completeness and validity of data, recipient and provider eligibility, and necessity for manual pricing and dental consultant review.

EDITS/AUDITS:
In the claims processing system, edits are performed daily to validate the document against validity requirements or CD-MMIS support files. Audits are performed daily to validate the document against history.

ELECTRONIC MEDIA:
Methods of delivering or storing data via electronic or electromechanical energy.

ELECTRONIC MEDIA DOCUMENT:
Claims processing documents, sent to and from the FI, which are in machine-readable format on electronic media. EMDs include documents that are on magnetic tape, tape cartridges, diskette, or transmitted via modem.

ELIGIBILITY HISTORY FILE:
A computer file maintained by DHCS, which contains the current plus previous seventeen (17) months of eligibility status for all persons determined to be eligible for Medi-Cal benefits.

EMERGENCY SERVICES:
Means dental care services rendered by an eligible Medi-Cal provider to a Medi-Cal beneficiary for any condition, in which the beneficiary is in danger of loss of life, serious injury or illness, or is experiencing severe pain and suffering.

ENCOUNTER DATA:
Encounter data is the record of a face-to-face delivery of a dental (or medical) service or supply by a managed care health care provider on a given date of service.

ENROLLMENT AND CERTIFICATION:
The application process for a dentist who wishes to become a provider of services under the California Medi-Cal Dental Program.

ENTERPRISE SERVICE MANAGEMENT PROCESS:
A formal process including automated tools to support the State's effort to manage and report on all relationships and the overall performance of the supplied Contractor services. The

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Contractor must establish the contract methodology, tools, expectations and requirements that will be used to ensure regular review and assessment of the Contractor provided services.

ERRONEOUS PAYMENT CORRECTION:
Refers to a re-adjudication of claims that share a set of specific parameters and were originally adjudicated improperly.

ESCROW ACCOUNT:
The Escrow account holds all documentary information developed by the Contractor in preparation of bid prices for this procurement.

ESCROW BID DOCUMENTS:
Escrow Bid Documents are those documents used to assist in the negotiation for the settlement of claims, in the resolution of disputes, and in Charge Order pricing. They will not be used for pre-award evaluation of the bidder's anticipated method of operation, or to assess the Contractor's qualifications for performing the work. The successful bidder agrees, as a condition of award of the contract, that the Escrow Bid Documents constitute all of the information used in preparation of the bid, and that no other bid preparation information will be considered in resolving claims. Nothing in the Escrow Bid Documents shall change or modify the terms or conditions of the contract. Escrow Bid Documents are due at the bid submission date.

EVALUATION ELIGIBILITY PERIOD:
The time period from the date of application for Medi-Cal to the date of determination of eligibility (BIC issue date).

EXCEPTIONAL PROCESSING INSTRUCTION:
Directive by the Department to temporarily alter current processing procedures.

EXECUTIVE DIRECTOR:
The primary point of contact with the State's Contracting Officer for activities related to contract administration, overall project management and scheduling, correspondence between the State and Contractor, dispute resolution, personnel issues with Contractor staff, and status reporting to the State. The Executive Director also leads and coordinates the Contractor's implementation activities including implementation evaluation, training, coaching, mentoring, reporting, and recommendation activities; he or she shall remain assigned to the contract for a period of not less than three (3) years.

EXPANDED ACCESS TO PRIMARY CARE:
The purpose of the EAPC program is to improve the quality and expand the access of outpatient health care for medically indigent persons residing in under-served areas of California.

EXPANDED FUNCTION AUXILIARY:
A person who may perform dental supportive procedures authorized by the provisions of the 1982 Dental Practice Act (see Business and Professions Code section 1741(e),).

EXPLANATION OF BENEFITS:
This is the term previously utilized to describe the itemized list of all adjudicated claims by line item, reflecting any cutbacks and denials with an explanatory code and any accounts receivable activity. Also provides a listing of claims/TARs in suspense over eighteen (18) days.

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EXPLANATION OF MEDICARE BENEFITS:
An itemized list of adjudicated claim lines issued by Medicare carriers. Copy must accompany all hard copy crossover claims submitted for Medi-Cal residual payment.

EXTERNAL QUALITY REVIEW GROUP:
A group of California School of Dentistry faculty members responsible for conducting annual reviews of the Contractor's Dental Consultants' professional judgment/decisions.

FACILITY:
The physical building site(s) used by Contractor to perform CD-MMIS operations.

FAME:
See FISCAL INTERMEDIARY ACCESS of MEDI-CAL ELIGIBILITY

FEDERAL FINANCIAL PARTICIPATION:
That portion of Medi-Cal funding provided by the Federal Government. The FFP must be matched by a varying percentage of State funds.

FEE-FOR-SERVICE:
Reimbursement on a fixed-fee basis for each encounter or service rendered.

FEE SCHEDULE:
A listing of established allowances for specified dental procedures. As used in Medi-Cal, it represents the maximum amounts the program will pay for the specified procedures. See also SCHEDULE OF MAXIMUM ALLOWANCES (SMA).

FILE:
Used to describe 1) A collection of many occurrences of the same type of records commonly referred to as a data set. Entity type that refers to magnetic tape, cartridges, disk storage both sequential and direct access and other non-database files. 2) Logical unit of database storage.

FISCAL INTERMEDIARY:
In California, a Contractor who performs Medi-Cal and other health program claims processing and management reporting functions for DHCS.

FISCAL INTERMEDIARY ACCESS OF MEDI-CAL ELIGIBILITY:
A file used by the FI to determine a patient's Medi-Cal eligibility. An abbreviated version of the MEDS (Medi-Cal Eligibility Data System) file.

FISCAL YEAR:
Any twelve (12)-month period for which annual accounts are kept. The State fiscal year is July 1 through June 30; the federal fiscal year is October 1 through September 30.

FIXED COSTS:
Costs that do not change with fluctuations in enrollment, in utilization of service, or in Medi-Cal billings.

GAP ANALYSIS:
Assessment or comparison of actual performance to potential performance.

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GENERAL SYSTEM DESIGN:
The federal Title XIX (Social Security Act) standards against which a state's Medicaid system is compared for certification for increased levels of FFP.

GENERAL TERMS AND CONDITIONS:
Specifies the term and requirements of the contract applicable throughout the life of the contract.

GENETICALLY HANDICAPPED PERSONS' PROGRAM:
The health program that provides medical services to persons with specific genetic conditions, such as hemophilia, cystic fibrosis, etc. GHPP clients must be twenty-one (21) years of age. Persons under that age are covered by California Children's Services (CCS). Persons under the age of twenty-one (21) with a specific GHPP eligible genetic condition may also be eligible for GHPP if they have first been determined financially ineligible to receive services from the CCS Program.

GEOGRAPHIC MANAGED CARE:
A managed care program in specific counties. The GMC program is designed to provide a choice of managed care providers, all of which are expected to assure access to comprehensive primary care, preventive care, specialty care, and other necessary health services. Under the GMC, designated eligible medical beneficiaries residing in GMC counties are required to enroll in a health care service plan participating in GMC. Other designated Medi-Cal beneficiaries may voluntarily enroll in these plans under the GMC or remain in the FFS Medi-Cal delivery system.

GUARANTEED PER CAPITA PURE PREMIUM RATE:
A single fixed monthly payment to the Contractor, for the number of persons eligible for Medi-Cal benefits each month. A fixed rate is paid per recipient to cover a specified package of services, regardless of actual utilization.

HEALTH CARE FINANCING AND ADMINISTRATION:
See Centers for Medicare and Medicaid Services

HEALTH CARE PLAN:
HCPs can be managed care capitated, FFS/MCN Pilot; or other health coverage (OHC). All three are treated uniquely in CD-MMIS, which uses the terms HCP (health care plan), managed care plan (MCP), and PHP (prepaid health plan) interchangeably. Unless the documentation specifically speaks to prepaid health plans, PHP, HCP, and MCP are one and the same for CD-MMIS purposes.

HEALTH and HUMAN SERVICES DATA CENTER:
Formerly the Health and Welfare Data Center (HWDC). The HHSDC provides information systems infrastructure, support, and training for HHS Agency programs and related needs.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996:
A federal law allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II of this law gives the Department of Health and Human Services authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical, dental, and administrative code sets should be used within those standards; to require the use of national identification systems for

health care patients, providers, payers and employers; and to specify the types of measure required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Cassenbaum Act, K2, or Public Law 104-191.

HEALTH MAINTENANCE ORGANIZATION:
The term "health maintenance organization" is specifically defined in the Health Maintenance Act of 1973 (Public Law 93-222) as a legal entity or organized system of health care that provides directly or arranges for a comprehensive range of basic and supplemental health care services to a voluntarily enrolled population in a geographic area on a primarily prepaid and fixed period basis. The term is sometimes used to denote any organized prepaid system; however, there are formal federal qualification procedures for official HMOs

HOLDTIME/WAITIME:
Defined as the time after a call reaches the Automated Call Distributor to the point where the call is answered by an operator.

IMMEDIATE NEED MEDI-CAL IDENTIFICATION CARD:
A paper Medi-Cal card produced by counties on an on-line printer, which allows a recipient's provider to verify eligibility and provide immediate-need medical services. Also given to minor consent recipients.

INCUMBENT:
The contractor who was responsible for executing the terms and conditions of the FI Contract Number 04-35745.

INFORMATION ASSET:
Policies, procedures, guidelines, and safeguards that protect data confidentiality and privacy rights, and ensure the integrity and availability of information systems.

INTERACTIVE VOICE RESPONSE SYSTEM:
Touch tone telephone system that providers may use as a primary source of check write, claim and prior authorization information for services rendered through the Medi-Cal program.

INTERIM PAYMENTS:
Special payments made in advance to providers, usually for unpaid claims that have been in the system due to Contractor or Department errors. These payments may be made only after evaluation on a case-by-case basis. Only DHCS staff can authorize interim payments.

INTERIM RESPONSES:
Preliminary analyses, priority designations, and identification of where the problem exists within the system.

INTERNALLY REPROCESSED TAR NON-BILLABLE:
A TAR that is reprocessed by the Contractor to allow processing of a subsequent TAR, due to a conflict in history.

INVALID CARD:
A BIC card that contains illegible, erroneous or missing data elements.

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INVITATION FOR BID:
The second step in the "modified multi-step" procurement process. This document contains specific instructions for the calculation and presentation of price bids, so that all bids can be judged on an equivalent basis. Only proposers who have submitted acceptable technical proposals (Step One) are issued an Invitation for Bid.

ISO/IEC 12207:2008:
Establishes a common framework for software life cycle processes, with well-defined terminology, that can be referenced by the software industry. It contains processes, activities, and tasks that are to be applied during the acquisition of a software product or service and during the supply, development, operation, maintenance and disposal of software products. Since this standard is updated each year, it is expected that the Contractor will upgrade the system to meet the standard/s which are current at that time.

ISO/SR1:
HCS Information Technology Security Standards – Information Systems Security Requirements for Projects JAVASCRIPT OBJECT LIBRARY: A library that helps developers implement flexible web applications. It is built utilizing client-side cross-browser compliant JavaScript.

JULIAN DATE:
Julius Caesar adopted the Julian calendar in 46 BC, consisting of a twelve (12)-month solar year of three hundred and sixty-five (365) days, with an extra day every fourth (4th) year. A Julian Date is the number of the day of the year, where each day is numbered consecutively from one (1) through three hundred and sixty-five (365) (or 366); e.g., January 10 would be 010.

LETTER OF INTENT:
Letter sent to the OMCP by a potential proposer expressing interest in submitting a technical proposal and identifying the prime Contractor, address, liaison person(s), and any proposed subcontractor(s).

LINE ITEM:
See CLAIM SERVICE LINE

MAGNETIC MEDIA:
A computerized form of data or information storage. Magnetic tape is an example of this form.

MAGNETIC TAPE/TAPE CARTRIDGE:
All RFP references to magnetic tape and tape cartridge shall mean tape cartridge when referring to State and Contractor data exchanges. Tape cartridges must be useable in IBM 3480 Tape drives. The standard for all data exchanges between the Contractor and the State shall be tape cartridges unless the Contracting Officer approves the use of computer tapes.

MAKE AVAILABLE:
Requirement that materials be available to appropriate personnel during normal business hours for both announced and unannounced review.

MANAGED CARE PLAN:
Each MCP receives a monthly fee, or per capita rate, from the State for every enrolled recipient. Medi-Cal beneficiaries enrolled in contracting MCPs must receive Medi-Cal benefits from plan providers rather than the FFS program, unless the services are excluded from plan coverage.

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Recipients who are enrolled in Medi-Cal managed care plans fall into one of the following managed care plan models:

1. Geographic Managed Care (GMC) – See GEOGRAPHIC MANAGED CARE

2. Prepaid Health Plans (PHP) – See PREPAID HEALTH PLANS

MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM:
The CD-MMIS subsystem that is designed to generate reports for program management and system monitoring.

MANUAL OF CRITERIA FOR MEDI-CAL AUTHORIZATION (DENTAL SERVICES):
The document which defines criteria per California Code of Regulations, Title 22 for the utilization of dental services under the California Medi-Cal Dental Program. It provides parameters to dentists treating Medi-Cal beneficiaries. It sets program benefits and clearly defines limitations, exclusions, and special documentation requirements.

MEASUREMENT ITEM:
Statistical indicators or parameters used for S/URS and created by users to select data from the history files. Measurement items organize and manipulate history file data into a desired form or pattern. There are four (4) types of MIs: 1) S-Type, or Summary, which count every identified occurrence; 2) U-Type, or Unduplicated Count; 3) C-Type, or Compute, which are algebraic expressions and use other MIs; and 4) T-Type or Title, which merely give a subheading in a report to break up data.

MEDICAID:
The federal medical assistance program enacted by the 1965 Title XIX amendments to the Social Security Act.

MEDICAID MANAGEMENT INFORMATION SYSTEM:
A set of federally developed guidelines and requirements for development and operation of Medicaid claims processing and information systems.

MEDI-CAL:
In California, the Title XIX Federal Medical Assistance Program (Medicaid) intended to provide federal and State financial assistance for health and medical, and dental care of needy persons meeting program eligibility standards.

MEDI-CAL CARD:
In the past this was a computer printed or hand-typed card issued to a person certified to receive Medi-Cal benefits. The card identifies the person as a Medi-Cal beneficiary and provides other information necessary to show Medi-Cal entitlements: Medicare coverage, limited service status, private prepaid health coverage, long term care, Share –of Cost, etc. This has been replaced by a permanent plastic beneficiary identification card (BIC). (See also IMMEDIATE NEED MEDI-CAL IDENTIFICATION CARD and BENEFICIARY IDENTIFICATION CARD)

MEDI-CAL ELIGIBILITY DATA SYSTEM:
The automated eligibility information processing system operated by the State which provides on-line access to county welfare departments, Social Security offices, and health and human

services staff throughout California. Major functions include benefits identification card issuance and update of recipient eligibility data. MEDS also maintains data on Medi-Cal health care plan enrollments and eligibility, private health insurance, Medicare, SOC, and Supplemental Security Income/State Supplemental Payments (SSI/SSP).

MEDI-CAL POINT OF SERVICE NETWORK INTERFACE SPECIFICATIONS:
Formal document which details the dial-up communication specifications for accessing the Medi-Cal Point of Service (POS) Network, and the format for the data transactions and responses that will flow through the network. This network is used to support on-line real time transactions for eligibility verification, SOC clearance, Medi-Service reservations, Family Pact transactions, pharmacy drug claims, and HCFA 1500 claims submission, via dial-up for low-volume or lease-line for high volume.

MEDI-CAL POLICY:
Medi-Cal Policy is defined in a number of documents including the California Statutes, Title 22, California Code of Regulations, Dental Operating Instruction Letters, Medi-Cal Dental Bulletin Updates, adopted Change Orders, the California Standard Nomenclature, the Dental Criteria Manual, Suspense and Error Handling Process, Professional and Paraprofessional Adjudication Manual, the Requirements Definition Manuals, and other CD-MMIS manuals.

MEDICAL REVIEW:
1. Suspended claim review by FI paraprofessional and professional personnel to obtain additional information if needed in order to approve, re-price, or deny a claim.
2. The function conducted by physician/nurse teams in the Medi-Cal field office (see TREATMENT AUTHORIZATION REQUEST).
3. The federally mandated program to ensure that Medi-Cal skilled nursing facility and intermediate care facility patients are at the appropriate level of care and that the care provided is of an acceptable quantity and quality. A Medical Review Team consisting of a physician, nurse, and social service consultant interviews patients and staff in every facility at least once a year.

MEDICALLY INDIGENT:
Persons previously eligible for Medi-Cal benefits not otherwise eligible for such benefits under the Public Assistance or Medically Needy Programs, because they did not meet the eligibility criteria for those programs. Most of the services provided under the adult portion of the MI program were one hundred percent (100%) State funded. Under legislation in 1982, responsibility for the MI over twenty-one (21) who are not in long term care facilities, or a woman of any age with a confirmed pregnancy, or a person under refugee medical assistance, was transferred to the counties. Some counties contract back to the State for payment of these services under the CMSP.

MEDICALLY NEEDY:
Persons who are determined to meet the eligibility criteria for cash welfare assistance in that they are aged, blind, disabled, or TANF-linked. However, they are disqualified for cash assistance because they refuse it, have excess earnings, income, or hours of employment, or are in long term care facilities. Some MNs have an SOC for their medical care.

MEDICARE:
The federally financed program under Title XVIII of the Social Security Act, which provides health insurance primarily for the aged, sixty-five (65) and over. It also covers persons eligible

for Social Security disability payments and for certain individuals who need kidney dialysis or transplantation.

1. PART A: Hospital Insurance Program - The compulsory portion of Medicare which automatically enrolls all persons aged sixty-five (65) and over; those entitled to benefits under OASDI or railroad retirement; persons under sixty-five (65) who have been eligible for disability for over two years; and insured workers (and their dependents) requiring renal dialysis or kidney transplantation. The program pays, after various cost-sharing requirements are met, for inpatient hospital care and care in skilled nursing facilities and home health agencies following a period of hospitalization. The program is financed from a separate trust fund funded with a contributory tax (payroll tax) levied on employers, employees and the self-employed. The Medicare program contracts with intermediaries to process claims under the program. The intermediaries determine amounts to be paid for claims based on set payment rates.

2. PART B: Supplementary Medical Insurance Program - The voluntary portion of Medicare in which eligible persons may become entitled to the services listed below. The program is financed from monthly premiums paid by persons insured under the program and a matching amount from federal general revenues. About ninety five percent (95%) of eligible people are enrolled. During any calendar year, the program will pay (with certain exceptions), eighty percent (80%) of the reasonable charges (as determined by the program) for all covered services, after the insured pays a deductible on the costs of such services. Covered services include physician services, home health care, medical and other health services, outpatient hospital services, and laboratory, pathology and radiology services. Any individual over sixty-five (65) may elect to enroll in Part B Medi-Cal buys Part B coverage for elderly, blind and disabled public assistance recipients and pays the premiums, deductibles and coinsurance on their behalf. The Medicare program contracts with carriers to process claims under the program. The carriers determine amounts to be paid for claims based on reasonable charges.

MEDS:
The Medi-Cal Eligibility Data System.

MEDS ID:
The SSN or pseudo-SSN; used in the State Medi-Cal Eligibility Data System (MEDS) as the primary recipient identifier. In the CD-MMIS, the MEDS ID or pseudo-SSN assigned by the Contractor is the primary recipient identifier in the Contractor's system. The Medi-Cal label on computer issued cards has been changed to remove the fourteen digit BID and replace with the MEDS ID, a check digit, county code and the aid code.

MILESTONE:
A significant point in development.

MODIFIED MULTI-STEP:
A procurement process involving several separate steps.

MOST RECENT DOCUMENT CONTROL NUMBER:
The document control number assigned to a Notice of Authorization (NOA) or Resubmission Turnaround Document (RTD) when each is returned to the Contractor for processing.

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NEGATIVE BALANCE:
A condition that can occur during a payment process when a provider has negative adjustments that exceed the amount of payment due him. The result is a "negative" balance for the provider.

NOTICE OF AUTHORIZATION:
The document generated by the computer when a Treatment Authorization Request (TAR) is fully adjudicated. This document 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 adding service dates, provider signature or initials and returned to the Contractor as a claim for processing, often referred to as a claim at this point, completes the NOA.

NOTICE OF CLAIM:
The contract provides that the Contractor may bring to the attention of the Contracting Officer, through specified procedures, a claim for adjustment to the price or performance schedule if the Contractor believes that an event or set of circumstances warrants such adjustment.

ON ASSIGNMENT:
An agreement in which a patient assigns to another party, usually a provider, the right to receive payment from a third-party for the service the patient has received. Assignment is used instead of a patient paying directly for the service and then receiving reimbursement from public or private insurance programs. In Medicare, if a dentist accepts assignment from the patient, he must agree to accept the program payment as payment-in-full (except for specific coinsurance, co-payment and deductible amounts required of the patient). Where Medi-Cal has paid for care and a third party legal or contractual asset is available, Medi-Cal has first right to that asset.

ON REQUEST:
A provision requiring the Contractor to provide, within state-defined timeframes, a specific product or service at the direction of the Contracting Officer as a part of the fixed-price contract. On-request reports are provided the next workday after request.

ON-LINE:
A CD-MMIS function that allows the user (State or Contractor) to have terminal/CRT access to computer maintained files and/or reports. This access may be a read-only function or have update intent, as required.

OPTIONAL CONTRACTUAL SERVICES:
Proposed methods of providing contract services beyond those required in the RFP which will improve contract administration, including methods to improve the fiscal intermediary's performance through system improvements.

OPTICAL CHARACTER RECOGNITION:
A high-speed automated process in which machine-printed (and sometimes hand printed) words, letters, numbers and symbols are recognized and translated into computer processable information. Thus, data is entered into the computer without the necessity of key entry.

OTHER COVERAGE, OTHER HEALTH COVERAGE:
The responsibility of insurers other than Medi-Cal to pay legal or contractual entitlements to health care. (W&I Code, Section 10020, et seq, and Section 14024.) Typically, the provider must bill the other health coverage before billing Medi-Cal. See also THIRD PARTY LIABILITY

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OVERRIDE:
A manual exemption of a specific data element on a claim/TAR from the application of a prescribed edit/audit during suspense processing. No automated exemptions are allowed.

P FACTOR:
Percentage of connected calls versus non-connected calls and/or busy signals.

PARAPROFESSIONAL:
Person who is not a licensed dentist but who has experience in a dental office (or the equivalent) in the direct provisions of services to patients and has the ability to read and identify radiographs (e.g., Dental Assistant, Registered Dental Assistant, and Dental Hygienist).

PEER REVIEW:
Generally, the evaluation by other members of the same specialty or profession of the appropriateness, effectiveness and efficiency of services ordered or performed by the provider under review.

PENDED CLAIMS:
All claims within the automated system that has not reached final adjudication status. This includes suspended claims and claims approved but waiting checkwrite.

PER DIEM RATES:
The daily rate established for a facility to provide specific and/or all-inclusive services to a Medi-Cal recipient. The rate is established through application of an approved reimbursement formula or by special negotiation.

PER CAPITA RATE:
Same as CAPITATION FEE

PERMANENT ID NUMBER:
The ID number under which a recipient's complete claims history is filed or cross-referenced. At this time, the permanent ID is the beneficiary's first Social Security number known to the CD-MMIS: either the real SSN or the Contractor-issued pseudo-Social Security number.

PILOT PROJECT:
By legislative mandate or under the provisions of the W&I Code, DHCS establishes pilot projects to evaluate the feasibility and cost effectiveness of providing dental care through innovative delivery systems.

POINT OF SERVICE DEVICE (or T-7):
Terminal/device used by providers to submit electronic eligibility, SOC, Medi-Services, FPACT, and pharmacy transactions to the FI. See also CALIFORNIA ELIGIBILITY VERIFICATION AND CLAIMS MANAGEMENT SYSTEM (CA-EV/CMS)

POINT OF SERVICE NETWORK:
A network that enables providers to perform eligibility, SOC, and Medi-Services transactions for Medi-Cal and CMSP recipients using a POS (T7) device, Claims and Eligibility Real Time Software (CERTS), the Internet, or through approved user-developed/modified systems.

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The eligibility verification systems will confirm or deny a beneficiary's eligibility; provide information on SOC, other coverage, and PHP status; and identify any service restrictions that have been placed on that recipient. Periodically, changes in the Medi-Cal program will require that the messages be modified, deleted or added. For example, a new service restriction might be added, or a health care plan's telephone number may change. Addition and deletion of health care plan numbers are also required.

PORTFOLIO MANAGEMENT:
Selection and management of all of an organization's projects, programs and related business activities.

POST ELIGIBILITY PERIOD:
The eligibility period after the BIC has been issued to the beneficiary.

POSTSERVICE PREPAYMENT REVIEW:
A review by the FI for medical necessity and program coverage after service was rendered but before payment is made. Payment may be withheld or reduced if the service rendered was inappropriate.

POSTPAYMENT RECOVERY:
A process to recover monies, which have been paid for a Medi-Cal recipient when that recipient was covered for that service by a liable third party. The Postpayment Recovery method is used when cost avoidance is federally excluded for persons with Other Health Coverage codes A, M, X, Y, or Z, for preventive pediatric services, and for the cost of services provided to persons who are retroactively identified with other health coverage.

PREPAID HEALTH PLAN:
One type of managed care health care plan. An organized system of health care, which guarantees to provide one or more medical services for an enrolled group of people for a fixed, prepaid period payment. This term describes some programs that contract with DHCS to provide services to Medi-Cal recipients on a prepaid basis. See also HEALTH CARE PLAN

PRIOR AUTHORIZATION:
See TREATMENT AUTHORIZATION REQUEST (TAR)

PROBLEM CORRECTION SYSTEM:
A system that receives, process, tracks, and reports on all problem statements issued by the Department and/or Contractor.

PROBLEM STATEMENT:
The PSs are written to identify a potential problem with supporting data to initiate evaluation and resolution of each problem within the Contractor's Operation of CA-MMIS. PSs shall be used by the Department and Contractor staff for documenting all problems identified.

PROFESSIONAL:
A California-licensed dentist.

PROFESSIONAL REVIEW ORGANIZATION:
Federally funded organizations charged with comprehensive and ongoing quality review of services provided under the Medicare and Medicaid programs.

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PROFILE/PROFILING:
A statistical description of program activity in accordance with State-defined parameters. The process is a method of detecting areas/instances of potential abuse or misutilization. Activity may be described for individual Medi-Cal program participants, a class of participants, or by diagnosis, or a dental provider.

PROGRAM DIRECTOR:
See EXECUTIVE DIRECTOR

PROJECT MANAGEMENT PLAN:
A formal, approved document that defines how the project is executed, monitored, and controlled. It may be summary or detailed and may be composed of one or more subsidiary management plans and other planning documents.

PROOF OF ELIGIBILITY:
Verification that a beneficiary is certified eligible to receive benefits for a specific month.

PROOF OF PAYMENT:
A receipt or account ledger showing payment for dental services rendered.

PROPOSER:
A firm that submits or plans to submit a narrative or cost proposal in response to the RFP.

PROVIDER:
Any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agent of any partnership, group association, corporation, institution, or entity, that provides services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary and that has been enrolled in the Medi-Cal Program.

PROVIDER IDENTIFICATION NUMBER:
PIN to be used to access the telephone response system on a touch-tone telephone. The PIN identifies the provider as an authorized user and is the first data requested by the network to locate checkwrite, claim, prior authorization and continuing care recipient information in the system.

PROVIDER MANUALS/HANDBOOKS/BULLETINS:
Provider manuals and/or provider bulletins contain information to providers regarding Medi-Cal dental procedures, policy, statutes and regulations. The provider manual is updated by bulletins that replace outdated pages with current Medi-Cal information.

PROVIDER MASTER FILE:
The on-line file (database), which, contains a record for each dentist or dental group certified to provide services under the Medi-Cal fee-for-service program. The file also includes rendering providers, providers who are suspended from participation in the program, and those placed on special prepayment review, including special prior authorization review. The file is used in the daily payment of provider claims and for accomplishing various MARS and S/URS reporting.

Appendix 4
Glossary of Terms

PROVIDER RELATIONS ORGANIZATION:
Contractor employees dedicated to this function, and whose sole purpose is and whose work responsibilities are exclusively dedicated to provider relation's functions. These functions include responses to provider inquiries via correspondences and/or on-site visits.

PSEUDO MEDS ID:
A pseudo SSN is generated by the Medi-Cal Eligibility Data System (MEDS) when the MEDS user adds an individual to MEDS without a real SSN. It is nine digits in length, beginning with an eight (8) or nine (9) and ending with a "P."

QUALITY MANAGEMENT/QUALITY ASSURANCE:
Ensuring that all the activities within the contract are effective and efficient with respect to the system and its performance.

QUALITY MANAGEMENT UNIT:
Contractor employees who coordinate and conduct quality management activities for Contractor staff. They provide reactive measurement and reporting of system performance and proactive policy review and recommendations.

RECIPIENT:
A person enrolled in and eligible for benefits under the Medi-Cal program. This term is used interchangeably with "beneficiary."

RECIPIENT ELIGIBILITY HISTORY FILE:
This is the recipient file(s) and database used for claims adjudication, which the Contractor constructs from the State's Eligibility History File and MEDS update.

RECIPIENT ID NUMBER:
The recipient ID number is used in the current contract to mean the recipient Social Security number (SSN) or pseudo SSN. It is the nine (9)-digit number assigned by the federal Social Security Administration (SSA) and required for all Medi-Cal eligibles. The State MEDS system will assign a pseudo SSN to recipients who have not yet been assigned a number by SSA or who are eligible to obtain one. The pseudo SSN is nine (9) digits in length, beginning with an eight (8) or nine (9) and ending with a "P." For purposes of locating recipient claims history prior to the current contract, the recipient ID was the beneficiary ID number assigned by the county. (See BENEFICIARY ID NUMBER.)

RECOVERY POINT OBJECTIVE:
The acceptable point in time to which data must be recovered after a disaster as defined by DHCS.

RECOVERY TIME OBJECTIVE:
The duration of time and a service level within which a business process must be restored after a disaster in order to avoid unacceptable consequences associated with a break in business continuity.

REIMBURSEMENT INVOICE FORM:
The form used to submit an invoice to the Department for direct beneficiary reimbursement.

Appendix 4
Glossary of Terms

RELEASE MANAGEMENT:
Software engineering process intended to oversee the development, testing, deployment and support of software releases. The practice of release management combines the general business emphasis of traditional project management with a detailed technical knowledge of the systems development lifecycle (SDLC) and IT Infrastructure Library (ITIL) practices.

REMITTANCE ADVICE DETAIL:
An itemized list of all adjudicated claims by line-item, reflecting any cut-backs and denials with an explanatory code and any accounts receivable activity. Also provides a listing of claims in suspense over thirty (30) days. This is sent to all providers with claim activity.

REMOTE JOB ENTRY:
Submission of jobs through an input unit that has access to a computer through a data link.

REPLACE AND SUBSTITUTE:
Modifications of procedure codes submitted by the provider on the claim/TAR form. The Contractor may replace (modify) the submitted procedure code to another dental procedure code(s) using the guidelines specified in the Professional/Paraprofessional Adjudication Manual.

REQUEST FOR PROPOSAL:
The document that describes to prospective proposers the requirements of the FI system, terms and conditions of the contract, and technical information.

REQUIREMENT, CONTRACT REQUIREMENT:
Any service, deliverable, or other duty that the Contractor is required to provide or perform under the contract.

RESUBMISSION TURNAROUND DOCUMENT:
The system generated document duplicating a suspended TAR or claim. This is sent to the provider for corrections and/or additional information. It is then returned to the FI for processing.

RETRO ELIGIBILITY PERIOD:
The three (3) month period before a beneficiary applies for Medi-Cal.

RETROACTIVE RATE CHANGE:
A re-adjudication of paid claims using a new rate, which may be necessitated by policy changes, budgetary statutes, lawsuits or other reasons. For the period covered by the rate change, the re-adjudication may result in either an increase, decrease or no change in the amount previously paid.

RUNNING CALENDAR YEAR:
Period of time covering twelve (12) consecutive months beginning with a month and continuing through the twelve (12)-month period with no exceptions.

RUNOUT:
Runout is defined as the last two (2) months of the Contract Operations Pure Premium Period and the fifteen (15) months immediately following the last day of the Contract Operations Pure Premium Period, for a total length of seventeen (17) months. During Runout, the Contractor shall complete its contractual obligations and fulfill its contractual liabilities in accordance with the provisions and requirements of this contract, and provide all services and activities

necessary from startup of TAR processing by the successor contractor through the end of this contract. Runout consists of Runout Startup, Runout Processing, and Contract Closeout.

SCHEDULE OF MAXIMUM ALLOWANCES:
A listing of procedure/ service codes with descriptions and a maximum reimbursement amount. Rates are determined by DHCS and published in Title 22 of the California Code of Regulations.

SELF-DEALING:
For purposes of the contract, the term “self-dealing” refers to a possible conflict between the Contractor's duty and self-interest. For example, self-dealing occurs if the Contractor prepares and submits claims for Medi-Cal providers to itself as the FI. In this circumstance, the Contractor's FI duty could require a decision against the shared interest of a provider-client. In addition, special knowledge gained as the FI could be used to benefit provider-clients to the detriment of the State.

SENIOR MANAGEMENT:
Key staff who meets the required minimum qualifications and whose names and resumes with names of backups should be presented in the proposal.

SHARE-OF-COST:
The monthly dollar amount, which Medi-Cal beneficiaries in certain aid categories must pay or obligate toward medical or dental services prior to becoming eligible for Medi-Cal benefits. Also called the "recipient liability."

SHORT-DOYLE PROGRAM:
Community Mental Health Services, which are administered by the Department of Mental Health.

SPECIAL CLAIMS REVIEW (SCR):
The process whereby a provider, identified as a program abuser, will have claims subject to manual review for those services previously "abused.”

STATE:
The State of California. The State acts through the Department of Health Services (DHCS), with the Department as the contract entity, and through a single Contracting Officer. Several other State agencies work closely with the Contractor

STATE CONTROLLERS OFFICE:
State constitutional officer and agency responsible for issuing provider payment warrants, RADs, and no-pay documents to providers.

STATE HEARING DATABASE:
The Department database used to process and track State Hearings.

STATEWIDE INFORMATION MANAGEMENT MANUAL:
Contains instructions, forms and templates that State agencies must use to comply with Information Technology (IT) policy. Located at:
http://www.cio.ca.gov/Government/IT_Policy/SIMM.html

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Glossary of Terms

STATE WORKDAY:
Any day except Saturday, Sunday, a furlough day, or an officially recognized State holiday.

STATE WORKDAY HOURS:
Any State Workday between the hours of 8:00 a.m. and 5:00 p.m., Pacific Time.

STATISCALLY VALID SAMPLE:
A random sample developed in accordance with the American Statistical Association.

SUBCONTRACT:
Subcontract, as used in this Contract, means any Contract which is a mutually binding legal relationship obligating the seller to furnish the supplies, funds or services (including construction) to the Contractor for use in meeting the requirements of this Contract. It also includes any type of written commitment that is not a part of this Contract, but that can obligate the DHCS to an expenditure of appropriated funds.

SUBCONTRACTOR:
As used in the Contract, the term “subcontractor” shall include any individual or entity, whether or not affiliated with the Contractor, which enters into a subcontract with the Contractor, or any other subcontractor.

SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENT (SSI/SSP):
The eligibility program authorized by Title XVI of the Social Security Act for aged, blind, and disabled persons.

SYSTEM DESIGN DOCUMENTATION:
See DETAILED DESIGN SPECIFICATIONS

SYSTEM VARIANCE REPORTS:

SYSTEMS DEVELOPMENT GROUP:
See SYSTEMS GROUP

SYSTEMS DEVELOPMENT NOTICE:
The document used to notify the Contractor of development activities required of the Systems Group.

SYSTEMS GROUP:
Contractor employees who design, develop, and install state-required modifications to the CD-MMIS. They also are dedicated to processing erroneous payment corrections, doing emergency program maintenance, and working to final resolution the problem statements that require programming changes to the CD-MMIS.

SYSTEMS MAINTENANCE GROUP:
See SYSTEMS GROUP

Appendix 4
Glossary of Terms

T-7 or T-7Q Device:
Point of Service (POS) device used by providers to submit eligibility, SOC, Medi-Services, FPACT, and pharmacy transactions.

TAPE CARTRIDGE:
See MAGNETIC TAPE/TAPE CARTRIDGE

TAR FORM:
Form used by a provider to request prior authorization to render services to Medi-Cal beneficiaries. See TREATMENT AUTHORIZATION REQUEST

TELEPHONE SERVICE CENTER:
Formerly known as the TOLL-FREE TELEPHONE GROUP. Contractor work activity and responsibility is exclusively dedicated to telephone responses to provider and beneficiary inquiries received over telephone lines.

THIRD PARTY LIABILITY (TPL):
The responsibility of an individual or entity, other than the Medi-Cal program, for the payment of all or part of the medical/dental costs incurred because of illness, injury trauma, disease, or disability sustained by a Medi-Cal recipient. This liability may result from fault or negligence of such third parties (e g., auto accidents or other personal injury casualty claims or workers compensation appeals). The Department is responsible for follow-up and collection of third party liability payments where it has paid for related care.

THRESHOLD LANGUAGE:
A language identified by the Medi-Cal Eligibility Data System (MEDS) as the primary language of 3,000 beneficiaries or five (5) percent of the beneficiary population, whichever is lower, in an identified geographic area, per Title 9, CCR, Section 1910.410(f)(3).

TITLE 22:
Title 22, Division 3, of the California Code of Regulations contains the rules and regulations governing the Medi-Cal program. These regulations define and clarify the provisions of state statute, chiefly the Welfare and Institutions Code.

TITLE XIX (19):
That portion of the federal Social Security Act that authorizes the Medicaid program (Medi-Cal is California's Medicaid program).

TITLE XVIII (18):
That portion of the federal Social Security Act that authorizes the Medicare program.

TITLE XXI (21):
That portion of the federal Social Security Act that authorizes the Healthy Families program.

TOLL-FREE TELEPHONE STAFF:
Contractor employees whose sole purpose and work responsibility are exclusively dedicated to telephone activities generated by beneficiary or provider inquiries/ complaints.

Appendix 4
Glossary of Terms

TRANSMITTAL LETTER:
Letter from proposer transmitting the narrative proposal. The transmittal letter shall be on official business letterhead and signed by an individual authorized to legally bind the proposer.

TREATMENT AUTHORIZATION REQUEST:
A request submitted by the dental provider for authorization to provide specified service(s) to a recipient. TARs are received and processed by the Contractor.

TURNOVER:
The portion of the contract that constitutes the work requirements associated with the transfer of the CD-MMIS from the current Contractor at the end of the contract. Turnover and Runout are closely linked responsibilities.

USE:
See UTILIZATION

USER DOCUMENTATION:
Contractor developed State-approved formal instructions for the operation of the system and performance of contract duties.

USER GUIDE/MANUAL:
Contractor-developed, State-approved formal User Guides for providers and/or other State users detailing various access methods into CD-MMIS including but not limited to AEVS User Guide and POS Device User Guide.

UTILIZATION:
Utilization is commonly examined in terms of patterns or rates of use of a single service or type of service. Measurement of utilization of all services in combination is usually done in terms of dollar expenditures. “Use” is expressed in rates per unit of population at risk for a given period.

VERIFICATION OF ELIGIBILITY:
Eligibility for the California Medi-Cal dental program is determined by each social services office and reported to the State of California. The State, in turn, issues a Medi-Cal Identification Card (BIC) to beneficiaries. Beneficiary eligibility information is immediately available through the Medi-Cal automated Eligibility Verification System (AEVS). This system is updated daily based on information received from the State.

WEB PORTAL:
A site that provides a single function via a web page or site. Web portals often function as a point of access to information on the World Wide Web. Portals present information from diverse sources in a unified way. Aside from the search engine standard, web portals offer other services such as e-mail, news, stock prices, infotainment and various other features. Portals provide a way for enterprises to provide a consistent look and feel with access control and procedures for multiple applications, which otherwise would have been different entities altogether.

WEB SERVICE:
A software system designed to support interoperable Machine to Machine interaction over a network. Web services are frequently just Web APIs that can be accessed over a network, such as the Internet, and executed on a remote system hosting the requested services.

Appendix 4
Glossary of Terms

WEIGHTING:
Method for assigning a relative proportion of the technical proposal score to plans and from the plans to criteria based on their importance and priority to the Department. These weights, and the maximum score allowed when added, will equal the total technical score available.

WELFARE AND INSTITUTIONS CODE:
The California code of law, which includes the Medi-Cal Act.

WORK(ING) DAY:
Any day the Contractor is open for business.

WORKERS COMPENSATION:
An insurance against liability imposed on certain employers to pay benefits and furnish care to employees injured, and to pay benefits to dependents of employees killed in the course of or arising out of their employment.

WORRY CRITERIA:
Established standards which, when exceeded, identify potential problem areas. Used in specific MARS Reports.

Appendix 5
Acronym List

#	Acronym	Meaning
1.	A&I	Audits and Investigations
2.	A/R	Accounts Receivable
3.	AB	Assembly Bill
4.	ACD	Automated Call Distributor
5.	ACF/2	Access Control Facility/2
6.	ACH	Adjudicated Claim History
7.	ACHF	Adjudicated Claim History File
8.	ACL	Adjudicated Claim Line
9.	ACS	Additional Contractual Services
10.	ACSL	Adjudicated Claim Service Line
11.	ADA	American Dental Association
12.	ADR	Automated Document Retrieval
13.	ADS	Application Development System
14.	AEVS	Automated Eligibility Verification System
15.	AFDC	Aid to Families with Dependent Children
16.	AHR	Aged History Reports
17.	AIIM	Association for Information & Image Management
18.	AKA	Also Known As
19.	ALJ	Administrative Law Judge
20.	ANSI	American National Standards Institute
21.	AOO	Assumption of Operations
22.	APD	Advance Planning Document
23.	AR	Accounts Receivable
24.	ASO	Administrative Services Organization
25.	BAA	Business Associate Addendum
26.	BCCTP	Breast and Cervical Cancer Treatment Program
27.	BCEDP	Breast Cancer Early Detection Program
28.	BCP	Base Control Program
29.	BIA	Business Impact Analysis
30.	BIC	Benefits Identification Card
31.	BID	Beneficiary Identification Number
32.	BRD	Business Requirements Document
33.	BRE	Business Rules Extraction
34.	BVMP	Base Volume Method of Payment
35.	CA-EV	California Eligibility Verification System
36.	CA-EV/CMS	California Eligibility Verification System and Claims Management System
37.	CALPOS	California Point of Service
38.	CA-MMIS	California Medicaid Management Information System
39.	CAP	Corrective Action Plan

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Acronym List

#	Acronym	Meaning
40.	CCC	California Civil Code
41.	CCIE	Cisco Certified Internetwork Expert
42.	CCN	Claim Control Number
43.	CCP	Cost Containment Proposals/Projects
44.	CCPI	California Consumer Price Index
45.	CCR	California Code of Regulations
46.	CCS	California Children's Services
47.	CD	Compact Disk
48.	CD-MMIS	California Dental Medicaid Management Information System
49.	CDR	Claim Detail Report
50.	CDRRN	CDR Requestor Numbers
51.	CDSS	California Department of Social Services
52.	CDT	Current Dental Technology
53.	CEAF	Commission Enterprise IT Architecture Framework
54.	CED	Contract Effective Date
55.	CERTS	Claim Eligibility Real Time System
56.	CFR	Code of Federal Regulations
57.	CHAMPUS	Civilian Health and Medical Program of the Uniform Services
58.	CHDP	Child Health and Disability Prevention Program
59.	CICS	Customer Information Control System
60.	CICS/TS	Customer Information Control System/Transaction Server
61.	CIF	Claims Inquiry Form
62.	CIN	Client Index Number
63.	CIO	Chief Information Officer
64.	CMC	Computer Media Claim
65.	CMD	Computer Media Document
66.	CMF	Comprehensive Management Facility
67.	CMH	County Mental Health
68.	CMHP	County Mental Health Plan
69.	CMIS	Case Management Information System
70.	CMS	Centers for Medicare and Medicaid Services
71.	CMSP	County Medical Service Program
72.	CMU	Contract Management Unit
73.	CN	Correction Notice
74.	COBRA	Consolidated Omnibus Budget Reconciliation Act
75.	COHS	County Organized Health Systems
76.	COM	Computer Output Microfilm (Microfiche)
77.	COPPP	Contract Operations Pure Premium Period

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Acronym List

#	Acronym	Meaning
78.	COS	Category of Service
79.	COTS	Commercial Off-The-Shelf
80.	CPA	Certified Public Accountant
81.	CPR	Cardio Pulmonary Resuscitation
82.	CPT	Current Procedural Terminology
83.	CPT-4	Common Procedural Terminology (4th Edition)
84.	CPU	Central Processing Unit
85.	CR	Cost Reasonableness
86.	CRC	Case Review Committee
87.	CRM	Customer Relationship Management System
88.	CRMS	Customer Relations Management System
89.	CRN	Correspondence Reference Number
90.	CRT	Cathode Ray Tube
91.	CT	Claim Type
92.	CTI	Computer Telephony Integration
93.	CTMS	Contact Tracking and Management System
94.	CTP	Children's Treatment Program
95.	CWL	Contract Waiver Letter
96.	CWR	Contract Waiver Request
97.	CWSP	Certified Wireless Security Professional
98.	DASD	Direct Access Storage Device
99.	DB/DC	Database/Data Communications
100.	DBA	Doing Business As
101.	DBC	Dental Board of California
102.	DBD	Database Design
103.	DC	Dental Consultant
104.	DCC	Data Control Center
105.	DCN	Document Control Number
106.	DD	Data Definition
107.	DD&I	Design, Development, and Implementation
108.	DDD	Detail Design Document
109.	DDI	Design, Development, and Implementation
110.	DDS	Detailed Design Specifications
111.	DED	Data Element Dictionary
112.	DELTA	Dental Plan of California
113.	DFSMS	Data Facilities Storage Management System
114.	DGS	Department of General Services
115.	DHCS	Department of Health Care Services
116.	DHHS	Department of Health and Human Services (federal)

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Acronym List

#	Acronym	Meaning
117.	DIMS	Document Imaging Management System
118.	DMC	Dental Managed Care
119.	DMH	Department of Mental Health
120.	DMS	Database Management System
121.	DOF	Department of Finance
122.	DOIL	Dental Operating Instruction Letter
123.	DOJ	Department of Justice
124.	DOS	Date of Service
125.	DPA	Department of Personnel Administration
126.	DPAG	Dental Policy Advisory Group
127.	DPD	Detailed Program Design
128.	DR	Disaster Recovery
129.	DRP	Disaster Recovery Plan
130.	DSD	Detailed System Design
131.	DSFH	Dental Scope Fair Hearing
132.	DSS	Department of Social Services
133.	DTMF	Dual Tone Multi Frequency
134.	DTSDC	Department of Technology Services Data Center
135.	DVBE	Disabled Veterans Business Enterprise
136.	E2E	End-to-End
137.	EAPC	Expanded Access to Primary Care
138.	ECC	Early Childhood Caries
139.	EDI	Electronic Data Interchange
140.	EDMS	Electronic Document Management System
141.	EDP	Electronic Data Processing
142.	EFT	Electronic Funds Transfer
143.	EIMS	Enterprise Image Management System
144.	EMC	Electronic Media Claims
145.	EMD	Electronic Media Documents
146.	EOB	Explanation of Benefits
147.	EOMB	Explanation of Medicare Benefits
148.	EOS	Enterprise Output Solution
149.	EPC	Erroneous Payment Correction
150.	EPCN	Erroneous Payment Correction Notification
151.	EPCS	Erroneous Payment Correction System
152.	EPI	Exceptional Processing Instruction
153.	EPLS	Excluded Parties List System
154.	EPM	Enterprise-Wide Project Management
155.	EPMO	Enterprise Project Management Office

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Acronym List

#	Acronym	Meaning
156.	EPSDT	Early Periodical Screening, Diagnosis and Treatment
157.	EPSDT-SS	Early and Periodic Screening, Diagnosis and Treatment Supplemental Services
158.	EQRG	External Quality Review Group
159.	EVC	Eligibility Verification Confirmation
160.	EVCOI	Eligibility Verification Other Intermediary
161.	FAME	Fiscal Intermediary Access of Medi-Cal Eligibility
162.	FAR	Federal Acquisition Regulations
163.	FAVER	Fast Virtual Export Restore
164.	FDB	First Data Bank
165.	FFP	Federal Financial Participation
166.	FFS	Fee for Service
167.	FFS/MCN	Fee for Service/Managed Care Network
168.	FH	Fair Hearing
169.	FI	Fiscal Intermediary
170.	FIPS	Federal Information Processing Standards
171.	FLA	First Level Appeal
172.	FPL	Federal Poverty Level
173.	FQHC	Federally Qualified Health Center
174.	FS	Final Select
175.	FTB	Franchise Tax Board
176.	FTE	Full-time-equivalent
177.	FY	Fiscal Year
178.	GAAP	Generally Accepted Accounting Principles
179.	GAO	General Accounting Office
180.	GFR	General Functional Requirements
181.	GHPP	Genetically Handicapped Persons Program
182.	GMC	Geographic Managed Care
183.	GSD	General System Design
184.	GUI	Graphical User Interface
185.	HAM	Health Administrative Manual
186.	HCFA	Health Care Financing Administration
187.	HCO	Health Care Options
188.	HCP	Health Care Plan (i.e., MCP)
189.	HCS	Health Care Services or Health Care Software
190.	HEDIS	Health Care Effectiveness Data and Information Set
191.	HF	Healthy Families
192.	HHSDC	Health and Human Services Data Center
193.	HIC	Health Insurance Claim
194.	HIDS	Host-Based Intrusion Detection System

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Acronym List

#	Acronym	Meaning
195.	HIPAA	Health Insurance Portability and Accountability Act
196.	HIPDB/NPDB	Healthcare Integrity and Protection Data Bank/National Practitioner Data Bank
197.	HIPP	Health Insurance Premium Payment
198.	HIS	Health Insurance System
199.	HLD	Handicapping Labiolingual Deviation
200.	HMO	Health Maintenance Organization
201.	I/O	Input/Output
202.	IBNR	Incurred But Not Reported
203.	ICF	Intermediate Care Facility
204.	ICN	Internal Control Number
205.	ICR	Intelligent Character Recognition
206.	ID	Identification (See BIC ID Number; HAP ID Number; PE ID Card Number; Recipient ID; MEDS ID.)
207.	IDD	Integrated Data Dictionary
208.	IDMS	Integrated Database Management System
209.	IEEE	Institute of Electronic and Electrical Engineers
210.	IFAR	Institutional Financial Audit Reports
211.	IFB	Invitation for Bid
212.	IHSS	In-Home Support Services
213.	IMP	Implementation Phase
214.	IMS	Image Management System
215.	IP	Internet Protocol
216.	IPO	Independent Project Oversight
217.	IR	Interim Response
218.	IRCA	Immigration Reform Control Act
219.	IRS	Internal Revenue Service
220.	ISO	International Organization for Standardization
221.	ISO/IEC 12207: 2008	Explained in Glossary
222.	ISO/SR1	Explained in Glossary
223.	ISP	Information Systems Plan
224.	ISPF	Interactive Systems Productivity Facility
225.	IT	Information Technology
226.	ITIL	Information Technology Infrastructure Library
227.	ITSD	Information Technology Services Division
228.	IV&V	Independent Verification and Validation
229.	IVR	Interactive Voice Response
230.	JAD	Joint Application Development
231.	JAR	Joint Application Requirements

Appendix 5
Acronym List

#	Acronym	Meaning
232.	JCL	Job Control Language
233.	JOBLib	JavaScript Object Library
234.	KDE	Key Data Entry
235.	LAN	Local Area Network
236.	LDD	Logical Design Document
237.	LEIE	List of Excluded Individuals/Entities
238.	LEP	Limited English Proficient
239.	LTC	Long Term Care
240.	MAR	Management Administrative Reports
241.	MARS	Management and Administrative Reporting Subsystem
242.	MCD	Miscellaneous Change Document
243.	MCM	Medical Case Management
244.	MCN	Managed Care Network
245.	MCO	Managed Care Organization
246.	MCP	Managed Care Plan
247.	MDS	Monthly Deliverable Status
248.	MDSD	Medi-Cal Dental Services Division
249.	MEDS	Medi-Cal Eligibility Data System
250.	MI	Medically Indigent
251.	MIS/DSS	Medi-Cal Information System/Decision Support System
252.	MITA	Medicaid Information Technology Architecture
253.	MMIS	Medicaid Management Information System
254.	MN	Manual
255.	MOC	Manual of Criteria
256.	MOS	Month of Service
257.	MRDCN	Most Recent Document Control Number
258.	MRP	Manual Replacement Page
259.	MVS	Multiple Virtual Storage
260.	NCP	Network Control Program
261.	NCQA	National Committee for Quality Assurance
262.	NIST	National Institute of Standards and Technology
263.	NOA	Notice of Action/Authorization
264.	NP	Narrative Proposal
265.	NPI	National Provider Identifier
266.	NPPES	National Plan and Provider Enumeration System
267.	OASDI	Old Age, Survivors and Disability Income
268.	OBRA	Omnibus Budget Reconciliation Act
269.	OCR	Optical Character Recognition
270.	OCS	Optional Contractual Service

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Acronym List

#	Acronym	Meaning
271.	OES	Office of Emergency Services
272.	OHC	Other Health Coverage
273.	OI	Other Intermediary
274.	OIG	Office of Inspector General
275.	OLCC	Online Claim Correction
276.	OLS	Office of Legal Services
277.	OMB	Office of Management and Budget
278.	OMCP	Office of Medi-Cal Procurement
279.	OPC	Operations & Planning Control
280.	OS	Online Software or Operations Support
281.	OTECH	Department of Technology, Office of Technology Services
282.	PA	Prior Authorization
283.	PA/SCR	Prior Authorization or Special Claims Review
284.	PACT	Planning, Access, Care and Treatment
285.	PAG	Policy Advisor Group
286.	PAR	Preliminary Audit Report
287.	PBX	Private Branch Exchange
288.	PC	Personal Computer
289.	PCCM	Primary Care Case Management
290.	PCH	Pended Claims History
291.	PCI	Personal Confidential Information
292.	PCL	Paid Claims Listing
293.	PCP	Primary Care Provider or Physician
294.	PCS	Problem Correction System
295.	PDA	Project Definition and Analysis
296.	PDF	Procedure, Diagnosis and Formulary
297.	PDS	Partitions Data Sets
298.	PEAP	Provider Enrollment Automation Project
299.	PF	Provider File
300.	PHI	Protected Health Information
301.	PHP	Prepaid Health Plan
302.	PI	Personal Information
303.	PII	Personally Identifiable Information
304.	PIN	Personal Identification Number
305.	PIR	Post Implementation Review
306.	PM	Project Manager
307.	PMBOK	Project Management Body of Knowledge
308.	PMF	Provider Master File
309.	PMI	Project Management Institute

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Acronym List

#	Acronym	Meaning
310.	PMIF	Pooled Money Investment Fund
311.	PMP	Project Management Professional
312.	POA&M	Plan of Action and Milestone
313.	POAM	Plan of Action and Milestones
314.	POE	Proof of Eligibility
315.	POS	Point of Service
316.	PPAM	Paraprofessional/Professional Adjudication Manual
317.	PPF	Pure Premium Fund
318.	PPM	Postservice Prepayment Audit
319.	PPP	Pure Premium Period
320.	PR	Provider Relations
321.	PRA	California Public Records Act
322.	PRU	Provider Review Unit
323.	PS	Problem Statement
324.	PSF	Provider Sanctions File
325.	PST	Pacific Standard Time
326.	PT	Pacific Time
327.	PTN	Provider Telecommunication Network
328.	PTXR	Paid TAR Cross Reference
329.	QA	Quality Assurance
330.	QC	Quality Control
331.	QIP	Quality Improvement Program
332.	QM	Quality Management
333.	QMDC	Quality Management Dental Consultant
334.	QOS	Quality of Service
335.	QRC	Quality Review Committee
336.	R&S	Replace and Substitute
337.	RA	Remittance Advice
338.	RACF	Resource Access Control Facility
339.	RAD	Risk Assessment Deliverable
340.	RAF	Referral Authorization File
341.	RAQ	Risk Assessment/System Security Questionnaire
342.	RDHAP	Registered Dental Hygienist in Alternative Practice
343.	REHF	Recipient Eligibility History File (pre-FAME)
344.	RFI	Request for Information
345.	RFP	Request for Proposal
346.	RHC	Rural Health Clinic
347.	RIC	Request for Information/Clarification
348.	RJE	Remote Job Entry

Appendix 5
Acronym List

#	Acronym	Meaning
349.	RMM	Removal Media Manager
350.	RPO	Recovery Point Objective
351.	RRI	Recognition Research Incorporated
352.	RSD	Roger Software Development
353.	RTD	Resubmission Turnaround Document
354.	RTO	Recovery Time Objective
355.	S/URS	Surveillance and Utilization Review Subsystem
356.	SAEVS	Supplemental AEVS
357.	SAHR	Special Aged History Reports
358.	SAM	State Administrative Manual
359.	SANS	Security Administration Networking and Security
360.	SAR	Service Authorization Request
361.	SAS	Statistical Analysis System/Software
362.	SAS70	Statements of Audited Standards 70
363.	SAT	S/URS Activity Tracking
364.	SB	Situation Bulletin
365.	S-CED	Successor-Contract Effective Date
366.	SCO	State Controller's Office
367.	SCR	Special Claims Review
368.	SD	Systems Development
369.	SDLC	System Development Life Cycle
370.	SDN	Systems Development Notice
371.	SDSF	Systems Display & Search Facility
372.	SDX	State Data Exchange
373.	SFD	Specific Functional Design
374.	SFTP	Secure File Transfer Protocol
375.	SG	Systems Group
376.	SH	State Hearing
377.	SHDB	State Hearing Database
378.	SIA	Security Impact Assessment
379.	SID	State Integration Division
380.	SIEM	Security Information and Event Management
381.	SIMM	Statewide Information Management Manual
382.	SLA	Service Level Agreement
383.	SMA	Schedule of Maximum Allowances
384.	SMF	Systems Management Facility
385.	SMG	Systems Maintenance Group
386.	SMM	State Medicaid Manual
387.	SOA	Service Oriented Architecture

Appendix 5
Acronym List

#	Acronym	Meaning
388.	SOC	Share of Cost
389.	SOCMF	Share-of-Cost Master File
390.	SPF	Systems Productivity Facility
391.	SPG	Supplemental Processing Guide
392.	SPMP	Software Project Management Plans
393.	SPR	System Performance Review
394.	SRA	Security Risk Assessment/Assessor
395.	SS	Sample Select
396.	SSA	Social Security Administration
397.	SSADM	Structured Systems Analysis and Design Methods
398.	SSAE	Statement Standards for Attestation Engagements
399.	SSCP	Systems Security Certified Practitioner
400.	SSI	Supplemental Security Income
401.	SSI/SSP	Supplemental Security Income/State Supplemental Payment
402.	SSN	Social Security Number
403.	SSP	State Supplemental Payment
404.	STARS	Service Tracking Analysis Report System
405.	SURGE	Service, Utilization, Review, Guidance, and Evaluation
406.	S/URS	Surveillance and Utilization Review Subsystem
407.	SVR	System Variance Report
408.	SVS	Statistically Valid Sample(ing)
409.	T7	POS Network device
410.	TAR	Treatment Authorization Request
411.	TBIC	Temporary Benefits Identification Card
412.	TCP/IP	Transmission Control Protocol/Internet Protocol
413.	TDD	Telecommunication Device for the Deaf
414.	TIN	Taxpayer Identification Number
415.	TMJ	Temporomandibular Joint
416.	TNE	Tangible Net Equity
417.	TPL	Third Party Liability
418.	TS	Transaction Server
419.	TSC	Telephone Service Center
420.	TSD	Technical System Design
421.	TSO	Time Sharing Option
422.	TTD	text-telephone device
423.	UAT	User Acceptance Test
424.	UCR	Usual, Customary Reasonable Charges
425.	UI	User Interface
426.	UMD	Utilization Management Division

Appendix 5
Acronym List

#	Acronym	Meaning
427.	UPS	Uninterrupted Power Supply
428.	VSAM	Virtual Storage Access Method
429.	W&I	Welfare and Institutions Code
430.	WAN	Wide Area Network
431.	WAN/LAN	Wide Area Network/Local Area Network
432.	WBS	Work Breakdown Schedule
433.	WDE	Weekly Deliverable Exception
434.	WDS	Weekly Deliverable Status
435.	WIFI	Wireless
436.	WR	Work Request
437.	WSI	Web Static Inquiry
438.	WTD	Week-to-Date
439.	WTR	Work Turnover Report
440.	XOVER	Medicare Crossover Claims