STATE OF ARKANSAS

Department of Human Services
Office of Procurement
700 Main Street
Little Rock, Arkansas 72201

REQUEST FOR PROPOSAL

RFP SOLICITATION DOCUMENT

SOLICITATION INFORMATION			
Solicitation Number:	710-23-0081	Solicitation Issued:	September 20, 2023
Description:	Dental Managed Care		
Agency:	Department of Human Services, Division of Medical Services		

SUBMISSION DEADLINE			
Proposal Submission Date and Time	November 9, 2023 1:00 p.m., Central Time	Proposal Opening Date and Time:	November 9, 2023 2:00 p.m., Central Time

Proposals **shall not** be accepted after the designated bid opening date and time. In accordance with Arkansas Procurement Law and Rules, it is the responsibility of Contractors to submit proposals at the designated location on or before the bid opening date and time. Proposals received after the designated bid opening date and time **shall** be considered late and **shall** be returned to the Contractor without further review. It is not necessary to return "no bids" to the Office of Procurement (OP).

DELIVERY OF RESPONSE DOCUMENTS	
Drop off Address:	Arkansas Department of Human Services Attn: Office of Procurement 700 Main Street Slot W345 Little Rock, AR 72201
United States mail (USPS):	Arkansas Department of Human Services Attn: Office of Procurement P.O. Box 1437 Slot W345 Little Rock, AR 72203-1437
Commercial Carrier (UPS, FedEx, or USPS Exp):	Arkansas Department of Human Services Attn: Office of Procurement 112 West 8th Street, Slot W345 Little Rock, AR 72201 Delivery providers, USPS, UPS, and FedEx deliver mail to OP's street address on a schedule determined by each individual provider. These providers will deliver to OP based solely on the street address. **Prospective Contractors assume all risk for timely, properly submitted deliveries.**
Proposal's Outer Packaging:	Seal outer packaging and properly mark with the following information. If outer packaging of proposal submission is not properly marked, the package may be opened for proposal identification purposes. • Solicitation number • Date and time of proposal opening • Vendor's name and return address

OFFICE OF PROCUREMENT CONTACT INFORMATION			
OP Buyer:	Arnetia Dean	Buyer's Direct Phone Number:	501-683-5969
Email Address:	DHS.OP.Solicitations@dhs.arkansas.gov	OP's Main Number:	501-396-6045
DHS Website: OSP Website:	https://humanservices.arkansas.gov/do-business-with-dhs http://www.arkansas.gov/dfa/procurement/bids/index.php		

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1 GENERAL INFORMATION AND INSTRUCTIONS

- ***Do not** provide responses to items in this section unless specifically and expressly required.*

1.1 INTRODUCTION

This Request for Proposal (RFP) is issued by the Office of Procurement (OP) for the Arkansas Department of Human Services (DHS) to obtain pricing and contracts for the Arkansas Medicaid Dental Managed Care Services.

DHS is responsible for administering the Medicaid program in the State of Arkansas. The Division of Medical Services (DMS), a division of DHS, is conducting a procurement that will reprocure systems, services, and business processes for the Arkansas Medicaid Dental Managed Care Program.

The Arkansas Department of Human Services (DHS or the Department), Division of Medical Services (DMS or the Division), is planning to procure at least two, but no more than three Contractors who will provide, through a managed care model, comprehensive Dental Services under Arkansas Medicaid.

1.2 INTERGOVERNMENTAL/COOPERATIVE USE OF PROPOSAL AND CONTRACT

In accordance with Arkansas Code §19-11-249, this proposal and resulting contract is available to any State Agency or Institution of Higher Education that wishes to utilize the services of the selected proposer, and the proposer agrees, they may enter into an agreement as provided in this solicitation.

1.3 TYPE OF CONTRACT

A. As a result of this RFP, OP intends to award a contract to multiple Contractors.

A. The term of this contract shall be for one (1) year. The anticipated start date for the contract is December 1, 2023.Upon mutual agreement by the Prospective Contractor and agency, the contract may be renewed by OP, on a year-to-ear basis, for up to six (6) additional one-year terms or portions thereof.

B. The transition period is anticipated to be through April 30, 2024, with the Go-Live of any new Dental Managed Care Plans taking place on May 1, 2024.

C. The total contract term shall not be more than seven (7) years.

1.4 ISSUING AGENCY

The Office of Procurement (OP), as the issuing office, is the sole point of contact throughout this solicitation process. Vendor questions regarding this Bid Solicitation should be made through the Issuing Officer as shown on page one (1) of this document.

1.5 BID OPENING LOCATION

Bids submitted by the opening date and time will be opened via video conference. DHS will publish a link to the live bid opening on the DHS website for public access. Individuals will not be permitted to attend in-person. If the bid opening cannot be held as scheduled due to technical or other issues, DHS will publish an updated schedule and video conference link on the DHS website.

1.6 ACCEPTANCE OF REQUIREMENTS

D. The words “must” and “shall” signify a Requirement of this solicitation and that the Contractor’s agreement to and compliance with that item is mandatory.

E. A Contractor’s proposal will be disqualified if a Contractor takes exceptions to any Requirements named in this RFP.

F. Contractor may request exceptions to NON-mandatory items. Any such request must be declared on, or as an attachment to, the appropriate section’s Agreement and Compliance Page. Contractor must clearly explain the requested exception and should reference the specific solicitation item number to which the exception applies. (See Agreement and Compliance Page.)

G. DHS must not be required to accept any requested exceptions. Only exceptions expressly accepted by DHS will become part of the resulting contract.

1.7 DEFINITION OF TERMS

A. Unless otherwise defined herein, all terms defined in Arkansas Procurement Law and used herein have the same definitions herein as specified therein.

B. "Prospective Contractor," means a responsible offeror who submits a proposal in response to this solicitation.

C. "Prospective Contractor," "Contractor," "bidder," "vendor," and "respondent" are used synonymously in this document. For purposes of this RFP, Dental Managed Care Organization (DMO) may also be used synonymously in this document with these same terms.

D. The terms "buyer" and "Issuing Officer" are used synonymously in this document.

E. The terms "Request for Proposal," "RFP," "RFP Solicitation," "Bid Solicitation" and "Solicitation" are used synonymously in this document.

F. "Responsive proposal" means a proposal submitted in response to this solicitation that conforms in all material respects to this RFP.

G. "Proposal Submission Requirement" means a task a Prospective Contractor shall complete when submitting a proposal response. These requirements will be distinguished by using the term "shall" or "must" in the requirement.

H. "Requirement" means a specification that a contractor's commodity and/or service must meet or exceed in the performance of its contractual duties under any contract awarded as a result of this RFP. These specifications will be distinguished by using the terms "shall" or "must" in the requirement.

I. "State" means the State of Arkansas. When the term "State" is used herein to reference any obligation of the State under a contract that results from this solicitation, that obligation is limited to the State Department using such a contract.

J. Additional definitions as defined in Attachment B.

1.8 RESPONSE DOCUMENTS

A. Original Technical Proposal Packet

B. The following items are Proposal Submission Requirements and must be submitted in the original Technical Proposal Response Packet.

1. A hard copy of the original Technical Proposal Packet must be received on or before the bid submittal date and time. Copy should not be two sided.
2. The Proposal Packet should be clearly marked "Original" and must include the following:
    a. Original signed Proposal Signature Page. (See Proposal Signature Page.)
    b. Original signed *Agreement and Compliance Pages*. (See *Agreement and Compliance Pages.)*
    c. Original *Proposed Subcontractors Form.* (See *Subcontractors*.)
    d. EO 98-04 Disclosure Form. (See Attachment I.)
    e. *Technical Proposal* response to the *Information for Evaluation* section included in the *Technical Proposal Packet*.
    f. Original signed Client History Form (See Attachment N)
    g. Other documents and/or information as may be expressly required in this *Bid Solicitation*.
3. The following items should be submitted in the original *Technical Proposal Packet*.

h. Copy of Contractor's Equal Opportunity Policy. (See Equal Opportunity Policy.)

i. Signed addenda to this RFP, if applicable. (See Requirement of Addendum.)

j. Voluntary Product Accessibility Template (VPAT), if applicable. (See Technology Access.)

4. **DO NOT** include any other documents or ancillary information, such as a cover letter or promotional/marketing information.

C. *Official Bid Price Sheet*. (See Pricing.)

1. Contractor's original *Official Bid Price Sheet* **must** be submitted in hard copy format.

2. Contractor should also submit one (1) electronic copy of the *Official Bid Price Sheet*, in PDF format, preferably on a flash drive. A CD will also be acceptable. All items on flash drive or CD should be in PDF or Excel format.

3. The *Official Bid Price Sheet, Cost Proposal Template*, and Written Actuary Statement including the hard copy and electronic copy, **must** be separately sealed from the *Technical Proposal Packet,* and should be clearly marked as "Pricing." Vendor **must not** include any pricing in the hard copies or electronic copies of their *Technical Proposal Packet*.

D. Additional Copies and Redacted Copy of the Technical Proposal Packet

E. In addition to the original Technical Proposal Packet and the Official Bid Price Sheet, the following items should be submitted:

1. Additional Copies of the *Technical Proposal Packet*

k. Three (3) complete hard copies (marked "COPY") of the Technical Proposal Packet.

l. Four (4) electronic copy of the *Technical Proposal Packet*, preferably on flash drives. A CD will also be acceptable. All items on flash drive or CD should be in PDF format.

m. All additional hard copies and electronic copies **must** be identical to the original hard copy. In case of a discrepancy, the original hard copy **shall** govern.

n. One (1) redacted copy, in PDF format, if applicable, (marked "REDACTED") of the original *Technical Packet*, preferably on a flash drive. A CD will also be acceptable. *(See Proprietary Information.)*

o. If OP requests additional copies of the proposal, the copies **must** be delivered within twenty-four (24) hours of request.

2. Additional Copies of the *Official Bid Price Sheet and Cost Proposal Template*

a. Prospective Contractor should also submit one (1) electronic copy of the *Official Bid Price Sheet and Cost Proposal Template*, preferably on a flash drive and in PDF format. A CD will also be acceptable. Do not send electronic copies via email or fax.

b. *The Official Bid Price Sheet, Cost Proposal Template*, and Written Actuary Statement including the hard copy and electronic copy, **must** be separately sealed from the *Technical Proposal Packet,* and should be clearly marked as "Pricing." Prospective Contractor **shall not** include any pricing in the hard copies or electronic copies of their *Technical Proposal Packet*.

3. One (1) redacted (marked "REDACTED") copy the original Technical Proposal Packet, preferably on a flash drive and in PDF format. A CD will also be acceptable. Do not send electronic copies via email or fax. (See Proprietary Information.)

1.9 ORGANIZATION OF RESPONSE DOCUMENTS

A. It is strongly recommended that Contractors adhere to the following format and suggestions when preparing their Technical Proposal response.

B. The original Technical Proposal Packet and all copies should be arranged in the following order:

- *Proposal Signature Page*.
- All *Agreement and Compliance Pages*.
- Signed Addenda, if applicable.

- E.O. 98-04 – *Contract Grant and Disclosure Form*.
- *Equal Opportunity Policy.*
- *Proposed Subcontractors Form*.
- Other documents and/or information as may be expressly required in this *Bid Solicitation*. Label documents and/or information to reference the Bid Solicitation's item number.
- Technical Proposal response to the *Information for Evaluation* section of the *Technical Proposal Packet.*

1.10 CLARIFICATION OF RFP SOLICITATION

A. Contractor may submit written questions requesting clarification of information contained in this *Bid Solicitation.* Written questions should be submitted via email by 4:00 p.m., Central Time on or before September 29, 2023. Submit questions to the OP buyer as shown on page one (1) of this *Bid Solicitation*. It is the contractor's responsibility to guarantee receipt of the questions by the specific time and date. DHS accepts no responsibility for accurate or timely receipt of email submission.

B. The attached response template (*Attachment* H) should be used for submission of all written questions. For each question submitted, Vendor should reference the specific solicitation item number to which the question refers. Written questions submitted in a different format may not be answered by DHS.

C. Contractor's written questions will be consolidated and responded to by the State. The State's consolidated written response is anticipated to be posted to the OP website by the close of business on October 11, 2023.

D. Answers to verbal questions may be given as a matter of courtesy and **must** be evaluated at contractor's risk.

E. Oral statements by OP **shall not** be part of any contract resulting from this solicitation and **may not reasonably be relied on by any vendor as an aid to interpretation unless it is reduced to writing and expressly adopted by DHS**.

1.11 PROPOSAL SIGNATURE PAGE

A. An official authorized to bind the Contractor(s) to a resultant contract **must** sign the *Proposal Signature Page* included in the *Technical Proposal Packet*.

B. Contractor's signature on this page **shall** signify contractor's agreement that either of the following **shall** cause the contractor's proposal to be disqualified:

1. Additional terms or conditions submitted intentionally or inadvertently.
2. Any exception that conflicts with a Requirement of this *Bid Solicitation*.

1.12 AGREEMENT AND COMPLIANCE PAGES

A. Contractor **must** sign all Agreement and Compliance Pages relevant to each section of the Bid Solicitation Document. The Agreement and Compliance Pages are included in the Technical Proposal Packet.

B. Contractor's signature on these pages **shall** signify agreement to and compliance with all Requirements within the designated section.

1.13 SUBCONTRACTORS

A. Contractor **must** complete, sign, and submit the *Proposed Subcontractors Form* included in the *Technical Proposal Packet* to indicate contractor's intent to utilize, or to not utilize, subcontractors.

B. Additional subcontractor information may be required or requested in following sections of this *Bid Solicitation* or in the *Information for Evaluation* section provided in the *Technical Proposal Packet*. **Do not** attach any additional information to the *Proposed Subcontractors Form*.

C. The utilization of any proposed subcontractor is subject to approval by the State agency.

1.14 PRICING

A. Contractor(s) shall include all pricing on the Official Price Bid Sheet only**.** Any cost not identified by the successful contractor but subsequently incurred to achieve successful operation **shall** be borne by the Contractor. The *Official Bid Price Sheet* is provided as a separate PDF file posted with this *Bid Solicitation*.

B. Prospective Contractor's pricing must fall within the Per Member Per Month Composite Rate Range of $18.29 - $19.25. Pricing bid outside of this rate range shall be cause for rejection of a proposal.

C. Prospective Contractor **must** include a Written Statement by a qualified Actuary confirming the Per Member Per Month (PMPM) Composite Rate bid.

D. To allow time to evaluate proposals, prices **must** be valid for 180 days following the bid opening.

E. The *Official Bid Price Sheet*, Cost Proposal Template, and Written Actuary Statement including the hard copy and electronic copy, **must** be separately sealed from the *Technical Proposal Packet,* and should be clearly marked as "Pricing." DO NOT submit any ancillary information not related to actual pricing in the sealed pricing package. The *Official Bid Price Sheet* is provided as a separate file posted with this *Bid Solicitation*.

F. Contractor **must not** include any pricing in the hard copies or electronic copies of their *Technical Proposal Packet*. Should hard copies or electronic copies of their *Response Packet* contain any pricing, the response **shall** be disqualified.

G. Failure to complete and submit the *Official Bid Price Sheet and Cost Proposal Template* **shall** result in disqualification.

H. All proposal pricing **must** be in United States dollars and cents.

I. The Official Bid Price Sheet may be reproduced as needed.

1.15 PRIME CONTRACTOR RESPONSIBILITY

A. A single contractor **must** be identified as the prime contractor and shall be the sole point of contact.

B. The prime Contractor **shall** be held responsible for the contract and jointly and severally liable with any of its subcontractors, affiliates, or agents to the State for the performance thereof.

1.16 INDEPENDENT PRICE DETERMINATION

A. By submission of this proposal, the Contractor certifies, and in the case of a joint proposal, each party thereto certifies as to its own organization, that in connection with this proposal:

- The prices in the proposal have been arrived at independently, without collusion; and
- No prior information concerning these prices has been received from, or given to, a competitive company.

B. Evidence of collusion **shall** warrant consideration of this proposal by the Office of the Attorney General. All Contractors **shall** understand that this paragraph may be used as a basis for litigation.

1.17 PROPRIETARY INFORMATION

A. Submission documents pertaining to this *Bid Solicitation* become the property of the State and are subject to the Arkansas Freedom of Information Act (FOIA).

B. In accordance with FOIA and to promote maximum competition in the State competitive bidding process, the State may maintain the confidentiality of certain types of information described in FOIA. Such information may include trade secrets defined by FOIA and other information exempted from the Public Records Act pursuant to FOIA.

C. Contractor may designate appropriate portions of its response as confidential, consistent with and to the extent permitted under the Statutes and Rules set forth above, by submitting a redacted copy of the response.

D. By so redacting any information contained in the response, the Contractor warrants that it has formed a good faith opinion having received such necessary or proper review by counsel and other knowledgeable advisors that the portions redacted meet the requirements of the Rules and Statutes set forth above.

E. Under no circumstances will pricing information be designated as confidential.

F. One (1) complete copy of the submission documents from which any proprietary information has been redacted should be submitted on a flash drive in the *Technical Proposal Packet*. A CD is also acceptable. Do not submit documents via e-mail or fax.

G. Except for the redacted information, the redacted copy **must** be identical to the original hard copy, reflecting the same pagination as the original and showing the space from which information was redacted.

H. The Contractor is responsible for identifying all proprietary information and for ensuring the electronic copy is protected against restoration of redacted data.

I. The redacted copy **shall** be open to public inspection under the Freedom of Information Act (FOIA) without further notice to the Contractor.

J. If a redacted copy of the submission documents is not provided with Contractor's response packet, a copy of the non-redacted documents, except for financial data (other than pricing), **will** be released in response to any request made under the Arkansas Freedom of Information Act (FOIA).

K. If the State deems redacted information to be subject to FOIA, the Contractor will be notified of the State's determination prior to release of the documents.

L. The State has no liability to a Contractor with respect to the disclosure of Contractor's confidential information ordered by a court of competent jurisdiction pursuant to FOIA or other applicable law.

1.18 CAUTION TO CONTRACTORS

A. Prior to any contract award, all communication concerning this *Bid Solicitation* **must** be addressed through the OP buyer.

B. Contractor **must not** alter any language in any solicitation document provided by the State.

C. Contractor **must not** alter the Official Bid Price Sheet.

D. All official documents and correspondence related to this solicitation **shall** be included as part of the resultant contract.

E. Proposals **must** be submitted only the English language.

F. The State **shall** have the right to award or not award a contract, if it is in the best interest of the State to do so.

G. Contractor **must** provide clarification of any information in their response documents as requested by OP.

H. Qualifications and proposed services **must** meet or exceed the required specifications as set forth in this *Bid Solicitation*.

I. Contractors may submit multiple proposals. Each proposal shall be submitted separately and must include all documents and information required under this RFP to advance to evaluation.

1.19 REQUIREMENT OF ADDENDUM

A. This *Bid Solicitation* **shall** be modified only by an addendum written and authorized by OP.

B. Contractors are cautioned to ensure that they have received or obtained, and have responded to, all

addenda to the Bid Solicitation prior to submission of response.

C. An addendum posted within three (3) calendar days prior to the bid opening **shall** extend the bid opening and may or may not include changes to the Bid Solicitation.

D. The vendor **shall** be responsible for checking the websites listed on page one (1) for all addenda up to bid opening.

1.20 AWARD PROCESS

A. Award Determination

The Grand Total Score for each Contractor, which shall be the sum of the Technical Score and Cost Score, shall be used to determine the ranking of proposals. The State may move forward to negotiations pursuant to Arkansas Code Annotated § 19-11-230, with those responsible Contractors determined, based on the ranking of the proposals, to be reasonably susceptible of being selected for award.

B. Discussions and Negotiations

1. If the agency so chooses, it shall also have the right to enter discussion with the qualifying vendor(s), to further define contractual details. All such discussions shall be conducted at the sole discretion of the State and may be conducted at any lawful time of the State's choosing. The State shall solely determine the items to be discussed or negotiated.
2. If discussions or negotiations fail to result in a contract, the negotiation process may be repeated until an anticipated successful vendor(s) has been determined or an award made, or until such time the State decides not to move forward with an award.
3. The State may elect to request best and final offers. Any best and final offer request made by the State will be conducted with the responsible Contractors that meet the minimum qualifications in Section 2.2.

C. Anticipation to Award

1. Once the anticipated successful Contractor has been determined, the anticipated award will be posted on the websites listed on page one (1) of this RFP.
2. The anticipated award will be posted for a period of fourteen (14) days prior to the issuance of a contract. Contractors and agencies are cautioned that these are preliminary results only, and a contract will not be issued prior to the end of the fourteen-day posting period.
3. DHS **shall** have the right to waive the fourteen (14) day anticipated award posting period when it is in the best interest of the State.
4. It is the Contractor's responsibility to check the OP website for the posting of an anticipated award.

D. Issuance of Contract

1. Any resultant contract of this *Bid Solicitation* **shall** be subject to State approval processes which may include Legislative review.
2. A State Procurement Official will be responsible for award and administration of any resulting contract.
3. DHS reserves the right to award multiple contracts.

1.21 MINORITY AND WOMEN-OWNED BUSINESS POLICY

E. A minority-owned business is defined by Arkansas Code Annotated § 15-4-303 as a business that is at least fifty-one percent (51%) owned by a lawful permanent resident of this State who is:

- African American
- American Indian
- Asian American
- Hispanic American
- Pacific Islander American
- A Service-Disabled Veteran as designated by the United States Department of Veteran Affairs

F. A woman-owned business is defined by Arkansas Code Annotated § 15-4-303(9) as a business that is at least fifty-one percent (51%) owned by one (1) or more women who are lawful permanent residents of this State.

G. The Arkansas Economic Development Commission conducts a certification process for minority-owned and women-owned businesses. If certified, the Prospective Contractor's Certification Number should be included on the *Proposal Signature Page*.

1.22 EQUAL OPPORTUNITY POLICY

H. In compliance with Arkansas Code Annotated § 19-11-104, the State is required to have a copy of the anticipated Contractor's *Equal Opportunity (EO) Policy* prior to issuing a contract award.

I. *EO Policies* should be included as a hardcopy accompanying the solicitation response.

J. Contractors are responsible for providing updates or changes to their respective policies, and for supplying *EO Policies* upon request to other State agencies that must also comply with this statute.

K. Vendors who are not required by law by to have an *EO Policy* **must** submit a written statement to that effect.

1.23 PROHIBITION OF EMPLOYMENT OF ILLEGAL IMMIGRANTS

L. Pursuant to Arkansas Code Annotated § 19-11-105, prior to the award of a contract, selected Contractor(s) **must** have a current certification on file with OSP stating that they do not employ or contract with illegal immigrants. If selected, the Contractor certifies that they will not employ or contract with illegal immigrants during the aggregate term of a contract.

M. OSP will notify the selected contractor(s) prior to award if their certification has expired or is not on file. Instructions for completing the certification process will be provided to the contractor(s) at that time.

1.24 RESTRICTION OF BOYCOTT OF ISRAEL

N. Pursuant to Arkansas Code Annotated § 25-1-503, a public entity **shall not** enter a contract with a company unless the contract includes a written certification that the person or company is not currently engaged in and agrees for the duration of the contract not to engage in, a boycott of Israel.

O. This prohibition does not apply to a company which offers to provide the goods or services for at least twenty percent (20%) less than the lowest certifying business.

P. By checking the designated box on the Proposal Signature Page of the response packet, a Contractor agrees and certifies that they do not, and will not for the duration of the contract, boycott Israel.

1.25 PAST PERFORMANCE

In accordance with provisions of State Procurement Law, specifically OSP Rule R5:19-11-230(b)(1), a Contractor's past performance with the State may be used to determine if the Contractor is "responsible." Proposals submitted by Contractors determined to be non-responsible **shall** be disqualified.

1.26 TECHNOLOGY ACCESS

Q. When procuring a technology product or when soliciting the development of such a product, the State of Arkansas is required to comply with the provisions of Arkansas Code Annotated § 25-26-201 et seq., which expresses the policy of the State to provide individuals who are blind or visually impaired with access to information technology purchased in whole or in part with state funds. The Contractor expressly acknowledges and agrees that state funds may not be expended in connection with the purchase of information technology unless that technology meets the statutory Requirements found in 36 C.F.R. § 1194.21, as it existed on January 1, 2019 (software applications and operating ICSs) and 36 C.F.R. § 1194.22, as it existed on January 1, 2019 (web-based intranet and internet information and applications), in accordance with the State of Arkansas technology policy standards relating to accessibility by persons with visual impairments.

R. ACCORDINGLY, THE CONTRACTOR EXPRESSLY REPRESENTS AND WARRANTS to the State of

Arkansas through the procurement process by submission of a Voluntary Product Accessibility Template (VPAT) for 36 C.F.R. § 1194.21, as it existed on January 1, 2019 (software applications and operating ICSs) and 36 C.F.R. § 1194.22, that the technology provided to the State for purchase is capable, either by virtue of features included within the technology, or because it is readily adaptable by use with other technology, of:

1. Providing, to the extent required by Arkansas Code Annotated § 25-26-201 et seq., equivalent access for effective use by both visual and non-visual means;
2. Presenting information, including prompts used for interactive communications, in formats intended for non-visual use;
3. After being made accessible, integrating into networks for obtaining, retrieving, and disseminating information used by individuals who are not blind or visually impaired;
4. Providing effective, interactive control and use of the technology, including without limitation the operating system, software applications, and format of the data presented is readily achievable by nonvisual means;
5. Being compatible with information technology used by other individuals with whom the blind or visually impaired individuals interact;
6. Integrating into networks used to share communications among employees, program participants, and the public; and
7. Providing the capability of equivalent access by nonvisual means to telecommunications or other interconnected network services used by persons who are not blind or visually impaired.

S. State agencies cannot claim a product as a whole is not reasonably available because no product in the marketplace meets all the standards. Agencies **must** evaluate products to determine which product best meets the standards. If an agency purchases a product that does not best meet the standards, the agency must provide written documentation supporting the selection of a different product, including any required reasonable accommodations.

T. For purposes of this section, the phrase “equivalent access” means a substantially similar ability to communicate with, or make use of, the technology, either directly, by features incorporated within the technology, or by other reasonable means such as assistive devices or services which would constitute reasonable accommodations under the Americans with Disabilities Act or similar state and federal laws. Examples of methods by which equivalent access may be provided include, but are not limited to, keyboard alternatives to mouse commands or other means of navigating graphical displays, and customizable display appearance. As provided in Arkansas Code Annotated § 25-26-201 et seq., if equivalent access is not reasonably available, then individuals who are blind or visually impaired shall be provided a reasonable accommodation as defined in 42 U.S.C. § 12111(9), as it existed on January 1, 2013.

U. If the information manipulated or presented by the product is inherently visual in nature, so that its meaning cannot be conveyed non-visually, these specifications do not prohibit the purchase or use of an information technology product that does not meet these standards.

1.27 COMPLIANCE WITH THE STATE SHARED TECHNICAL ARCHITECTURE PROGRAM

The Contractor’s solution **must** comply with the State’s shared Technical Architecture Program which is a set of policies and standards that can be viewed at: https://www.dfa.arkansas.gov/intergovernmental-services/state-technology-cost-analysis/architecture-compliance/. Only those standards which are fully promulgated or have been approved by the Governor’s Office apply to this solution.

1.28 VISA ACCEPTANCE

V. Awarded Contractor should have the capability of accepting the State’s authorized VISA Procurement Card (p-card) as a method of payment.

W. Price changes or additional fee(s) **shall not** be levied against the State when accepting the p-card as a form of payment.

X. VISA is not the exclusive method of payment.

1.29 PUBLICITY

Y. Contractors shall **not** issue a news release pertaining to this *Bid Solicitation* or any portion of the project without OP's prior written approval.

Z. Failure to comply with this Requirement **shall** be cause for a Contractor's proposal to be disqualified or for the contract to be terminated.

1.30 RESERVATION

The State **shall not** pay costs incurred in the preparation of a proposal.

1.31 DATA LOCATION

Contractor shall under no circumstances allow Arkansas data to be relocated, transmitted, hosted, or stored outside the continental United States in connection with any services provided under this contract entered into under this RFP, either directly by the Contractor or by its subcontractors.

1.32 SCHEDULE OF EVENTS

Table 1: Solicitation Schedule

ACTIVITY	DATE
Public Notice of RFP	September 20, 2023
Deadline for Receipt of Written Questions	September 29, 2023, 4:00 p.m. CST
Response to written Questions, On or About	October 11, 2023
Proposal Due Date and Time	November 9, 2023, 1 p.m. CST
Opening Proposal Date and Time	November 9, 2023, 2 p.m. CST
Intent to Award Announcement Posted, Onn or About	December 8, 2023
Contract Start Date (Subject to State Approval)	April 1, 2024

1.33 STATE HOLIDAYS

Holidays are those days as declared legal state holidays by authority of Act 304 of 2001. Those days are as follows:

Table 2: State Holidays

HOLIDAY	DATE
New Year's Day	January 1
Dr. Martin Luther King's Birthday	Third Monday in January
George Washington Birthday	Third Monday in February
Memorial Day	Last Monday in May
Independence Day	July 4
Labor Day	First Monday in September
Veteran's Day	November 11
Thanksgiving Day	Fourth Thursday in November
Christmas Eve	December 24
Christmas Day	December 25

Additional days can be proclaimed as holidays by the Governor through executive proclamation. State offices are normally closed on holidays; however, there are occasions (i.e., during legislative sessions) when it may become necessary to keep state offices open on holidays. The Contractor **shall** maintain adequate staff on such working holidays.

2 SCOPE OF WORK

- ***Do not** provide responses to items in this section unless specifically and expressly required.*

2.1 INTRODUCTION

This Request for Proposal (RFP) is issued by the Arkansas Department of Human Services (DHS), Office of Procurement (OP) for the Department of Medical Services (DMS) to obtain pricing and contract(s) for Dental Managed Care. The Office of Procurement is the sole point of contact throughout this solicitation process.

The Arkansas Department of Human Services (DHS) currently contracts to provide managed care dental services to approximately 630,000 enrolled Medicaid and Child Health Insurance Program (CHIP) members. The DHS Dental Managed Care Program, also known as Healthy Smiles, has a seven-year contract approaching expiration, and DHS is seeking to procure new Dental Managed Care Organization (DMO) contracts to provide, through a managed care model, comprehensive Dental Services for the Medicaid Program.

The current DMOs receive monthly capitation payments to support the Primary Care Dentists (PCD) who deliver routine dental services like teeth cleanings, x-rays, and crowns, as well as to provide emergency or specialized dental services, such as orthodontia or dental surgeries. Arkansas residents eligible for Medicaid dental services are enrolled in a dental plan through the AR Medicaid Management Information System (MMIS) “Auto-Assignment” feature or by selecting a plan during open enrollment through AR Foundation for Medical Care (AFMC) and are assigned a PCD upon successful enrollment.

The primary objective of the new Request for Proposal (RFP) is to enhance the delivery of dental services to enrolled members in Arkansas. DHS aims to continue to improve the quality of care, increase access to dental services, and ensure cost-effective utilization of resources.

The RFP requires prospective Contractors to meet all the Dental Managed Care Program’s operational and system requirements. Additionally, this document identifies new or updated requirements that must be implemented to continue to improve the quality and services for the State.

DHS, at its sole discretion, reserves the right to request services for additional DHS divisions and locations.

2.2 OVERVIEW OF DHS ORGANIZATION AND OPERATIONS

DHS is the largest State agency in Arkansas with approximately 7,000 employees. Act 348 of 1985 allowed DHS to create a unified, comprehensive delivery system to improve the accessibility, availability, quality, and accountability of services delivered or purchased by DHS and to improve the administration and management of resources available to DHS.

The Division of Medical Services is one of 14 Divisions and Offices that comprise DHS. The Divisions provide services to the people of Arkansas, and the Offices provide necessary support to the Divisions and DHS. A DHS organizational chart is provided in Attachment F Bidder’s Library.

The Division of Medical Services (DMS) is the administrative arm of Arkansas Medicaid, overseeing provider enrollment, billing, pharmacy, beneficiary support, and fee-for-service and managed care programs funded by Medicaid. Arkansas Medicaid, which is jointly funded and operated by DHS and the Centers for Medicare & Medicaid Services (CMS), provides medically necessary health care services for eligible Arkansans from birth through end-of-life.

2.3 MINIMUM QUALIFICATIONS

The Prospective Contractor **must** meet the following requirements:

AA. The Prospective Contractor **must** be registered to do business in the State of Arkansas and be in good standing by the initial start of any resulting contract. For verification purposes, Prospective Contractor **must** provide a Certificate of Good Standing, Certificate of Authority, and other required Arkansas Secretary of State documentation such as non-filing or nonqualifying statements, upon DHS request.

BB. The Prospective Contractor **must** include a copy of all required licensure and certification documents in Contractor’s response to this solicitation. See Section 1.8 “Response Documents.”

CC. Prospective Contractor Experience and Licensure

1. The Prospective Contractor or a corporate subsidiary or subcontractor of the Prospective Contractor **must** have a minimum of five (5) years of experience administering a comprehensive dental managed care program for Medicaid Beneficiaries to a similar sized population as the population described in this RFP within the last eight (8) calendar years. To validate this qualification, bidders **must** complete and sign Attachment N *Client History Form*.
2. The Prospective Contractor or a corporate subsidiary or subcontractor **must** have a minimum of (5) years of experience establishing and maintaining a Provider Network to effectively accommodate 650,000-700,000 Beneficiaries within the last eight (8) calendar years. Actuarial information on Arkansas Beneficiaries is included in Attachment F Bidder's Library, Exhibit 7 *Milliman Letter.* To validate this qualification, bidders **must** complete and sign Attachment N *Client History Form*.
3. The Prospective Contractor **shall** disclose all incidents related to the following items regarding any other states' Medicaid managed care programs within the past five (5) years:
    a. All states' departments of insurance market conduct examinations and findings.
    b. All history of litigation relating to the management of a DMO including without limitation, on-going litigation and any litigation that has been resolved (including by settlement).
    c. To validate this qualification, a listing of all incidents **must** be included in Attachment N Client History Form.

    An incomplete listing may, at the sole discretion of DHS, result in disqualification of a bid.

    DHS reserves the right to request additional details and/or documentation to clarify any incident listed to validate this requirement.
4. The Prospective Contractor **must** complete a Client History Form as part of the Response Packet.

DD. Prospective Contractor Financials

1. The Prospective Contractor **must** meet one of the following two Criteria and **must** provide the indicated documentation to validate the selected criterion
    a. Criterion 1: The Prospective Contractor currently possesses a certificate of authority issued by the Arkansas Insurance Department (AID), is fully authorized to conduct business in the State, and plans to maintain such certificate. To validate this requirement:
        i. The Bidder **shall** provide a copy of the current AID Certificate of Authority and
        ii. The Bidder **shall** provide a written statement signed by an authorized signatory stating that the bidder will maintain AID certification through the entirety of the contract period including all extensions. This statement may be contingent on the Bidder being awarded the Contract.
    b. Criterion 2: The Prospective Contractor **must** maintain a fiscally solvent operation in accordance with federal requirements and Arkansas Insurance Department (AID) requirements for minimum net worth. To validate this requirement:
        i. The Bidder **shall** provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Beneficiaries, and the State, will not be liable for the Vendor's debts if the entity becomes insolvent. The State reserves the right to request additional information to validate submitted assurances.
        ii. Bidder assurances **must** be signed by an officer of the Prospective Contractor (and parent entity if applicable), must run for the entirety of the contract period including all extensions, and may be contingent on the Vendor being awarded the Contract

    Prospective Contractors who do not meet either of the Criteria listed under this requirement may be disqualified at the sole discretion of DHS.

2.4 EXPECTATION OF SERVICES

The Prospective Contractor **shall** perform all services described in this RFP and **shall** comply with all applicable State and federal statutes, State, and federal regulations (including any applicable regulations in CMS's State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval), and State and federal policies transmitted through published notices, letters, manual provisions, or transmittals.

The selected Dental Managed Care Contractor **shall** perform services during the Arkansas Medicaid Dental Managed Care project and **shall**:

- Provide all services and meet all requirements requested in this RFP and all Attachments.
- Perform services and produce required deliverables by the due dates outlined in this RFP.
- Provide any/all hardware or software required for project tracking, reporting, management, and production of deliverables.
- Comply with federal regulatory requirements in 45 CFR 95.626.
- Comply with all security and privacy laws, regulations, and policies, including HIPAA, and related breach notification laws and directives.
- Comply with federal and State Dental Managed Care expectations in support of the CMS Certification process and in accordance with the most current certification guidance from CMS.
- The Dental Managed Care Contractor **shall** develop and provide deliverables and services in accordance with the following standards:
    a. Institute of Electrical and Electronics Engineers (IEEE) Standard 1012- 2004, as well as all other applicable, lifecycle-appropriate IEEE Standards (e.g., 12207 Software Life Cycle Process, 703 Software QA Plans, 1074 Developing Software Project Lifecycle Process, 828 Configuration Management Plans, and 830 Requirement Specifications, to name a few)
    b. The Capability Maturity Model Integration (CMMI)
    c. The current edition of the Project Management Institute's (PMI) Standard for Portfolio Management, Standard for Program Management, Project Management Body of Knowledge (PMBOK® guide)

Bidders are encouraged to propose solutions in addition to the minimums stated.

Prospective Contractors, either directly or through their subcontractors, **shall** be able to provide all necessary services and meet all the requirements requested in this RFP and Attachment G DHS Standard Security Requirements.

2.5 PRINCIPLES AND GUIDELINES

To ensure success for the Dental Managed Care services, the following principles and guidelines are required by DHS leadership:

- **Adherence to Federal Requirements:** The Dental Managed Care solution must adhere to all current and future Federal requirements.
- **Improved Access to Dental Care -** DHS is seeking to expand access to dental care by ensuring the DMOs provide medically necessary covered services to enrolled members beginning on the member's date of enrollment, regardless of pre-existing conditions or receipt of any prior health care services. DHS will require DMOs to ensure at least 95% of enrolled members have access to PCDs within 30-60 miles of their residence, ensuring that DMOs have network adequacy.
- **Integrated Access and Consistent Interface**: The Dental Managed Care solution's user interface needs to provide users with integrated access to services relevant to the user group. Each user should be provided with a consistent, customizable, and easy to use interface.
- **Ease of Use:** The Dental Managed Care solution must provide user-defined criteria for ease of learning, use, and support for State staff.

- **Agile:** The Dental Managed Care solution must be able to readily adapt to changing business needs quickly and with minimal technical resources.
- **Scalable and Extensible:** The Dental Managed Care solution needs to be scalable to accommodate additional users and extensible in expanding capabilities to meet future business needs and Federal and State mandates.
- **Secure and Manageable:** The target architecture for the Dental Managed Care solution needs to be protected against the common Internet threats and will be manageable within the existing operational and financial constraints.
- **Electronic Data Collection:** The Dental Managed Care solution employs an electronic data exchange standard to improve efficiency, reduce duplicate data collection, and promote a common understanding of data elements.

2.6 PERFORMANCE STANDARDS

State law requires that all contracts for services include Performance Standards for measuring the overall quality of services provided. Attachment C: Performance Standards identifies expected deliverables, performance measures, or outcomes and defines the acceptable standards the Contractor must meet to avoid assessment of damages.

The State may be open to negotiations for Performance Standards prior to contract award, prior to the commencement of services, or at times throughout the contract duration.

The State shall have the right to modify, add, or delete Performance Standards throughout the term of the contract, should the State determine it is in its best interest to do so. Any changes or additions to performance standards will be made in good faith following acceptable industry standards and may include the input of the Contractor to establish standards that are reasonably achievable.

All changes made to the Performance Standards shall become an official part of the contract.

Performance Standards shall continue throughout the term of the contract.

Failure to meet the minimum Performance Standards as specified may result in the assessment of damages. *See also Section 2.16 below.*

In the event a Performance Standard is not met, the Contractor will have the opportunity to defend or respond to the insufficiency. The State may waive damages if it determines there were extenuating factors beyond the control of the Contractor that hindered the performance of services or if it is in the best interest of the State to do so. In these instances, the State shall have final determination of the performance acceptability.

Should any compensation be owed to the agency due to the assessment of damages, Contractor shall follow the direction of the agency regarding the required compensation process.

2.7 ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

2.7.1 ELIGIBILITY & ENROLLMENT

EE. The Contractor **shall** maintain and utilize an enrollment system that **shall** accept, and process daily eligibility files and full replacement data files provided by DHS in order to verify active enrollment in Arkansas Medicaid prior to authorizing or paying for any Dental Services.

1. Each Beneficiary's eligibility file shall include the Beneficiary's Medicaid ID number.
2. The full replacement file shall occur at the discretion of DHS.
3. The Contractor must use the data contained in Medicaid files to replace the Contractor's existing eligibility files.
4. By the time of Readiness Review, the Contractor shall develop a system to accept and load an initial full file of Beneficiary eligibility data from DHS.
5. The Contractor shall develop a system to accept and update daily Beneficiary eligibility data from DHS.
6. The Contractor will have provider-level access to the DHS Medicaid eligibility system through the DHS Provider Portal.

FF. DHS will be responsible for the following:

1. Providing updated enrollment information to the Contractor for eligible Medicaid Beneficiaries Tuesday through Saturday of each week, subject to change based on holiday scheduling.
2. Developing and administering a process through which Potential Members will select the Contractor through which they will access Covered Services.
3. Offering a choice of a Contractor for all Potential Members.
4. If a Potential Member does not choose a Contractor within 90 days after enrollment, DHS shall assign to a Contractor.
5. In assigning Potential Members to a Contractor, DHS will endeavor to select the same Contractor for individuals in the same household.
6. Notifying Enrolled Members of the Contractor selected for them by DHS, and DHS will inform them that they may switch Contractors for any reason for ninety (90) days from the date on the notice. Enrollment for new enrollees will not be limited to an open enrollment period. Plans must accept new enrollees at any point during the year. Reassignment opportunities for Enrolled Members will occur on an annual basis, during Open Enrollment.

GG. The Contractor shall:

1. Determine whether a person requesting assistance, or for whom prior authorization is requested, is eligible for a specific service, pursuant to Arkansas Medicaid policies.
2. Refer individuals that have lost eligibility to the Division of County Operations for assistance.
3. Verify during Claims adjudication that the Enrolled Member was eligible for Dental Services on the date of service.

2.7.2 ELIGIBILITY

HH. All Arkansas Medicaid beneficiaries who are eligible for dental benefits will be enrolled in a DMO except for:

1. The Spend Down Population.
2. Beneficiaries who are fully admitted to a Human Development Center (HDC).
3. Beneficiaries who are only enrolled in the ARChoices in Homecare or Independent Choices programs or a successor waiver for the elderly or physically disabled.
4. Beneficiaries who are enrolled in the Program for All Inclusive Care for the Elderly (PACE) (42 CFR § 460 et seq.).
5. Adults made eligible for Medicaid under the Patient Protection and Affordable Care Act (42 U.S.C. §§ 18001 et seq.), except individuals designated as American Indian or Alaskan Native and individuals who are 19 and 20 years of age.
6. Beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

2.7.3 AUTO ASSIGNMENT

II. A newly identified Enrolled Member that meets the criteria for mandatory enrollment will be assigned to the Contractor based upon the following rules:

1. Enrolled Members will be auto assigned to the Contractor based upon proportional assignment. Under proportional assignment, the first Enrolled Member is assigned to DMO A, the next to DMO B, the next to DMO C, the next to DMO A, etc.
2. DHS may modify the auto assignment algorithm to change or add criteria including but not limited to ensuring DMOs have an adequate enrollment to ensure sustainability, quality measures, network capacity, or performance in cost or utilization management.
3. The proportional assignment methodology will be utilized to assign Enrolled Members to the DMO, unless at least one of the following conditions exists:

c. The DMO fails to meet specified quality metrics as defined in Attachment C Performance Based Contracting and Attachment F Bidder's Library, Exhibit 2 Quality Measures and DHS notifies the DMO that it will no longer receive Auto Assignments; or

d. The DMO is subject to a sanction, including a moratorium on having members assigned.

JJ. An Enrolled Member may voluntarily transition from their assigned DMO and choose another DMO within ninety (90) calendar days of Auto Assignment. An Enrolled Member will not be permitted to change his/her DMO more than once within a twelve-month period, unless:

1. The change occurs during the open enrollment period; or
2. There is cause for transition, as described in 42 CFR § 438.56

2.7.4 ENROLLMENT

KK. The effective date of DMO enrollment will be the first day of the month after Auto Assignment, or voluntarily enrollment, unless enrollment occurs after the 15th day of the month. Enrolled Members who are enrolled after the 15th day of the month will have an effective date of the 1st day of the second month after enrollment.

LL. The execution of enrollments will occur daily, and the results of the enrollment will be sent to the DMO nightly in the daily 834-file.

MM. DHS reserves the right, upon advanced written notice to the DMO, to cap enrollment of additional members to the DMO for any of the following reasons, as determined by DHS, in its sole discretion:

1. Consistently poor-quality performance;
2. Inadequate Network capacity;
3. High number of Enrolled Member complaints about the DMO's services or access to care;
4. Financial solvency concerns;
5. Failure to meet the Performance Indicators outlined in Attachment C; or
6. Failure to meet quality metrics outlined in Attachment F Bidder's Library, Exhibit 2 Quality Measures
7. Anti-Discrimination Policy

NN. The DMO must accept new enrollment from Potential Members in the order in which they apply without restriction, unless enrollment is capped by DHS, up to the limits set under the Agreement.

OO. The DMO is prohibited from discriminating against Potential Members eligible to enroll on the basis of health status or need for health care services.

PP. The DMO is prohibited from discriminating against Potential Members eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability.

2.7.5 DISENROLLMENT

QQ. Disenrollment shall be based solely upon a determination by DHS that an Enrolled Member is no longer eligible to receive DMO services.

RR. Disenrollment will occur only because of the following:

1. The Enrolled Member is placed in a setting or begins receiving services excluding them from enrollment in Healthy Smiles
2. The Enrolled Member voluntarily disenrolls from the Healthy Smiles or Medicaid program.

SS. The DMO cannot request disenrollment of an Enrolled Member. However, the DMO must alert DHS if it becomes aware that an Enrolled Member may meet one of the criteria listed above in 2.7.5 B.

TT. Capitated Payments made by DHS to a DMO on behalf of a disenrolled Enrolled Member will be reconciled to the date of disenrollment.

2.7.6 RE-ENROLLMENT

UU. An Enrolled Member who was previously disenrolled will be assigned to the same DMO if re-enrollment occurs within ninety (90) calendar days of previous disenrollment.

1. After ninety (90) calendar days, the Enrolled Member who was previously disenrolled will be auto assigned into a DMO utilizing the proportional assignment method. That Enrolled Member will have ninety (90) calendar days to voluntarily transition to a different DMO, including the DMO the Enrolled Member was previously enrolled in.
2. If a temporary disenrollment (less than ninety (90) calendar days) causes the Enrolled Member to miss the annual open enrollment period, the Enrolled Member may voluntarily transition to a different DMO, without cause, within thirty (30) days of re-enrollment.

2.7.7 TRANSITION

A. DHS shall complete transition of an Enrolled Member from the DMO, as follows:

1. For cause, at any time, and in accordance with 42 CFR § 438.56. For cause reasons for transition include:
    a. The DMO is sanctioned pursuant to the Contract, the Healthy Smiles Waiver, or any applicable state or federal law.
    b. The Enrolled Member loses Medicaid eligibility.
    c. The Enrolled Member needs related services to be performed at the same time, and not all related services are available within the Network of the DMO. The Enrolled Member's PCD or other provider must determine that receiving the related services separately would subject the enrollee to unnecessary risk.
    d. The DMO does not, because of moral or religious objections, cover the services the Enrolled Member seeks; or
    e. Any other reason that rises to the level of good cause, including poor quality of care, lack of access to services covered under the Agreement, or lack of access to providers experienced in dealing with the Enrolled Member's care needs. Other just cause reasons will be determined by DHS, in its sole discretion.
2. Without cause, the member may transition to a different DMO for any reason at one of the following times:
    a. Within the first ninety (90) calendar days after initial enrollment or re-enrollment (or within the first ninety (90) days after notification of initial enrollment, whichever is later), or
    b. During the annual Open Enrollment Period.
3. If no action is taken by the Enrolled Member during one of the times set out in 2.7.7 A, 2, he/she will remain in the DMO and will not be permitted to transition to a new DMO, unless for cause, until the next annual Open Enrollment Period.
4. The Enrolled Member (or his or her representative) must request transition by submitting an oral or written request to DHS's Enrollment Vendor.
5. The DMO is not authorized to process transition requests. If the DMO receives a transition request from an Enrolled Member, the DMO shall forward the request to DHS's Enrollment Vendor within three (3) business days of receipt of the request.
6. DHS shall process transitions with an effective date in accordance with Section 2.7.7.A, but that is no later than the first day of the second month following the month in which the Enrolled Member requested a transition.
7. A transition is effective at midnight on the date provided in the enrollment or disenrollment file.

8. If DHS fails to make a transition determination within a specified time, the transition is considered approved for the effective date that would have been established had DHS made a determination in the specified timeframe.
9. The DMO must implement transition policies and procedures that, at a minimum:
    a. Ensure that it does not restrict the Enrolled Member's right to voluntarily transition to a different DMO, in accordance with the Contract, in any way; and
    b. Are consistent with the federal requirements outlined in 42 CFR § 438.62.
10. The DMO and its subcontractors, providers and vendors must assist in the transition of an Enrolled Member from its DMO to another, and vice versa.
11. The DMO may not request that an Enrolled Member be transitioned to a different DMO unless it completes the following process:
    a. Submits a request for transition to DHS's designated reviewer for approval. The request must be made in writing and must specify the reason for transition.
    b. The DMO discovers the member was incorrectly enrolled due to any of the following:
        i. Other members of the household are in another DMO. The member is in an eligibility category not covered by the DMO. The Enrollee has exhibited disruptive behaviors to the extent that the Contractor cannot effectively manage their care, and the Contractor has made all reasonable efforts to accommodate the Enrollee.
        ii. The Enrollee has committed Fraud, including but not limited to, loaning an ID card for use by another person
12. The DMO cannot request transition of an Enrolled Member for the following reasons:
    a. An adverse change in the Enrolled Member's health status;
    b. Due to the Enrolled Member's utilization of services;
    c. Due to the Enrolled Member's diminished mental capacity; or
    d. Due to the Enrolled Member's uncooperative or disruptive behavior resulting from his or her special needs (except when failure to transition seriously impairs the ability of the DMO to furnish services to this Enrolled Member or other Enrolled Members).
13. If DHS approves the request, the DMO must continue to provide services to the Enrolled Member until DHS sends notice to the Enrolled Member of the transition, the reason for the transition, the new DMO and the effective date of the transition.
14. Once transition is approved, the current DMO must assist in the transition of the member.

2.7.8 REINSTATEMENT

A. An Enrolled Member who was disenrolled from the DMO may be reinstated for the following month with no lapse in coverage if the Enrolled Member re-establishes his/her eligibility and such eligibility is entered into MMIS by the last day of the month of disenrollment, which would generate notification to the DMO that they will continue to be responsible for the Enrolled Member.

B. A lapse in eligibility that is not resolved in the timeframe set out in Section 2.7.8.A would lead to the Enrolled Member not being reinstated for the following month. That Enrolled Member would be disenrolled from the DMO.

C. If a continuity of care issue arises and it is mutually agreed to by all parties (DHS, the DMO, and the Enrolled Member), then the Enrolled Member can be reinstated to the DMO for the following month and the Capitated Payment will be reconciled between DHS and the DMO.

2.8 ENROLLED MEMBER INFORMATION AND SERVICES

2.8.1 GENERAL REQUIREMENTS

A. The Contractor shall design, produce, and distribute to Enrolled Members outreach and education materials that are appropriate for the Enrolled Member’s age, language, culture, and reading level, as

defined by the Federal Plain Language requirements referenced in this RFP.

B. Educational materials to be produced shall include those specified in this RFP, as well as other materials necessary to provide information to Enrolled Members as required by this RFP. However, the Vendor may propose in its Technical Proposal additional materials and information beyond those described in this RFP.

C. The Contractor shall take a proactive role in reaching out to Enrolled Members to ensure that each Enrolled Member has the information necessary to receive Medically Necessary Covered Services.

D. The Contractor shall conduct regularly scheduled and targeted outreach and education activities for all covered Enrolled Members in accordance with the Member Outreach and Education Plan.

1. The Contractor shall identify targeted populations and/or service areas for outreach and education activities and shall identify these populations or service areas in the plan required to be submitted to the Contractor Monitor.
2. A minimum of 75 outreach events per year shall be conducted by the Contractor, with no less than fifteen (15) per quarter, equally distributed across the State in both urban and rural areas. Some outreach activities each quarter must be designed to reach special populations, such as children or individuals with Intellectual or Developmental Disabilities.
3. The Contractor shall develop creative means to achieve effective outreach and communications, including collaborating with groups in the community who interact with Enrolled Members, such as local health department eligibility staff, local departments of social services case workers, Provider-Led Shared Savings Entities (PASSE) care coordinators, and other interested community workers. The Contractor shall contract a minimum of 25 of these community- based groups per year to educate them on the services provided through the Contractor.
4. If a review of the scheduling and targeted Enrolled Members is requested, the Contract Manager shall have the right to require modifications to these factors of the outreach plan.
5. The Contractor shall submit all Member materials to the Contract Manager for DHS approval at least ten (10) calendar days prior to use, on an on-going basis, including those developed by entities outside of the Contractor.
    a. All Member materials, including final copies of approved Member materials, shall be submitted by the Contractor in an electronic format approved by the Contract Manager, unless the type of material prohibits it from being produced or copied in an electronic format.
    b. DHS reserves the right to withdraw or modify its approval of any material at any time.
    c. Initial materials must be submitted to the Contract Manager by the time of Readiness Review.
6. The DMO must provide information to Enrolled Members in accordance with 42 CFR § 438.10, and as required by DHS. Additionally, and in accordance with the CFR, the DMO must notify Enrolled Members, on at least an annual basis, of their right to request and obtain information.
7. The DMO must notify all Enrolled Members when it adopts a policy to discontinue coverage of a service due to moral or religious objections. The notice must be provided at least thirty (30) calendar days prior to the effective date of the policy and must be sent in accordance with the terms of the Contract and any amendments thereto.
8. The DMO must make all information provided to Potential and Enrolled Members, whether required by the Agreement or otherwise, accessible. Additionally, the DMO must notify all Potential or Enrolled Members of their right to accessible information at no additional cost and how to access information in an accessible format.
9. At a minimum, "accessible" means that:
    a. All member communications, including written materials, spoken scripts, and websites must be at or below the sixth (6th) grade comprehension level.
    b. All written materials must be provided in a font size no smaller than 12-point.
    c. All written materials critical to obtaining services must be made available in English, Spanish, and Marshallese.

d. For all individuals whose primary language is not English, an interpreter must be provided, free of charge, in accordance with the Federal Limited English Proficiency (LEP) regulations.

e. Interpretation, either oral or written, of any provided information must be made available in any language spoken by the Enrolled Member or Potential Member.

f. All written and oral information must be provided in alternative formats, when appropriate, and in a manner that takes into consideration an Enrolled Member's or Potential Member's special needs, including any visual impairment, hearing impairment, limited reading proficiency, or limited English proficiency.

g. Auxiliary aids and services must be made available upon request for Enrolled Members and Potential Members with disabilities.

h. A Teletypewriter Telephone/Text Telephone (TTY/TDY) number must be provided for Enrolled Members and Potential Members.

i. Written materials that are critical to obtaining services are referenced in 42 CFR § 438.10(d)(3) and include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. Taglines must be in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand information provided, information on how to request auxiliary aids and services, and the toll-free and TTY/TDY telephone number of the DMO's Member Support Services unit. Auxiliary aids and services must also be available upon request of the Enrolled Member or Potential Member at no cost.

j. All written materials must be available in large print. Large print means printed in a font size no smaller than 18-point.

10. The DMO must mail all Enrolled Member materials to the Enrolled Member's primary address provided by DHS on the enrollment file unless an updated alternate address has been obtained from the Enrolled Member, and in accordance with the following requirements:

    a. The DMO's name or logo must be included on the envelope or the front of every mailing so that it is easily distinguishable.

    b. All information sent to Enrolled Members by mail must include instructions for how a member can change or update their address.

    c. If material sent to Enrolled Members is returned to the DMO as "undeliverable," the DMO must notify Division of County Operations (DCO) within thirty (30) calendar days on a monthly undeliverable mail report. Report contents and formatting must be approved by DHS.

    d. Due to the high rate of undeliverable mail, the DMO is allowed to utilize postal service address correction software when mailing Enrolled Member materials. However, the DMO must also send Enrolled Member materials to the address of record supplied by DHS.

    e. Information required to be provided by the DMO may be sent to the member's parent/legal guardian or authorized responsible person, as appropriate.

    f. All information provided to Potential Enrollees must be provided in accordance with 42 CFR 438.10(e) and as required by DHS.

    g. The DMO may send emails in lieu of mailing if the Enrolled Member has agreed, in writing, to receive information by email. This does not include notices of adverse action or appeal rights.

    h. If an Enrolled Member agrees to receive information by email, the DMO must provide an opt-out process for that Enrolled Member to elect to no longer receive information by email.

11. Marketing is only allowed in accordance with the criterion set out in Attachment F Bidder's Library, Exhibit 4 Marketing Guidelines issued by DHS. The Contractor shall submit to the Contract Manager any marketing and advertising materials referencing the services it is providing on behalf of DHS for approval at by the time of Readiness Review or at least thirty (30) days prior to intended use, whichever is sooner. All marketing material developed after Contract Go-Live must be submitted to the Contract Manager for DHS approval at least thirty (30) days prior to intended use. Marketing and advertisement materials include but are not limited to bulk mailers, television advertisements, radio advertisements, newspaper advertisements, billboard artwork, etc. All marketing materials must comply with all State and federal rules and regulations. Written approval from DHS of all marketing materials shall be required.

E. Orientation Materials and Member Handbook

1. The Contractor shall produce a Member Handbook and a Provider Directory that shall be made available online.
2. The Contractor shall also produce a Member orientation packet, including a letter introducing the Contractor and the Enrolled Member's identification card.
    a. The introductory letter and identification card shall be mailed to all Enrolled Members at least fifteen (15) days prior to the Go-Live Date and to all Enrolled Members becoming eligible for Covered Services after the Go-Live Date within ten (10) days of enrollment.
    b. The introductory letter shall direct the Enrolled Member to those online resources and shall state that the Enrolled Member may request hardcopies of the Member Handbook and Provider Directory, which the Contractor shall mail free of charge.
3. The DMO must mail new informational materials to an Enrolled Member who was disenrolled and subsequently re-enrolled, if:
    a. It has been more than one hundred eighty (180) calendar days since the disenrollment; or
    b. It has been less than one hundred eighty (180) calendar days since disenrollment and there was a significant change in the Member materials during the time the Enrolled Member was disenrolled
4. When the DMO provides required information electronically to Potential or Enrolled Members, the DMO must:
    a. Comply with the electronic and information technology accessibility requirements under the state and federal civil rights laws, including A.C.A. § 25-26-201 et seq., Section 504 and Section 508 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA);
    b. Provide the material in a format that is accessible as defined in Section 2.8.1.D;
    c. Place the information on the DMO's website in a location that is prominent and easy to access;
    d. Provide the information in an electronic format which can be electronically retained and printed;
    e. Follow the content and language requirements set forth in this RFP;
    f. Notify the Enrolled Member that the information is available in paper form without charge upon request and how to request paper forms of the information; and
    g. Provide the information in paper form within five (5) business days of a request.
5. Contractor must submit to annual 508 compliance and ADA testing as required by DHS. Contractor must correct any findings from the audit within a mutually agreed upon timeframe.
6. The identification card shall include:
    a. The Contractor's name.
    b. The Enrolled Member's unique identification number (as established by the Contractor).
    c. The Contractor's Call Center 800 number.
    d. The Contractor's website address.
    e. Primary Care Dentist (PCD), as well as the PCD's address and phone number
    f. The Healthy Smiles customer service number.
7. The Member Handbook and other orientation materials **must**:
    a. Explain the nature of the Enrolled Member's relationship with the Contractor.
    b. List the toll-free telephone number for the Contractor's Call Center with a statement that the Enrolled Member may contact the Contractor to locate a dentist, obtain appointment assistance, or for any other questions.
    c. Explain the importance of regular Dental Services and good oral hygiene, emphasizing preventive care such as visiting the dentist regularly and proper oral hygiene instructions, including brushing and flossing.

d. Explain the appropriate schedule for Dental Services.

e. Describe Covered Dental Services, including how to obtain emergency dental care services.

f. Explain how to access transportation services such as those currently offered by Arkansas Medicaid.

g. Explain that Covered Dental Services are available at no cost and without point-of-service Cost Sharing responsibilities for Enrolled Members, except that Enrolled Members covered by ARKids B shall be subject to point-of-service Cost Sharing obligations for some services in accordance with the CHIP State Plan.

h. Explain Members' Rights and Responsibilities.

i. Explain the Member Grievance and Appeal System.

j. Inform Enrolled Members of the availability of Medicaid Healthy Smiles customer service line.

k. Explain the relationship between the Enrolled Member and the PCD and encourage Enrolled Members to maintain PCD relationships.

8. Member Handbook - In addition to the requirements set out in the solicitation or resulting Contract, as of the Effective Date the Member Handbook must meet the requirements set forth in 42 CFR § 438.10(g), including, at a minimum:

a. A Table of Contents;

b. The terms, conditions, and procedures for enrollment and disenrollment, including reinstatement;

c. The Enrolled Member's rights and responsibilities;

d. How to access information in accessible formats;

e. A description of services provided by the DMO in sufficient detail to ensure that Enrolled Members understand the services that may be available to them, including the availability of Emergency Care from the DMO, including (i) how Emergency Care is provided; (ii) definitions of what warrants and what constitutes Emergency Care; (iii) that prior authorizations are not required for Emergency Care; and (iv) that an Enrolled Member may use any hospital or other setting for Emergency Care, regardless of whether it is a Network Provider for the DMO.

f. Any limitations and general restrictions on provider access, exclusions from use of Out-of-Network Providers, including how to access those providers.

g. Procedures for obtaining required services, including:

i. second opinions, at no cost to the Enrolled Member (in accordance with 42 CFR § 438.206(b)(3)

ii. authorization requirements, including service authorization documentation requirements

iii. any services available without prior authorization

iv. information about the extent to which, and how, after-hours care is provided

h. Describe services not covered under the requirements of the solicitation or any resulting Contract, as well as how and where to access any benefits that are available under the Arkansas Medicaid State Plan but are not covered under the Contract.

i. Procedures for reporting Medicaid fraud, waste, abuse, and overpayment.

j. Information on the right to file a Grievance or Appeal an Adverse Benefit Determination, and the procedure by which a Member Grievance or Appeal may be filed, including the address, toll-free telephone number, and hours of the DMO's Member Appeals and Grievance staff and the availability of assistance with filing a Member Grievance or Appeal.

k. Information on the right to a Fair Hearing through DHS and the procedures for filing a request for a Fair Hearing, including the DHS-approved timeframes, the address for filing a request for Fair Hearing, and the availability of assistance with requesting a Fair Hearing.

l. Notice that an Enrolled Member's benefits will continue upon timely filing an Appeal of a denial of services, but that the Enrolled Member may have to pay for the denied services if there is an Adverse Benefit Determination.

m. Notice of Privacy Practices for Protected Health Information, as required by the HIPAA Privacy Rule, 45 CFR § 164.520.

n. Procedures for reporting abuse, neglect, or exploitation of the Enrolled Member by the DMO, its subcontractor, or a provider providing services on behalf of the DMO.

o. Notice of the right to file a complaint against the DMO, any of its subcontractors, or Network Providers; and information on the procedure for filing a complaint;

p. Directions for how to obtain the following information about the DMO, upon request:

i. The DMO's non-discrimination policies and the individual responsible for overseeing those policies, as well as responding to accessibility and discrimination claims made against the DMO; and

ii. A list of any services not provided by the DMO due to moral or religious objections, and how the Enrolled Member may obtain information on those services and how to access them through DHS.

q. Currently effective practice guidelines.

r. Explain how to access transportation services, such as those currently offered by Arkansas Medicaid.

s. Explain that Covered Services provided by the DMO are available at no cost to the Enrolled Member and without point-of-service cost sharing responsibilities, except that Enrolled Members covered by ARKids B shall be subject to point-of-service cost sharing obligations for some services.

t. The DMO must make the member handbook available to Enrolled Members within at least ten (10) business days of enrollment.

u. The DMO is required to provide each Enrolled Member notice of any significant changes of the information specified in the Member Handbook, at least thirty (30) calendar days before the effective date of the change. A significant change is one that materially affects the Enrolled Members' rights, access, or list of available services.

9. The Contractor must submit the Enrolled Member Handbook and identification card template, along with the Provider Directory discussed below, to the Contract Manager for DHS approval prior to Readiness Review and must make any required changes.

a. The Contractor must submit any revisions for re-review and approval whenever revisions and in enough time to ensure the information can be provided to Enrolled Members as required by this RFP are made.

10. During the Contract Term, the Contractor shall submit a monthly report to the Contract Manager by the 15th day of the following month, and by a method and format as approved by the Contract Manager, showing the date each new enrollment record was received and the date that the orientation packet was mailed.

F. Provider Directory

1. The Contractor shall provide all Enrolled Members with access to a Provider Directory, which shall be sorted by County and Specialty and list all office locations and meets the requirements set out in 42 CFR 438.10(h), including, at a minimum, the following:

a. Information on each Network Provider, including:

i. Name, street address, and telephone number(s);
ii. Group affiliations, if any;
iii. Website URLs, if any;
iv. Specialties, as appropriate;
v. If the provider is accepting new Medicaid Beneficiaries;
vi. The cultural and linguistic capabilities of the Network Provider, including the languages offered by the Network Provider or skilled medical interpreter at the Network Provider's office; and
vii. Practice limitations, including whether the Network Provider is willing to serve children and adults with special health care needs and whether the Network Provider's practice has age limitations.

b. Clearly explains the difference between a Network Provider and an out-of-network provider.

c. States that some Network Providers may choose not to perform certain services based on religious or moral beliefs, as required by the Social Security Act (the "Act').

d. Contains an attestation from the DMO that its Provider Network meets DHS's required network adequacy standards, set out in this RFP and the resultant Contract.

2. The DMO must makes its provider directory available online, and in print form upon request. The online version must be available to Beneficiaries and stakeholders (e.g., advocate and community organizations and local health departments) at all times in a machine-readable file and format.

3. The online version of the Provider Directory must be searchable, using single and multiple search criteria, according to:

a. Provider Name;
b. Specialty Type;
c. Distance from the member's address;
d. Zip code; and
e. Whether the provider is accepting new patients.

4. DHS must approve the Provider Directory, which the Contractor shall submit to the Contract Manager along with the Member Handbook for approval by the time of Readiness Review.

5. When distributing printed Provider Directories, the DMO must append to the Provider Directory a list of the providers who have left the Network and those who have been added since the Provider Directory was printed or, in lieu of the appendix to the Provider Directory, enclose a letter stating that the most current listing of providers is available by calling the DMO at its toll-free telephone number, or at the DMO's website. The letter must include the toll-free telephone number and the Internet address that will take the Enrolled Member or Potential Member directly to the online Provider Directory.

6. The DMO must mail a Welcome Packet to a Member who was disenrolled due to loss of Medicaid eligibility, and is subsequently re-enrolled in the DMO, if:

a. It has been more than 180 days since the disenrollment; or

b. It has been less than 180 days and there was a significant change in the Member materials during the time they were disenrolled.

7. When updating the Provider Directory:

a. The DMO must ensure the paper format provider directory is updated at least monthly and made available to Enrolled Members in accordance with 42 CFR § 438.10.

b. The DMO must ensure the electronic provider directory is updated no later than thirty (30) calendar days after the DMO receives updated provider information.

8. The Contractor shall submit Provider Directory information monthly to HRSA on the Insure Kids Now web portal.

G. Content of Education Materials

1. The Contractor must educate Enrolled Members (and their parents/caregivers, as applicable) on topics including the importance of oral health, appropriate usage of Dental Services to prevent and treat oral disease, effective home care techniques, and the impact of lifestyle factors on oral health.

2. Education materials shall be based on standards and resources from reputable sources, including but not limited to, the American Dental Association and the American Academy of Pediatric Dentistry.

H. Member Incentives

1. The Contractor shall annually submit for DHS approval a Member incentive plan that will promote the goals of the dental program, including any goals identified by State Directed Performance Improvement Plans.

I. Standards for Development of Written Outreach and Education Materials

1. During the Transition Period and the Contract period, the Contractor shall produce oral health outreach and educational materials including but not limited to:

a. A Member Handbook that meets the requirements listed in this RFP.

b. Educational brochures, posters, advertisements, fact sheets, videos, story boards for the production of videos, audio tapes, letters, and other materials necessary to provide information to Enrolled Members.

c. Materials needed for other forms of public contact, such as health fairs and telemarketing scripts.

2. All Member materials shall meet the following standards:

a. Be worded in plain language in accordance with the Federal Plain Language Guidelines,

b. Be clearly legible with a minimum font size of 12 pt., unless otherwise approved by the Contract Manager.

c. Be translated and available in Spanish and Marshallese. Additionally, all vital documents must be translated and available to any group with limited English proficiency identified by DHS.

d. Be made available in alternative formats upon request for Enrolled Members with special needs or appropriate interpretation services shall be provided by the Contractor at no charge to the Enrolled Member.

3. All materials must be pre-approved by DHS prior to use.

4. The Seal of Arkansas or any DHS logo, trademark, or copyrighted material shall not be used on communication material without written approval from DHS.

5. The Contractor shall provide written notice to Enrolled Members of any changes in policies or procedures described in written materials previously sent to Enrolled Members at least thirty (30) days before the effective date of the change.

6. The cost of design, printing, and distribution (including postage) of all Enrolled Member materials shall constitute Allowable Expenses.

a. The Contractor shall comply with all Federal postal regulations and requirements for mailing of all materials.

J. Outreach to Target Groups

1. The Contractor shall submit an Outreach Plan to the Contract Manager annually that outlines objectives and strategies that will increase awareness of the importance of dental care and the availability of Dental Services, as well as increase utilization to meet DHS goals for all Enrolled Members.

2. The Contractor shall target specific efforts to children and adults with special health care needs, pregnant women, children in foster care and those Enrolled Members who have not seen a dentist in the last 12-months.

3. If requested by DHS, the Contractor must coordinate its efforts with outreach projects being conducted by DHS or other state agencies.

4. The Contractor shall conduct regularly scheduled outreach activities on a quarterly basis of each Contract year, which must be designed to inform each Enrolled Member about the availability of Dental Services and to meet or exceed DHS-established utilization goals.

a. The first two (2) attempted contacts with each Enrolled Member should be telephone calls, at least one (1) day apart, within ten (10) days of enrollment with the Contractor.

b. If this contact is unsuccessful, a written notice should be sent within ten (10) days of the second phone attempt.

c. The Contractor shall document all outreach and education attempts and submit a report to the Contract Manager outlining the time and date of the attempted contact, the individual within the Contractor’s organization who made the contact, and the result of the attempted contact.

d. The Contractor shall have 60 days to meet this requirement for those Enrolled Members on the initial eligibility file on the “Go-Live” date.

5. For each identified population, the DMO shall provide a plan for Outreach and Education services based on the DMO’s determination of the most effective method for doing so for each identified population:

a. Children

b. Adults
c. Children in Foster Care
d. Children and Adults with I/DD

6. The Contractor shall submit a quarterly report no more than fifteen (15) days after the close of each quarter of each Contract Year detailing outreach activities completed during the preceding quarter, as well as activities planned for the current quarter.

   a. This report shall describe activities conducted, measures of activity effectiveness, and other entities involved in the activity.

K. Coordination with Public Health and Other Entities.

1. The Contractor will work closely and cooperatively with DHS, the Arkansas Department of Health (ADH), local health departments, and Federally Qualified Health Centers (FQHCs). The Contractor must do the following:

   a. Promote early effective prevention in conjunction with community-linked early childhood dental programs and services, such as school-based health centers and Head Start;

   b. Coordinate with the non-emergency medical transportation providers participating in the Medicaid program when an Enrolled Member requires transportation services;

   c. Work closely and cooperatively with entities who are working on behalf of an Enrolled Member to secure needed Dental Services for the Enrolled Member.

      i. Such entities may include case management providers in local communities, community services organizations, dental provider associations, advocacy groups, dental providers, schools, ADH, DHS, local health departments and departments of social services, and family members.

      ii. The Contractor's coordination with other entities shall comply with all applicable federal and State confidentiality requirements, and, at minimum, shall include following up with the Enrolled Member or his or her responsible party regarding the issue/need communicated by the interested party, such as a Care Coordinator or a Community Based Organization.

2.8.2 MEMBER RIGHTS POLICY

L. The DMO must develop and implement a written policy, in clear and understandable language, to protect Enrolled Member's rights.

M. The DMO must take reasonable action to inform Enrolled Members of their rights and responsibilities by dissemination of the DMO's Member Handbook.

N. The DMO must ensure the following Enrolled Member rights, at a minimum:

1. The right to receive information on the DMO in accordance with 42 CFR § 438.10;
2. The right to be treated with respect and with due consideration for his or her dignity and privacy;
3. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrolled Member's ability to understand;
4. The right to participate in decisions regarding his or her care, including the right to refuse treatment;
5. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
6. The right to choose a Network Provider for any service the Enrolled Member is eligible and authorized to receive;
7. As applicable, the right to request and receive a copy of his or her medical records and request that they be amended or corrected under HIPAA; and
8. The right to obtain needed, available, and accessible dental care services covered by the DMO.

O. The DMO, its subcontractors, and Network Providers are prohibited from treating an Enrolled Member adversely for exercising his or her rights, as outlined above.

2.8.3 CULTURAL COMPETENCY PLAN

In accordance with 42 CFR § 438.206, the DMO must have a written Cultural Competency Plan (CCP) to ensure that services and settings are provided in a culturally competent manner to all Enrolled Members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. The CCP must be submitted to DHS annually for review and approval.

2.8.4 GRIEVANCE AND APPEAL SYSTEM

P. General Requirements

1. To the extent not covered below, the Contractor's Grievance and Appeal System must comply the requirements set forth in § 160.000 and § 190.000 of the Arkansas Medicaid Provider Manual, and with all applicable federal and State laws, including 42 CFR Part 431, Subpart E (Fair Hearings for Applicants and Beneficiaries) and 42 CFR Part 438, Subpart F (Grievance and Appeal System), the Medicaid Fairness Act, Ark. Code Ann. § 20-77-1701 et seq., and the Arkansas Administrative Procedures Act, Ark. Code Ann. § 25-15-201 et seq.
2. The Contractor must ensure that all Adverse Benefit Determinations, Grievance decisions, or Appeal resolutions are made by an Arkansas-licensed Provider with the appropriate clinical expertise in treating the Enrolled Member's condition or disease, and approved by the Contractor's Dental Director, under the following circumstances:
    a. The decision involves a denial of services based on lack of medical necessity;
    b. The decision involves a denial of an expedited resolution of appeal; or
    c. The decision involves a clinical issue.
3. The Contractor must ensure that the decision makers for Appeals and Grievances do not have a conflict of interest. At a minimum, this means that the decision makers must not be:
    a. Involved in any previous level of review or decision-making; and
    b. The subordinate of any individual who engaged in a previous level of review or decision-making.
4. Upon request, the Contractor shall give Enrolled Members reasonable assistance in completing all Grievance and Appeal forms and other procedural steps related to Grievances and Appeals, including but not limited to auxiliary aids and services, such as interpreter services and toll-free numbers with TTY/TDD and interpreter services.
5. The Contractor shall not take any punitive action against an Enrolled Member or provider for filing or participating in a Grievance or Appeal.
6. Grievances and Appeals **shall** include a process for reconsiderations of Adverse Benefit Determinations, as defined in 42 CFR 438.400.
7. The State will conduct any Administrative Hearings requested after the Beneficiary, or the Provider appealing on the Beneficiary's behalf, has exhausted a single level of appeals. The Contractor **shall** be bound by any decision made during the State's Administrative Hearing, regardless of whether the decision is made through the DHS beneficiary Appeals process or combined with a provider Appeal proceeding before the Arkansas Department of Health.
8. The Contractor shall:
    a. Maintain a knowledgeable staff capable of distinguishing between Grievances and Appeals and routing them accordingly.
    b. Maintain sufficient staff trained to investigate and resolve all Grievances within the following time frames:
        i. Emergency, clinical issues: within twenty-four (24) hours of receipt or by the close of the next Business Day.
        ii. Non-Emergency clinical issues: within five (5) business days of receipt.
        iii. Non-clinical issues: within thirty (35) business days of receipt.
    c. Handle all Grievances and Appeals in compliance with 42 CFR §§ 438.400–410 and the Arkansas Medicaid Fairness Act (a copy of which is included in the Bidders' Library).

d. Have an electronic documentation system that includes, at a minimum, a complete description of the issue, investigation, resolution, and Enrolled Member notification. All written Member notifications **shall** utilize a DHS-approved template, and a copy of all Member notifications should be sent to the Provider who requested the service, if applicable.

e. Aggregate and analyze Grievance and Appeal data, and as requested by the Contract Manager on an ad-hoc basis.

f. Provide the appropriate clinical Provider for all Dental Administrative Hearings.

g. Submit a monthly report of all Grievances received. The report **must** contain at least the following information for each Grievance:

i. Enrolled Member name
ii. Medicaid ID number
iii. Subject of Grievance
iv. Provider name
v. Date received
vi. Date resolved
vii. Classification of Grievance:
- Emergency clinical
- Non-Emergency clinical
- Non-clinical

h. Provide reports of Grievance and Appeal data aggregated for the month, separated by complaint classifications. The Contractor shall create and maintain an easily accessible website of information for Enrolled Members and Providers.

Q. Appeals Procedure

1. The Contractor must have an internal Appeal procedure by which an Appellant may challenge an Adverse Benefit Determination by the Contractor.

2. The Contractor must provide the Appeal procedure to Enrolled Members and Network Providers. Additionally, the Contractor must send written notice of significant changes to the Appeal process to all Enrolled Members and Network Providers at least thirty (30) calendar days prior to implementation.

3. At a minimum, the Contractor Appeal process must include the following provisions:

a. The following individuals may file an Appeal as the Appellant:

i. The Enrolled Member;
ii. The Enrolled Member's parent(s) or legal guardian(s) in the event that the Enrolled Member is a minor or is not legally competent;
iii. An attorney authorized to represent the Enrolled Member;
iv. Another authorized representative of the Enrolled Member, including the representative of the Enrolled Member's estate, if the Enrolled Member is deceased; or
v. A provider that is the subject of an Adverse Benefit Determination, or the provider's legal representative or attorney.

4. The Appellant may file an Appeal with the Contractor, orally or in writing, at any time within sixty (60) calendar days from the date on the notice of the Adverse Benefit Determination.

5. The Contractor must ensure that oral requests to appeal are treated as appeals.

6. Unless an expedited resolution is requested, the Contractor must require the oral filing of an Appeal to be followed by a written, signed appeal request.

7. The Contractor must acknowledge each Appeal in writing unless the Appellant requests an expedited resolution.

8. Unless the Appellant requests an expedited resolution, the Appeal must be heard and notice of the appeal resolution sent to the Appellant no later than thirty (35) calendar days from receipt of the Appeal.

9. The timeframe for resolution of an Appeal may be extended for up to fourteen (14) calendar days if the Appellant asks for an extension or the Contractor documents that additional information is needed, and the delay is in the Enrolled Member's best interest.

10. The Contractor must resolve the Appeal as expeditiously as the Enrolled Member's health requires, and not later than the date the extension expires.
11. If the timeframe is extended other than at the Appellant's request, the Contractor must provide oral notice of the reason for the delay to the Appellant by close of business on the day of the determination, and written notice of the reason for the delay to the Appellant within two (2) calendar days of the determination. The DMO must also inform the Appellant of the right to file a Grievance if he or she disagrees with the decision.
12. If the Contractor fails to adhere to the notice and timing requirements for resolution of the Appeal, the Appellant is deemed to have completed the DMO's Appeal process, and the Appellant may initiate a fair hearing.
13. The Contractor must have an expedited review process for appeals that must be used when taking the time for a standard resolution could seriously jeopardize the Enrolled Member's life, health, or ability to maintain or regain maximum function. The expedited review process must:
    a. Require that the Appeal be resolved, and notice provided to the Appellant of the resolution as quickly as the Enrolled Member's health requires, but no longer than seventy-two (72) hours after receipt of the Appeal.
    b. Require that the Appellant be informed of the limited time available to present evidence and allegations of fact or law and ensure that the Appellant understands the applicable time limits.
    c. If the request for expedited Appeal is denied, the DMO must immediately transfer the Appeal to the timeframe for standard resolution and notify the Appellant of the applicable timeframes. The date of receipt of the Appeal does not change.
    d. The timeframe for resolving an expedited Appeal may be extended up to fourteen (14) calendar days, if the Appellant requests the extension or if the DMO shows that there is a need for additional information and that the delay is in the Enrolled Member's best interest. The DMO must resolve the Appeal as expeditiously as the Enrolled Member's health requires, and not later than the date the extension expires. If the timeframe is extended other than at the Appellant's request, the DMO must provide oral notice of the reason for the delay to the Appellant by close of business on the day of the determination, and written notice of the reason for the delay to the Appellant within two (2) calendar days of the determination. The DMO must also inform the Appellant of the right to file a Grievance if he or she disagrees with the decision.
14. The Contractor must provide the Appellant a reasonable opportunity to present evidence and testimony and make allegations of fact and law, either in person or in writing, as requested by the Appellant.
15. The Contractor must ensure the decision maker considers all comments, documents, records, and other information submitted by the Appellant, without regard as to whether such information was submitted or considered in the initial Adverse Benefit Determination.
16. The DMO must continue the Enrolled Member's benefits during the Appeal if the request for appeal is filed within sixty (60) days of notice of the Adverse Benefit Determination.
17. If the final resolution of the Appeal or Fair Hearing is averse to the Appellant, the DMO may recover the cost of services furnished to the Enrolled Member while the Appeal or Fair Hearing was pending to the extent the services were furnished solely because of the continuation of benefits.
18. The DMO must provide to the Appellant, free of charge, all documents and records considered or relied upon by the DMO to make the Adverse Benefit Determination that is the subject of the Appeal. This includes, without limitation, the Enrolled Member's case file, medical records, or any other applicable documents or records. These documents and records must be provided sufficiently in advance of the Adverse Benefit Determination to allow the Appellant to review the records and documentation in preparation for their Appeal.
19. The DMO must provide the Appellant with written notice of the resolution of the Appeal in a format that has been approved by DHS and includes the following:
    a. The resolution of the Appeal and the date it was completed;

b. If not decided wholly in the Appellant's favor, per §438.408(f)(2), information on the right to request a Fair Hearing no less than 90 calendar days and no greater than 120 calendar days of the decision and how to do so, including the address, phone number and email for Fair Hearings, as shown below:

Beneficiary Appeals	Provider Appeals
DHS Office of Appeals and Hearings P.O. Box 1437, Slot N401 Little Rock, AR 72203-1437 Phone 501-682-8622 Fax 501-404-4628	ADH Office of Medicaid Provider Appeals 4815 West Markham Street, Slot 31 Little Rock, AR 72205 Phone 501-683-6626 Fax:501-661-2357

c. A statement regarding the automatic continuation of benefits during the Fair Hearing process if the Appeal is filed timely and the statement that the Enrolled Member may have to pay for the cost of those benefits if the Medicaid Fair Hearing upholds the DMO's appeal resolution.

d. For expedited Appeals, provide oral notice of the resolution to the Appellant by close of business on the day of the resolution and provide written notice in accordance with paragraph (l), above, to the Appellant within two (2) calendar days of the resolution of the expedited Appeal.

R. Grievance Procedure

1. The DMO must have an internal grievance procedure that complies with 42 CFR § 438.402.
2. All Enrolled Members and Network Providers must receive information on how to access the DMO's Grievance Procedure, in accordance with 42 CFR 438.10. Any changes must be approved by DHS.
3. At a minimum, the Grievance Procedure must meet the following requirements:
   a. The following must be allowed to file a Grievance:
      i. The Enrolled Member, or his or her parent(s)/legal guardian(s) in the event that the Enrolled Member is a minor or not legally competent;
      ii. A direct service provider, whether in-network or not; or
      iii. An authorized representative on behalf of either (i) or (ii).
4. A Grievance may be filed either orally or in writing.
5. The DMO must resolve each Grievance as expeditiously as the Enrolled Member's health condition requires, but not to exceed ninety (90) calendar days from the date the DMO receives the Grievance, whether orally or in writing.
6. The timeframe to resolve the Grievance may be extended up to fourteen (14) calendar days if:
   a. The Enrolled Member requests the extension; or
   b. The DMO determines there is a need for additional information and the delay is in the Enrolled Member's best interest.
7. If the timeframe is extended not at the request of the Enrolled Member, the DMO must:
   a. Make reasonable efforts to give the Enrolled Member prompt oral notice of the delay; and
   b. Give the Enrolled Member written notice of the delay within two (2) calendar days of the decision. The written notice must include the reason for the extension and describe the Enrolled Member's right to file a Grievance if he or she disagrees.
8. The DMO must provide a written resolution of the grievance to the Enrolled Member, which includes a summary of the Grievance received and the right to request an Appeal if the grievance is not resolved entirely in the Enrolled Member's favor.
   a. The written resolution must conform to the requirements set out in the RFP.
   b. The resolution must be written in such a way as not to violate HIPAA.

S. Website Requirements

1. The website **shall** contain separate pages of information for Members and Providers.
2. The site **shall** be easy to access and user-friendly for its audiences.
3. The pages **shall** be maintained with accurate and timely information.
4. At a minimum, the website shall contain the following:
    a. A link to the Contractor's current Provider Directory with the capability to search for Network Providers by geographic locations, type of practice, and panel restrictions (i.e., accepting or not accepting new patients).
    b. An outline of Covered Services.
    c. The Member Handbook
    d. Contractor contact names, telephone numbers, and addresses for individuals to contact with respect to Covered Services.
    e. How to obtain program information in non-English languages.
    f. Information regarding how to submit Member and Provider Grievances and Appeals to the Contractor.
    g. A link to the Contractor's secure electronic Member portal where an Enrolled Member can view his or her Claims history.
    h. A link to the Contractor's secure electronic Claims submission portal.
    i. Information to assist Providers in relation to billing and/or prior authorization issues, access to the Provider Manual, frequently asked questions, etc.
    j. Education and Outreach materials.
5. The Contractor shall have the website prepared by the time of Readiness Review.
6. During the Contract Term, the Contractor shall:
    a. Update the website at least monthly, or more frequently as needed, to ensure that all Provider Directory information is current.
    b. Keep the website functioning with accurate and timely information.
    c. The DMO's Website, including the Member portal and the Provider portal, must have uptime of 99% each month, excluding maintenance time which shall be allowable from 1:00 a.m. to 5:00 a.m. Central Time each Saturday. The Contractor shall work with DHS to determine additional acceptable maintenance windows based on low-traffic time and resource availability while maintaining uptime metrics.
7. The DMO's website must be accessible and subject to the marketing material limitations described in Section 2.8.4 D of this RFP.

2.8.5 SERVICES

T. Service Requirement Overview

U. The Contractor must provide services to all Enrolled Members in accordance with the terms of the RFP, the resulting Contract, any amendments thereto, and any other applicable federal and State laws and regulations.

V. The Contractor must ensure that services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished.

W. The Contractor shall arrange for and pay for all Covered Services rendered to Enrolled Members. The Contractor must be capable of performing the following functions:

1. Credentialing and contracting with an adequate Network of Providers meeting the access requirements specified in this RFP. All Network Providers must be enrolled with the Arkansas Medicaid Program.
2. Performing Provider relations functions, including developing Provider manuals and addressing and tracking Provider Grievances and Appeals through the Grievance and Appeal System.

3. Educating and engaging Enrolled Members in their dental health.
4. Assisting Enrolled Members in accessing Covered Services and coordinating care across Providers and Coverage Entities.
5. Addressing and tracking Member Grievances through the Member Grievance and Appeal System.
6. Maintaining a call center and website.
7. Authorizing the provision of medically necessary Covered Services.
8. Monitoring utilization of Covered Services.
9. Processing and paying Claims for Medically Necessary Covered Services.
10. Maintaining quality assurance and quality improvement programs, including value-based payment and risk sharing programs.
11. Maintaining appropriate staff and systems.
12. Coordination of Benefits, third-party liability, and post-payment recovery.
13. Maintaining program integrity, including fraud, waste, and abuse investigation and recoveries.

X. The Contractor shall monitor and comply with all CMS Managed Care regulations (42 CFR Part 438) that apply to the Contractor.

Y. The Contractor must comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act.

Z. The Contractor shall cooperate with all other DHS contractors (e.g., MMIS contractor) involved in implementing and operating the program proposed in this RFP.

AA. Payment to the Contractor will begin when services are provided after Go-Live. No compensation will be paid to the Contractor for any activities it performs during the Transition Period.

2.8.6 MEDICALLY NECESSARY COVERED SERVICES AND VALUE-ADDED SERVICES

A. Covered Services

1. The DMO must provide, at a minimum, dental services provided under the Arkansas Medicaid State Plan to all Enrolled Members. Covered Services must be provided in an amount, duration and scope that is no less than what is available under Medicaid fee-for-service (FFS).
2. In accordance with 42 CFR § 438.114, the DMO must cover and pay for Emergency Dental Care for an Enrolled Member regardless of whether the provider that furnishes the services is a Network Provider, as long as the requirements of Section 2.8.7 herein are met.
3. In accordance with 42 CFR § 438.14, Indian Health Care Providers (IHCPs), whether participating or not, shall be paid for covered services, including emergency services.
4. The Contractor **shall** provide all Medically Necessary Covered Services to Beneficiaries, subject to any Benefit limits defined by DHS for certain Beneficiary populations. Medically Necessary Covered Services are described in Attachment F Bidder's Library, Exhibit 5 Arkansas Medicaid Dental Fee Schedule. The types and definitions of Medically Necessary Covered Services **shall** be subject to change by the State.
    d. After the Go-Live Date, the Contractor must begin providing Medically Necessary Covered Services to the Beneficiaries beginning on the Beneficiary's date of enrollment, regardless of pre-existing conditions or receipt of any prior health care services. Such date of enrollment may include a retroactive eligibility period.
5. The Contractor **must not** practice discriminatory selection among eligible Beneficiaries by excluding, seeking to exclude, or otherwise discriminating against any group or class of individuals.
6. The Contractor **shall** reimburse all Medically Necessary Covered Services provided to Beneficiaries, up to maximum Benefit amounts, including Medically Necessary Covered Services that were denied by

Contractor's utilization management process but were later overturned by DHS, an administrative law judge, or upon judicial or appellate review.

7. Beneficiaries who receive Medically Necessary Covered Services **shall not** be responsible for paying the costs of such services, aside from any Cost Sharing authorized by the State, as specified in Attachment F Bidder's Library, Exhibit 8 Cost Sharing, unless they have exhausted applicable maximum Benefit limits.

B. Value-Added Services

1. The Contractor may propose to offer Value-Added Services (VAS), defined as additional Covered Services beyond those required under this RFP. While VAS are optional, the Vendor will be evaluated based on the VAS it proposes.
2. All VAS **must** be offered at no cost to DHS, Enrolled Members, or Providers.
    e. The Contractor shall not receive additional compensation for any VAS offered. The Contractor may report VAS costs as Allowable Costs under the Contract. VAS costs will not be factored into rate setting.
    f. The Vendor **shall** provide detail on the VAS it proposes in the Technical Proposal, including the services covered, limitations that apply, the Enrolled Members that receive the VAS, the types of Providers responsible for proving the VAS including any limitation, and outreach efforts to Enrolled Members and Provider about VAS.
3. If proposed and implemented, the Contractor shall provide VAS for at least 12 months from the Go-Live Date of the Contract and shall identify VAS in Encounter Data submitted to DHS.
4. During the Contract Term, VAS **shall** only be added or removed by written direction of DHS. A Contractor's proposal to add or remove VAS is subject to DHS approval and **must** include the same elements as listed in the Vendor proposal.
5. Requests for approval of VAS must be submitted in a format defined by DHS, which will include anticipated improvements in outcomes and how it aligns with the goals of the program.
6. After VAS is added or removed, the Contractor **shall** update Member and Provider materials as necessary to reflect the VAS changes.

C. In Lieu of Services

1. The Contractor may cover services or settings for enrollees that are in lieu of those covered under the State plan if:
    a. DHS determines that the alternative service or setting is a medically appropriate substitute for the covered service or setting under the State plan.
    b. DHS determines that the alternative service or setting is a cost-effective substitute for the covered service or setting under the State plan.
    c. The enrollee is not required by the Contractor to use the alternative service or setting.
    d. The approved in lieu of services are authorized by DHS and identified in the contract.
    e. The approved in lieu of services are offered to enrollees at the option of the Contractor.
2. Requests for approval of in lieu of services must be submitted in a format defined by DHS, which will include anticipated improvements in outcomes and how it aligns with the goals of the program.

D. Coordination of Non-Capitated Services

1. In the event that a Contractor improperly receives a Claim for a service that is not a Covered Service, such as a Claim for a medical service, Contractor **shall** forward such Claims to the MMIS for processing and payment.
2. Contractor **shall** cooperate and **shall** require all Providers to cooperate, with other health professionals delivering non-capitated health care services to Enrolled Members. The contractor shall coordinate the provision of non-capitated services that are ancillary to covered services, including but not limited to, outpatient hospital services and anesthesia with DHS or the beneficiary's PASSE or ARHome insurer.

2.8.7 MEMBER AND PROVIDER ASSISTANCE

E. The Contractor shall operate a toll-free Call Center to provide accurate and timely assistance to Potential Members, Enrolled Members, and Providers, including setting appointments and handling Grievances and Appeals.

F. Call Center Requirements

1. The Contactor **shall** install, operate, monitor, and support an Automated Distribution Call (ADC) system, also called a "Call Center." The Call Center **shall** perform the following general functions:
    a. Responding to questions regarding Dental Benefits in an accurate and timely manner.
    b. Providing appointment assistance to Enrolled Members by:
        i. Locating a Network Provider and contacting the office for an appointment, either while the Enrolled Member is on the line or via call back, or
        ii. Locating an Out-of-Network Provider to treat the Enrolled Member when no Network Provider is available within Contract access standards.
        iii. In both cases, Call Center staff must ensure all necessary arrangements have been made, including transportation through non-emergency medical transportation providers, when necessary.
    c. Handling Enrolled Member Grievances and Appeals
    d. Handling Provider Grievances and Appeals.
    e. Transferring the Enrolled Members to DHS' eligibility system call center to resolve eligibility issues.
2. Specific service requirements for the Call Center **shall** include:
    a. Operating a toll-free, HIPAA-compliant, ADC center for Enrolled and Potential Members and Providers, either separately or combined.
        i. The Call Center **must** be able to accommodate all calls, including those requiring the use of interpreter services for the hearing impaired or for callers that have limited English proficiency.
        ii. Enrolled and Potential Members **shall not** be charged a fee for translator or interpreter services.
    b. Ensuring a sufficient number of adequately trained staff to operate the Call Center on Business Days from 7:30 am to 6:00 pm Central Time, at a minimum. All staff shall be responsive, courteous, and accurate when responding to calls.
    c. Having a method, approved by the Contract Manager, for handling calls received after normal Business hours, on weekends, and during State-approved holidays.
    d. Having a list of referral sources, which includes "safety net" Providers, teaching institutions and facilities necessary to ensure that Enrolled Members are able to access services that are not covered by Arkansas Medicaid.
    e. Having the technological capability to allow for monitoring and auditing of calls, both by the Contractor and designated DHS personnel, for quality, accuracy, and professionalism.
    f. Having an electronic system that allows Call Center staff to document calls in sufficient detail for reference, tracking, and analysis. The documentation system must contain sufficient flexibility and reportable data fields to accommodate production and ad-hoc reports. The system must also have reportable fields to accurately capture the type (inquiry or Grievance), date, and subject of each call.
    g. Having an executed and tested Call Center Disaster Recovery Plan approved by DHS by the time of Readiness Review for providing Call Center services in the event the primary Call Center facilities are unable to function in their normal capacity.
    h. Relinquishing ownership of the toll-free numbers upon Contract termination, at which time DHS shall take title to these telephone numbers.
3. During the Readiness Review, the Contractor shall demonstrate for DHS approval that all hardware, software, and staff necessary to administer the Call Center are available and operational.

a. DHS will approve or require corrective action, as necessary. All corrective action must be completed by the Contract go-live, unless otherwise specified, in writing, by DHS.

4. During the Contract Term, the Contractor shall:

a. Track and report monthly to the Contract Manager, by a method, format, and deadline approved by the Contract Manager, the number of requests for assistance to obtain an appointment, including the county in which the Enrolled Member required assistance.

b. After the Go-Live Date, for Contractors undergoing readiness review, report the following information to the Contract Manager weekly for months 1–3; monthly for months 4–12; and for all Contractors quarterly, no later than fifteen (15) days after the end of each quarter of the Contract Year, by a method and format approved by the Contract Manager, for the duration of the Contract Term:

i. Total call volume.
ii. Percentage of calls answered.
iii. Percentage of calls answered that were on hold, in 30 second increments.
iv. Percentage of calls abandoned.
v. Number of busy signals.
vi. Average speed of answer.
vii. Average hold time before answer.
viii. Average time before abandonment.
ix. Average length of call.
x. Type and subject of call by volume.
xi. Average number of Business Days to return calls from calls received during non-business hours.
xii. Percentage of calls answered within 3 rings or 15 seconds.
xiii. Percentage of calls on hold for 2 minutes or less.
xiv. Longest time to return a call.

c. Keep an electronic log of all Grievances, whether Grievances are received by the Call Center or in writing. This log **must** be submitted quarterly and made available to the Contract Manager upon request and **must** include the following at a minimum:

i. Name of customer service representative.
ii. Date of Grievance.
iii. Name of complainant.
iv. Name of Enrolled Member (if different from complainant).
v. Medicaid identification number.
vi. Nature of the complaint.
vii. Provider name (if applicable).
viii. Explanation of how complaint was resolved.
ix. Date of resolution.
x. Name of person resolving complaint

d. DHS shall have the right to amend the above list and reporting schedule at any time during the Contract term.

e. DHS **shall** have the right to request ad-hoc reports as needed.

2.9 NETWORK AND PROVIDER REQUIREMENTS

2.9.1 PROVIDER NETWORK PROVISIONS

A. Network Adequacy Standards

1. The DMO’s network must be supported by written Network Provider Agreements. The DMO must submit documentation bi-annually to DHS, in a format specified by DHS, to demonstrate:

a. That it offers an appropriate range of Dental Services for the Enrolled population;

b. That it has the capacity to serve the expected enrollment in accordance with DHS's standards for access and timeliness of care found in the Contract; and

c. That it maintains a Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrolled Members.

2. The DMO must regularly and systematically monitor the adequacy of its Network in accordance with the standards set forth in the Contract. The DMO must submit documentation of Network Adequacy as specified by DHS, but no less frequently than the following:
    a. At the beginning of the Contract term;
    b. On a bi-annual basis;
    c. Any time there has been a significant change (as defined by DHS) in the DMO's operations that would affect the adequacy of capacity and services, including changes in DMO services, benefits, geographic service area, composition of or payments to its Network; or
    d. At the enrollment of a new Medicaid eligibility group in the DMO.
3. The DMO is prohibited from discriminating against any dental provider (i.e., limiting his or her participation, reimbursement, or indemnification) who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.
4. If the DMO's Network is unable to provide Medically Necessary Dental Services covered under the Contract to an Enrolled Member, the DMO must adequately and timely cover the services out of network for as long as the DMO's Network is unable to provide them. This must be provided at no cost to the Enrolled Member.
5. The DMO must provide for a second opinion of a dental treatment, if requested by an Enrolled Member, from a Network Provider or arrange for the Enrolled Member to obtain a second opinion outside the Network.
6. The DMO must demonstrate that there are sufficient IHCPs participating in the provider network of the DMO to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services. If timely access to covered services by IHCP providers cannot be ensured the DMO must:
    a. Permit Indian enrollees to access out-of-State IHCPs; or
    b. Allow the enrollee to be disenrolled for good cause from both the DMO and the Healthy Smiles Dental Managed Care Program in accordance with 42 CFR § 438.56(c).

B. Provider Contracting

1. The DMO must enter into Network Provider Agreements to ensure Network adequacy is met. All Network Provider Agreements must meet the standards set out in this RFP.
2. The DMO must ensure that all Network Providers are enrolled Medicaid providers.
3. The DMO may enter into a provisional Provider Agreement with a provider for up to 120 calendar days, pending the outcome of the provider's screening, credentialing, or revalidation by the DMO; however, the provider must be enrolled with Medicaid to receive payment from the DMO.
4. The DMO may not prohibit or restrict a provider acting within the lawful scope of his or her practice from advising or advocating on behalf of an Enrolled Member who is his or her patient, regarding:
    a. The Enrolled Member's health status or treatment options, including any alternative treatments that may be self-administered.
    b. Any information the Enrolled Member needs to decide among all relevant treatment options.
    c. The risks, benefits, and consequences of treatment or non-treatment.
    d. The Enrolled Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and the right to express preferences about future treatment options.
5. The DMO must implement written policies and procedures for selection and retention of Network Providers.
    a. These policies and procedures must not discriminate against providers that serve high-risk populations or specialize in areas that require costly treatment. However, the DMO is not precluded from establishing policies and procedures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrolled Members.

6. The DMO's policies and procedures for selection of providers must comply with the Arkansas Any Willing Provider law, Ark. Code Ann. § 23-99-801 et seq.
7. The DMO must inform Providers, at the time they enter into a Provider Agreement, about:
    a. Enrolled Member and Provider Grievance, Appeal, and Fair Hearing procedures and timeframes as specified in 42 CFR § 438.400 through 42 CFR § 438.424.
    b. The Enrolled Member's and provider's right to file Grievances and Appeals.
    c. The availability of assistance to the Enrolled Member or Provider with filing Grievances and Appeals.
    d. The Enrolled Member's and Provider's right to request a Fair Hearing after the DMO has made a determination on an Appeal that is averse to the Enrolled Member or provider.
    e. The Enrolled Member's right to request continuation of benefits that the DMO seeks to reduce or terminate during an Appeal or Fair Hearing filing, if filed within the allowable timeframes, although the Enrolled Member may be liable for the cost of any continued benefits while the Appeal or Fair Hearing is pending, if the final decision is averse to the Enrolled Member.
8. The DMO may negotiate with its Network Providers for payment of services provided to Enrolled Members. Payment models may include, but are not limited to unit-based payment, per diem, performance incentive payment, value-based payment, episode of care payment, bundle, or global payment arrangement. All such payment arrangements must meet the requirements set out in the Contract, including, but not limited to, the prohibitions set out in this RFP.
9. The DMO may impose reasonable authorization requirements; however, the DMO must disseminate practice guidelines regarding these requirements to all Network Providers.
10. The DMO must make a good faith effort to notify Enrolled Members affected by the termination of a Provider Agreement within thirty (30) calendar days of the termination and help the Enrolled Members select a new practitioner.
11. The DMO shall, upon request, make available to DHS all Network Provider Agreements, and amendments thereto.

C. Provider Credentialing and Enrollment

1. The Contractor **shall** ensure that all Network Providers are licensed, credentialed, and eligible to render services in the Medicaid program under applicable State and Federal laws, regulations, bulletins, and industry best practices. The credentialing protocol **shall** include, but not be limited to, the applicable requirements outlined herein the Program Integrity Section 2.14. The Contractor **shall** implement these requirements with an efficient but thorough credentialing process presented to DHS for its approval no later than 120 days after the Commencement Date and before Readiness Review. Such credentialing and enrollment process **shall** also include re-credentialing.
2. During the Transition Period, the Contractor shall:
    a. Develop a process to accept an initial file load of Provider Network data from DHS with the file format to be determined by DHS. This process will also be used to reconcile the Contractor’s Network with DHS’s Dental Provider Network during the Readiness Review and prior to the Go-Live Date, as well as other times as may be required throughout the life of the Contract.
3. Using the Arkansas Provider Portal, submit monthly updates of Provider Network information beginning thirty (30) days after Contract Commencement.
    a. Submit to the Contract Manager proof of Network adequacy by the Readiness Review.
    b. Submit corrective action plans for areas that do not meet Network adequacy standards as referenced in this RFP.
4. During the Contract term, the Contractor shall:
    a. Submit to the Contract Manager, in a method and format, and by a deadline determined by the Contract Manager:
        i. A monthly report on Provider recruitment activities, including the type of Provider, location, date, and type of recruitment activity.

ii. A monthly report, following the Contract year schedule, of all Providers whose participation status was terminated during the preceding quarter, including the Provider's name, address, specialty, and reason for termination.

b. Utilize the provider master file that is provided by DHS MMIS to verify provider data.

c. Develop and submit corrective action plans to the Contract Manager in the timeframe specified by the Contract Manager to address Network Adequacy issues, whether geographic or specialty driven, that arise during the Contract Term per the standards defined in Attachment C Performance Based Contracting.

d. Relating to PCD assignment and capacity:

i. Submit, in a method and format determined by the Contract Manager, written procedures for assigning the Beneficiaries to a PCD for the Contract Manager's approval by the Readiness Review.

ii. When Beneficiary PCD assignments begin, issue durable dental identification cards to Beneficiaries within DHS-established time frames.

iii. Submit, in a method and format determined by the Contract Manager, a report of PCD capacity to the Contract Manager at the end of the 2nd and 4th quarter of each calendar year within thirty (30) days following the second and fourth quarters.

e. Update DHS's Provider Network data in a timely and accurate manner as approved by DHS, so as not to create discrepancies in the Contractor's Provider Network data and DHS's Provider Network data. DHS intends to move towards a model in which the DMO may act as agents for the providers, with provider approval, to ensure information is sourced correctly and provided to DHS as prescribed by state regulations.

5. The Contractor shall have a Provider credentialing and enrollment process. The Contractor's Provider credentialing and enrollment process shall:

a. Comply with all applicable Program Integrity Requirements, as well as all applicable State and Federal laws, rules, and regulations.

b. Require that all Network Providers complete the Enrollment Disclosure Form included in the Vendors' Library.

c. Process a completed credentialling application within 30 calendar days of receipt.

6. Ensure that all Providers possess the licenses and credentials necessary to render services under State law.

a. Ensure that the Network does not include Providers who have been suspended or excluded from federal healthcare programs, including Medicare and Medicaid.

b. Verify that all Network Providers have current professional liability insurance.

c. Review sanction history verified through the National Practitioner Data Bank or other appropriate entity and act accordingly.

d. Maintain an electronic database of all persons who apply to become Network Providers, which includes, at a minimum:

i. The date the application was received.

ii. The application.

iii. Attachments to the application and all subsequent information submitted as part of the application.

iv. The dates and nature of the actions taken and the date a decision was rendered.

v. Any subsequently executed Provider Agreement with the Provider.

e. Allow the Contract Manager and designees access to the Network Provider database.

f. Require that all Providers enroll to participate in the Arkansas Medicaid program as providers of Covered Services; and ensure that it only pays claims for Providers who are properly enrolled.

g. Assist Providers in completing required forms to participate in the Arkansas Medicaid program.

h. Provide, in a method and format and by a deadline determined by the Contract Manager, a monthly update file to DHS/DMS Dental Unit containing all additions and deletions from the Network.

D. Provider Re-Credentialing and Re-Validation.

1. At least once every three (3) years, the Contractor **must** review and approve the credentials of all Network Providers. The re-credentialing process **shall** confirm the same elements as the initial credentialing upon Provider enrollment.

E. Network Provider Agreements

1. The Contractor must enter into written contracts with properly credentialed Providers who participate in the Network. These Network Provider Agreements must be in writing, must comply with applicable federal and State laws and regulations, and must include the minimum requirements specified in Exhibit 3 Minimum Requirements for Provider Agreements located in the Bidder's Library.

a. The Contractor must submit model Network Provider Agreements DHS for review and approval during the Transition Period. Additionally, the Contractor must submit any substantive revisions to the Network Provider agreement to DHS for review and approval at least thirty (30) days prior to implementation of the revisions. DHS, through the Contract Manager, shall have the right to reject or require changes to any Network Provider Agreements that do not comply with the Contract.

b. The DMO's Network Provider Agreements with PCDs must contain the following provisions, at a minimum:

i. The requirements set forth under Sections 2 and 3 of this RFP and the resulting Contract.

ii. Performance standards, including sanctions that could be imposed as a result of failure to meet these standards.

c. The DMO must ensure that each provider furnishing services to Enrolled Members, including PCDs, maintains and shares an Enrolled Member's dental records in accordance with professional standards. Records must be retained for ten (10) years from the date of Contract termination or until all audit questions or review issues, appeal hearings, investigations or administrative or judicial litigation to which the records may relate are finally concluded, whichever period is later.

2. The Contractor shall be prohibited from the following:

a. Requiring a Provider or Provider group to enter into an exclusive contracting arrangement with the Contractor as a condition for Network participation.

b. Requiring Providers to participate in the Contractor's other lines of business as a condition of joining the Contractor's Network for Arkansas Medicaid.

c. Reimbursing Providers at rates lower than prevailing rates in the Arkansas Medicaid fee-for-service system.

i. If the Contractor enters into a capitated, bundled, or non-fee for service arrangement with a Provider, the Contractor must submit to the Contract Monitor a certification from an actuary to demonstrate that the capitated, bundled, or non-fee for service rate paid is sufficient at expected levels of utilization to cover the prevailing rates in the Arkansas Medicaid fee-for-service system.

ii. Such certification must be submitted to the Contract Monitor at least thirty (30) days before the Contractor begins making capitated payments to the Provider.

iii. The Contractor must adjust the amount of capitated, bundled, or non-fee for service payments in the event that the Contract Monitor determines that the capitated, bundled, or non-fee for service payments are not sufficient.

iv. Any such adjustments must be retroactive to the date on which the Contractor began making the capitated, bundled, or non-fee for service payments outlined in the actuary's certification.

v. The Contractor may enforce a withhold on Providers within the Contractors network as long as the payment amount, net of the withhold amount, is no lower than prevailing rates

3. The Contractor will not be responsible for cost settlements with Federally Qualified Health Centers (FQHCs) in accordance with federal requirements; DHS may elect at a future date to require the Contractor to ensure the FQHC receives the rate required under the Prospective Payment System.

F. Provider Relations and Education

1. The Contractor **shall** have a specific provider relations representative assigned to each dentist within the Provider Network.
    a. These representatives **shall** be contactable by phone, email, and mail via the United States Postal Service, and they **must** visit Provider offices a minimum of one visit per year, and additional visits as needed, for all dentists and mobile dental units.
    b. Provider relations staff shall respond to Provider inquiries within one (1) Business Day of receiving a phone or email contact and one (1) Business Day of receiving mail via the United States Postal Service.
    c. These staff **must** have the ability to provide individual training and education as needed and as requested by Network Providers. For example, if requested, these staff **shall** inform Network Providers of the Contractor's availability to assist with:
        i. Helping Enrolled Members or their PCD find dental specialists.
        ii. Helping dentists navigate the pre-authorization process.
        iii. Explaining the role and responsibilities of the PCD.
        iv. Addressing Claims-related problems and questions.
        v. Explaining the Grievance and Appeal System, including the process for Providers to lodge Appeals on behalf of Enrolled Members or on their own behalf.
        vi. Providing any other relevant information needed or requested by a Provider.
2. Practice Guidelines
    a. The DMO must adopt dental practice guidelines that are based on valid, reliable clinical evidence or a consensus of providers in the dental field.
    b. The practice guidelines must consider the needs of all Enrolled Members.
    c. The practice guidelines must be adopted in consultation with the Provider Advisory Committee.
    d. The DMO must review and update the practices guidelines regularly, as appropriate, but no less than once a year.
    e. The practice guidelines must cover, at a minimum, the following:
        i. Utilization management
        ii. Potential and Enrolled Member education and outreach
        iii. Coverage of services
    f. The DMO must disseminate the practice guidelines to all effected Providers and, upon request, to Enrolled Members and Potential Members.
    g. The Contractor shall educate Providers to follow practice guidelines for preventive oral health services identified by DHS and consistent with professional recommendations regarding the periodicity of Dental Services for both adult and pediatric populations.
    h. The Contractor shall coordinate with other provider types as needed to provide complete execution of the dental treatment plan. This includes, but is not limited to, medical providers, inpatient hospitals, and outpatient surgical centers.
    i. The Contractor shall coordinate enrolled members medical benefits for any necessary oral surgeries, including surgical professional service and anesthesia. DHS may require the Contractor to report data reflecting efforts and failures to assist enrolled members in receiving oral surgery services. Future years of the contract could include performance standards to measure and assess DMOs' compliance with this requirement.
    j. The Contractor shall work with DHS and other DHS contractors as necessary to develop dental education materials tailored for children, including specifically describing the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program requirements.

k. Practice guidelines for pediatric dental utilization shall include timely provision of exams, cleaning, fluoride treatment, sealants, and any medically necessary referral for treatment of children of all ages.

l. The Contractor shall provide training and education to Providers on dental practice guidelines for young children, pregnant women and intellectual or developmentally disabled (IDD), and behavioral health (BH) populations.

3. The Contractor shall be responsible for educating Providers on its utilization management system and the program requirements of Medicaid.

G. Provider Manual

1. The Contractor shall develop, produce, and distribute a Provider Manual that includes payment processes by the dates listed in this section, which at a minimum shall include:

a. A clear definition of the populations to be covered and the service package, including limitations and exclusions, for each population.

b. Utilization management and preauthorization procedures and requirements.

c. Documentation requirements for treatment of Enrolled Members.

d. Detailed description of the Grievance and Appeal System processes available to Providers, including the reconsideration process for denied or down-coded prior authorization or retrospective review decisions.

e. A detailed description of billing requirements and a copy of the Contractor's HIPAA-compliant paper billing forms and electronic billing format.

f. Instructions for all electronic Claim submissions and information on its no-cost direct data entry method for entering Claims through a web portal.

2. During the Transition Period, the Contractor shall:

a. Submit, in a method and format determined by DHS, drafts of the Provider Manual to the Contract Manager for DHS approval on the following schedule:

i. A draft must be submitted by the time of Readiness Review.

ii. A final draft for approval must be submitted within two (2) weeks of receiving comments from the Contract Manager.

b. Mail the approved Provider Manual to all Network Providers no less than one (1) month prior to the Go-Live Date.

c. Add the Provider Manual to their website and submit the Manual in PDF format to the Contract Manager for inclusion on the DHS Healthy Smiles website.

d. Offer Provider trainings to orient Providers and their staff to the information contained in the Provider Manual.

e. At least fifteen (15) days prior to the Go-Live Date, the Contractor shall provide to the Contract Manager, in a method and format determined by the Contract Manager, documentation of all formal training activities.

3. During the Contract Term, the Contractor shall:

a. Mail the Provider Manual to all new Providers in the Contractor's Network within one (1) week of the Provider's enrollment.

b. Maintain an accurate Provider Manual on its website.

i. Offer Provider trainings to update Providers and their staff on the information contained in the Provider Manual.

ii. The Contractor must provide documentation of all formal training activities to the Contract Manager by the 15th day after the end of each quarter of the Contract Year.

c. Update the Manual as frequently as needed, but no less than ten (10) days prior to the Commencement Date of any Contract renewal that may occur.

i. The Manual and any revisions must be submitted to the Contract Manager for approval at least thirty (30) days prior to distribution.

ii. After completing all modifications required by the Contract Manager, the Contractor shall distribute procedural or policy revisions to Providers at least fifteen (15) days prior to the effective date of the revision in the manner in which the Manual was originally given to the Provider.

2.9.2 ACCESS TO CARE

A. General Requirements

1. During the Contract Term, the Contractor's Provider Network **must** ensure that all Medically Necessary Covered Services **shall** be available to enrolled members on a timely basis consistent with appropriate dental guidelines, with generally accepted practice parameters, and with the Contract's requirements.

   a. The Contractor **shall** include in its Network the following classes of Providers in numbers that are sufficient to furnish services described in this RFP in accordance with the time, geographic, and other standards described in this RFP. The State will accept either Letters of Intent (LOIs) or Letters of Authorization (LOAs) to satisfy network coverage requirements prior to the Go-Live Date:

      i. Dentists and dental hygienists, pediatric dentists, orthodontists, periodontists, oral surgeons, and endodontists;

      ii. Dentists and other dental professionals described above with demonstrated experience in the provision of services to children and adults with acute and chronic medical conditions or special circumstances, including but not limited to cardiovascular conditions, HIV infection, cancer, developmental disability, or behavioral disorder; and

      iii. Other recognized dental professionals who are trained in dental care and oral health and experienced in performing triage for such care.

   b. As part of Network management, the Contractor shall track and analyze all Network changes and provide information to the Contract Manager as required.

   c. The Contractor shall ensure that its Providers provide Covered Services to Beneficiaries under this Contract at the same quality level and practice standards and with the same level of dignity and respect as provided to non-Medicaid patients.

   d. Without limiting the foregoing, the Contractor shall ensure that its Providers agree if they are accepting new patients, they must accept all new patients, regardless of payer source, and appointments are equally available, regardless of payer source.

   e. The Contractor shall not restrict Providers from enrolling in other Contractor's networks, in accordance with federal requirements.

   f. The Contractor shall follow the Any Willing Provider Law, A.C.A. §23-99-804(a) when entering into Network Provider Agreements.

2. The Network must be responsive to the linguistic, cultural, and other unique needs of any minority or disabled individuals or other special population in Arkansas Medicaid. This includes the capacity to communicate with Beneficiaries in languages other than English, when necessary, as well as with those who are deaf or hearing impaired. The Contractor must include in any Provider Directory the languages spoken by each Network Provider.

3. Unless otherwise specified in the Contract, the Contractor shall meet the following specific access standards:

   a. At least 95% of Enrolled Members **must** have access to two or more Primary Care Dentists who are accepting new patients within 30 miles of the Enrolled Member's residence in Urban counties and 60 miles of the Enrolled Member's residence in Rural counties.

   b. At least 85% of all Enrolled Members **must** have access to at least one specialty provider within 30 miles of the Enrolled Member's residence in urban counties and 60 miles of the Enrolled Member's residence in rural counties.

   c. At least 95% of pediatric Enrolled Members must have access to Pediatric Dental Services through two or more Primary Care Dentists who are accepting new patients within 30 miles of the Enrolled

Member's residence in Urban counties and 60 miles of the Enrolled Member' residence in Rural counties.

d. Emergency Care **must** be provided within 24 hours.

e. Urgent care, including urgent specialty care, **must** be provided within 48 hours.

f. Therapeutic and diagnostic care **must** be provided within 14 days.

g. Primary Care Dentists **must** make referrals for specialty care on a timely basis, based on the urgency of the Enrolled Member's dental condition, but no later than 30 days.

h. Non-urgent specialty care **must** be provided within 60 days of authorization.

B. Assigning a Primary Care Dentist

1. The Contractor **shall** maintain a sufficient Network for each Enrolled Member to have a Primary Care Dentist (PCD).

2. The Contractor must have a plan for pairing newly Enrolled Members with a PCD. This plan must conform to the following requirements:

   a. When Members enroll, the Contractor **shall** offer them a choice of PCDs within their geographic area. The Network adequacy standards for rural area is within 60 miles of the enrolled member's residence an urban area within 30 miles of the enrolled member's residence.

   b. If an Enrolled Member does not choose a PCD within 30 days after enrollment with the Contractor, the Contractor **shall** assign a PCD based on the geographic area in which the Enrolled Member resides. If there is a Medicaid Claims history for the Enrolled Member, the Contractor **shall** link auto-assigned Enrolled Members to their historic Provider. The Contractor shall notify the Enrolled Member and the PCD of the PCD assignment.

   c. Enrolled Members **shall** be given the opportunity to change their PCD at any time by calling the Contractor.

   d. The Contractor may choose whether the PCD assignment will match an Enrolled Member with an individual dental Provider or with a provider location such as a dental practice group.

3. The Contractor shall require PCDs, through contract provisions or payment processes, to:

   a. Provide children enrolled in Medicaid or CHIP with diagnostic and preventive services in accordance with American Academy of Pediatric Dentistry (AAPD) recommendations (Attachment F Bidder's Library, Exhibit 9). The Contractor **must** make best efforts to ensure that PCDs follow these periodicity dental requirements for children, including, Provider education, profiling, monitoring, and feedback activities.

   b. Provide adults enrolled in Medicaid with diagnostic and preventive services in accordance with American Dental Association. The Contractor **must** make best efforts to ensure that PCDs follow these guidelines for adults, including Provider education, profiling, monitoring, and feedback activities.

   c. Assess the dental needs of all Enrolled Members for referral to specialty care Providers and provide referrals as needed. The Contractor **must**, at a minimum, engage in Provider education and review of Provider referral patterns.

C. Out-of-Network Referrals

1. If a Medically Necessary Covered Service is not available through a Network Provider based on the standards outlined in this RFP, the Contractor **must** allow a referral to an out-of-network provider. A request for such referral may be made by a Network Provider or the Enrolled Member (or their parent or legal guardian).

2. The Contractor **must** review and act upon the request within a reasonable time in light of the circumstances, not to exceed five (5) Business Days after receipt of reasonably requested documentation.

3. When an Enrolled Member receives a Medically Necessary Covered Service from an out-of-network provider pursuant to a referral, as described above, the Contractor **must** reimburse the out-of-network provider using a single case agreement.

a. The Contractor must ensure the out-of-network provider has a State Medicaid number.

b. The Contractor must ensure that out-of-network providers do not balance bill Enrolled Members.

c. Out-of-network providers **must** submit Claims to the Contractor.

d. The prohibition on balance billing does not apply if an Enrolled Member seeks services from an out-of-network provider without following the required referral procedures.

e. The Contractor **shall** ensure no greater than 20% percent of the total dollars billed to the Contractor for outpatient services **shall** be billed by out-of-network providers.

D. Monitoring Access

1. The Contractor **must** regularly and systematically verify that Medically Necessary Covered Services furnished by Network Providers are available and accessible to Enrolled Members.

2. The Contractor **must** enforce access and other Network standards required by the Contract and take appropriate action with Providers whose performance is determined by the Contractor to be out of compliance.

3. By the time of Readiness Review and in a method and format as determined or approved by the Contract Manager, the Contractor **shall** submit for the Contract Manager's review and approval a plan for how the Contractor will monitor access and take appropriate action.

4. The Vendor **must** make modifications to any part of the plan not approved by the Contract Manager, and a modified plan **must** be re-submitted to the Contract Manager for approval in a timeframe agreed upon by the Contractor and Contract Manager.

2.10 PAYMENT TO PROVIDERS

2.10.1 CLAIMS PROCESSING

A. General Requirements

1. The DMO shall develop and maintain an accurate and efficient system for receiving and adjudicating claims for Medically Necessary Dental Services, operated in accordance with all applicable State and federal requirements, including CMS Medicaid Managed Care regulations (42 CFR Chapter 438) and the Arkansas Medicaid Fairness Act (a copy of which is included in the Bidder's Library). The claims system must meet the requirements contained herein within the general requirements, Scope of Work, and any relevant attachments.

2. The Contractor shall provide a Claims processing system that can be adapted to implement new or amended laws, policies, or regulations that affect the Claims-processing functions required by this Contract. Implementation of these system changes shall be at no cost to the State.

3. The Contractor shall retain Claims payment history for the duration of the Contract and ten (10) years thereafter.

4. All Claims data must be easily sorted and produced in formats as requested by DHS.

5. Without limiting permissible utilization management practices, the DMO must reimburse providers for the delivery of Medically Necessary Dental Services, including services prior authorized.

6. The DMO may deny claims not submitted for payment by the provider (either by mail or electronically) within 365 days of the date of service.

7. The DMO must NOT pay for an item or service that is:

a. Furnished by an individual during any period in which there is a pending investigation of a credible allegation of fraud against the individual or entity requesting reimbursement, unless DHS and OMIG determine that there is good cause not to suspend payments.

b. Furnished by an individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX, or pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act.

c. Furnished at the medical direction or prescription of a Provider, during the period when the dentist is excluded from participation under title V, XVIII or XX or pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

8. The DMO cannot make payments for any Provider Preventable Conditions in accordance with 42 CFR § 438.3(g). The DMO must track and report on all Provider Preventable Conditions associated with claims for payment that could otherwise be made. The report must include, at a minimum:
   a. Wrong surgical or invasive procedures performed on an Enrolled Member;
   b. Surgical or invasive procedure being performed on the wrong body part or the wrong Enrolled Member; or
   c. A service that has a negative consequence on the Enrolled Member.
9. The DMO must develop and maintain sufficient written documentation to support each service for which payment is made.
10. Nothing in this section precludes the DMO from using different reimbursement amounts for different specialties or different practitioners in the same specialty.
11. The DMO must prohibit balance billing by Network Providers and Out-of-Network Providers for Covered Services. This means that the Provider may not bill the Enrolled Member directly for any amount not paid by the DMO for the services provided.
12. The DMO must honor any authorizations for services issued by DHS or its authorization vendors prior to enrollment for any newly Enrolled Members. The DMO shall require the provider to submit documentation of an authorization by DHS or its authorization vendor after the effective date of DMO enrollment.
13. No Payment Outside of the U.S. – The DMO will not provide any payments for items or services provided as outlined herein to any financial institution, entity, or person located outside the United States of America.
14. IHCPs, whether participating or not, shall be paid for covered services provided to AI/AN enrollees who are eligible to receive services from such providers as follows:
    a. At the applicable encounter rate published annually in the Federal Register by the Indian Health Service., or
       i. In the absence of a published encounter rate, the amount the IHCP would receive if the services were provided under the State plan's FFS payment methodology.

       and

    b. Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR 447.45 and 447.46.
15. According 42 CFR 438.14 (c), the DMO must adhere to the following payment requirements regarding IHCPs:
    a. When an IHCP is enrolled in Medicaid as a FQHC but not a participating provider of the DMO, it must be paid an amount equal to the amount the DMO would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the State to make up the difference between the amount the DMO pays and what the IHCP FQHC would have received under FFS. The amount paid should be at least what the Arkansas Medicaid Program would have paid using the PPS methodology.
    b. When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the DMO's network, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's FFS payment methodology.
    c. When the amount a IHCP receives from the DMO is less than the amount required by FFS or the applicable encounter rate, the State must make a supplemental payment to the IHCP to make up the difference between the amount the DMO pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

B. During the Start-Up Period

1. The Contractor **shall** develop, and full cycle test a Claims system to receive, adjudicate, and pay Claims to dental Providers.

C. Throughout the Contract Term

1. The Contractor **must** maintain an automated Claims system that:

   . Registers the date a Claim is received by a Provider.
   a. Records the details of each Claim transaction.
   b. Has the capability to report each Claim transaction by date and type.
   c. Maintains information at the Claim and line detail levels.
   d. Maintains online and archived files.

2. The Contractor must offer its Providers the option of submitting and receiving Claims information through an electronic, HIPAA-compliant Provider portal that allows for automated processing, adjudication, and correction of Claims, allowing Providers to:

   . Verify Enrolled Member eligibility.

   a. Submit and view prior authorization requests.

   b. Provide functionality for claims appeals and reconsiderations.

   c. Submit online corrections or deletions whereby the Provider can “void” a claim prior to the close of a payment period and, if needed, resubmit a corrected claim for reprocessing of the voided claim.

   d. Engage in batch processing, allowing Providers to send billing information all at once in a “batch” rather than in separate individual transactions.

3. The Contractor shall implement a system, by the Readiness Review, to cost avoid and prevent payment of Dental Services when Arkansas Medicaid provides information on third-party insurance dental program coverage.

4. The Contractor must notify DHS of major claim system changes in writing at least 180 days prior to implementation of the change.

   a. The Contractor **must** provide an implementation plan and schedule of proposed changes, which **shall** be subject to DHS approval.

5. To accomplish the processing and adjudication of Dental Claims the Contractor shall (by way of a secure environment):

   a. Verify Enrolled Member eligibility on all Claim transactions submitted.

   b. Verify Provider eligibility on all Claim transactions submitted. The Contract **must** withhold all or part of payment for any Claim submitted by a Provider:

      i. Excluded or suspended from a federal healthcare program for fraud, abuse, or waste;
      ii. On payment hold under DHS authority, or
      iii. With debts, settlements, or pending payments due to the State or the federal government.

   c. Ensure that Provider information submitted on claims transactions matches the Provider information in Contractor’s database of Providers.

   d. Maintain clear billing instructions for Providers.

   e. Verify third-party insurance billing information.

   f. Verify prior authorization of Claims as required by Arkansas Medicaid.

   g. Accept and process Claims submitted on HIPAA-compliant ADA paper billing forms or on HIPAA-compliant 837D electronic format.

   h. Develop a web portal by the Readiness Review to accept direct data entry of Claims from dental Providers.

   i. Provide all safeguards to prohibit submission of duplicate claims, e.g., each submission instantaneously becomes part of the Enrolled Member's payment history.

j. Within five (5) Business Days of receipt of a paper Claim lacking sufficient information to process, return the Claim to the Provider that submitted it with an explanation of the reason that the Claim was returned.

k. Within two (2) Business Days of receipt of an electronic Claim lacking sufficient information to process, return the Claim to the Provider that submitted it with an explanation of the reason that the Claim was returned.

l. Receive and utilize the eligibility decision date in the adjudication of claims for retroactively eligible Enrolled Members so that a claim meets the timely filing limits if the claim is submitted within twelve (12) months of the decision date or notice of eligibility.

m. Deny or approve and submit for payment:

i. 100% of clean paper Claims within thirty (30) calendar days of receipt.
ii. 100% of clean electronic Claims within fourteen (14) calendar days of receipt.

n. Explain to Providers the process for appealing the decision of the Contractor for any Claim that is denied in whole or in part.

o. Assign to each Claim a unique transaction identifier that indicates the date the Claim was received by the Contractor and the input source (paper, electronic media, or web portal).

p. Generate an explanation of payments (remittance) as appropriate for each Provider in paper format (mailed if Provider requests and downloadable from web) or 835 ANSI X12N 5010A1 format (electronically if Provider requests).

q. Make payments to Providers consistent with DHS requirements, including the mandate that Providers to receive Electronic Funds Transfer (EFT) payments.

r. Accept medical Provider data, in a format to be determined by the Contract Manager and the Contractor, in order to pay claims from medical Providers that offer Dental Services as required in Attachment F Bidder's Library, Exhibit 1 834 Com.

s. Have a program to detect and promptly report suspected fraud and abuse to OMIG, Medicaid Fraud Control Unit (MFCU), and DHS and to cooperate in any prosecution.

t. Provide remote access to Contractor systems for up to ten (10) DHS staff for ad-hoc reporting and claims and prior authorization inquiry review.

6. The Contractor shall submit the following reports in the method and format, and by a deadline, approved by the Contract Manager:

a. A quarterly report to the Contract Manager showing, for each month's paper and electronic Claims, average adjudication time and disposition.

b. A monthly file to the Contract Manager, due the 15th of each month, of all denied Claims from the previous month.

7. The claims system **must** be able to process retrospective claims adjustments, including automated electronic mass adjustments processed in a batch format whereby a retroactive rate change or other change can be reprocessed to ensure correct Provider payment or other adjustments in the designated claims payment format.

D. Encounter Data

1. The DMO is required to submit all Encounter Data for all services provided to Enrolled Members, including allowed and paid amounts and value-added services, as required by the Managed Care regulations in 42 CFR § 438.818 and any additional requirements contained herein. The Encounter Data must include characteristics of the Enrolled Member, and the provider and must meet data quality standards, as established by CMS and DHS, to ensure complete and accurate data for program administration.

2. Weekly Encounter Data submissions must include information on denied claims. The submission of denied claims will begin upon both (a) mutual agreement of all parties and (b) a written statement from DHS' vendors that all systems are ready to exchange denied claims.

3. The accuracy of the Encounter Data must be closely monitored and enforced because Encounter Data is used as the basis for the following by DHS:

a. Actuarially sound Capitated Payments to the DMO for all Covered Services;

b. Determination of the DMO's compliance with the MLR requirement set out in Section 12.14.1.

c. Determination that the DMO has made adequate provisions against the risk of insolvency.

d. Certification that the DMO has complied with the State's requirements of availability and accessibility of services, including network adequacy.

4. The DMO must certify all Encounter Data to the extent required by 42 CFR 438.606. Such certification must be submitted to DHS with the certified data and must be based on the knowledge, information, and belief of the Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Medical Officer (CMO) or an individual who has written delegated authority to sign for, and directly reports to the CEO or CFO, that all data submitted in conjunction with the Encounter Data and all documents requested by DHS are accurate, truthful, and complete. The DMO must provide the certification at the same time it submits the certified data in the format and within the timeframe required by DHS.
5. Encounter Data **must** follow the format and include the data elements described in the most current version of HIPAA- compliant X12 837D Health Care Claim: Dental Companion Guides and Encounters Submission Guidelines.
6. DHS **shall** specify the method of transmission, the submission schedule, and any other requirements.
7. Encounter Data quality validation **must** incorporate assessment standards developed by DHS.
8. The Dental Contractor **must** make original records available for inspection by DHS for validation purposes.
9. Encounter Data that does not meet quality standards **must** be corrected and returned within a time period specified by DHS.
10. For reporting Claims processed by the Contractor and submitted on Encounter 837D format, the Contractor **must** use the procedure codes, diagnosis codes, provider identifiers, and other codes as directed by DHS.
11. Any exceptions will be considered on a code-by-code basis after DHS receives written notice from the Contractor requesting an exception.
12. The Contractor **shall** ensure at least 99% of all Encounter Data **must** be accurate, timely, and complete.

2.10.2 PAYMENT TO CONTRACTOR

E. Capitation Payments

1. DHS will make Capitated Payments to the DMO for all Medicaid-eligible Enrolled Members in accordance with Attachment F, Bidder’s Library, Exhibit 7 Milliman Letter.
2. Capitated Payments must be actuarially sound and guarantee cost effectiveness of the Healthy Smiles Program.
3. DHS will notify the DMO of the Capitated Payments and any changes thereto prior to implementation of those payments. The DMO will have the opportunity to respond prior to implementation of the rates.
4. DHS must consider any comments made by the DMO regarding the rates; however, the DMO will be required to accept the DHS-proposed Capitated Payments to participate in the Healthy Smiles program.

F. The DMO shall report to DHS when it has identified overpayment of the Capitated Payment, or any other amount specified in the contract, within thirty (30) calendar days of when the DMO identified the overpayment or was notified by a Subcontractor of the overpayment.

G. All disputes regarding the amount owed **shall** be addressed in accordance with the process determined in contract negotiations.

H. In the event that an Enrolled Member qualifies for retroactive coverage prior to the date of application for Medicaid coverage, the Contractor will receive a capitation payment for each month during the retroactive eligibility period.

I. In the event that an Enrolled Member is retroactively disenrolled from coverage for any reason, including but not limited to by death or incarceration, DHS **shall** recoup premiums paid for such

Enrolled Member.

J. At the end of each year, the Contractor **shall** submit reports on its Medical Loss Ratio calculated in accordance with the requirements established under federal regulations, 42 CFR 438.8.

2.10.3 COORDINATION OF BENEFITS & THIRD-PARTY LIABILITY

K. Identification of Third-Party Liability

1. The DMO is responsible for Third Party Liability (TPL). Medicaid is the payor of last resort, unless specifically prohibited by applicable State or federal law. Therefore, the DMO must pay for Covered Services only after all other sources of payment have been exhausted.
2. All other available Third-Party Liability (TPL) resources **must** meet their legal obligation to pay Claims before the Medicaid program pays for the care of an individual eligible for Medicaid.
3. The DMO must take reasonable measures to identify potentially legally liable third-party sources, in accordance with requirements outlined herein.
4. The DMO must have procedures to coordinate provision of and payment for DMO-furnished services with services furnished by:
    a. Any other insurance provider, including Medicare or Third-party insurance;
    b. Any other Medicaid Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), or Prepaid Inpatient Health Plan (PIHP), as those are defined by CMS; and
    c. Medicaid in the FFS environment.
5. DHS will provide the Contractor with a monthly TPL file including the names of all Enrolled Members who are known or believed to have other insurance.
6. The TPL file will include all information DHS possesses on the type of TPL, including the type of coverage, the insurance carrier, the effective date, and the name of the insured on the policy (if other than the Enrolled Member).
7. The DMO must identify the existence of potentially liable parties using a variety of methods, including referrals and data mining. The DMO must not pursue recovery in the following circumstances, unless the case has been referred to the DHS or DHS's authorized representative:
    a. Motor Vehicle Cases
    b. Other Casualty Cases
    c. Tortfeasors
    d. Restitution Recoveries
    e. Worker's Compensation Cases
8. Upon identification of a potentially liable third party in any of the above situations, the DMO must, within ten (10) business days, report the potentially liable third party to DHS for determination of a mass tort, total plan case, or joint case.
    a. A "mass tort case" is a case where multiple plaintiffs or a class of plaintiffs have filed a lawsuit against the same tortfeasor(s) to recover damages arising from the same or similar set of circumstances (e.g., class action lawsuits) regardless of whether any reinsurance or FFS payments are involved.
    b. A “total plan case” is a case where payments for services rendered to the Enrolled Member are exclusively the responsibility of the DMO; no reinsurance or Fee-For-Service payments are involved.
    c. By contrast, a "joint" case is one where Fee-For-Service payments and/or reinsurance payments are involved. The DMO must cooperate with DHS's authorized representative in all collection efforts.
9. In "total plan cases,” the DMO is responsible for performing all research, investigation, the mandatory filing of initial liens on cases that exceed $250, lien amendments, lien releases, and payment of other related costs in accordance with DHS guidelines. The DMO must use the DHS-approved casualty recovery correspondence when filing liens and when corresponding to others in regard to casualty recovery. The DMO may retain up to 100% of its recovery collections if all of the following conditions exist:

a. Total collections received do not exceed the total amount of the DMO's financial liability for the Enrolled Member,

b. There are no payments made by DHS related to FFS, or applied DHS administrative costs (i.e., lien filing fee, etc.), and

c. Such recovery is not prohibited by State or federal law.

10. Prior to negotiating a settlement on a "total plan case," the DMO must notify DHS to ensure that there is no reinsurance or FFS payment that has been made by DHS.

11. The DMO must report settlement information to DHS within ten (10) business days from the settlement date.

L. Payment of Claims

1. For Enrolled Members with an identified TPL resource listed in the TPL file, Contractor **shall** coordinate Benefits in accordance with 42 C.F.R. § 433.125 et seq.

a. Unless otherwise specified below, the Contractor **shall** cost-avoid a Claim if a TPL resource is included in the monthly TPL file.

b. The Contractor **shall** send the Claim back to the Provider, noting the source of TPL; and instructing the Provider to bill the TPL resource.

c. If a balance remains after the TPL resource has paid the provider or denied the Claim, the Provider can submit a claim to the Contractor for payment of the balance, up to the Contractor's maximum allowable amount.

d. Even if TPL has been identified, the Contractor **shall** pay Claims and then seek to recoup payment from the TPL resource in the following circumstances:

i. If the claim is for a Covered Service delivered to an Enrolled Member on whose behalf child support enforcement is being carried out if (1) the TPL file indicates that the TPL resource is through an absent parent and (2) if the Provider certifies that it billed the TPL resource and waited thirty (30) days from the date of service without receiving payment to bill Medicaid.

ii. If the Claim is for preventive pediatric services, including EPSDT.

2. For Enrolled Members without an identified TPL resource listed in the TPL file, the Contractor must pay Claims consistent with the requirements set forth in this RFP.

a. If the Contractor later establishes a TPL resource, or if the TPL file is updated to reflect a TPL resource, the Contractor **shall** have six (6) months from the later of the date the TPL file was updated to reflect the TPL resource or the date the Claim was paid to seek repayment.

b. Contractor may retain any recouped payments.

c. After that date, DHS will pursue recoveries from TPL resources, and DHS **shall** retain any recouped payments.

3. DHS has right of recovery for third party resources six (6) months after the later of the date of payment of the claim or the date of identification of TPL resources for a claim already paid. After that date, the Contractor must cease recovery efforts.

M. Third Party Liability Reporting Requirements

1. The Contractor **shall** maintain a system that is capable of tracking and generating reports on Claims cost-avoided and Claims recovered.

2. The Contractor **shall** include with Encounter Data any information regarding Claims cost-avoided or payments recovered.

3. The Contractor shall provide a quarterly report detailing claims cost-avoided and claims recovered.

2.11 STRATEGIC PLAN AND UTILIZATION MANAGEMENT

2.11.1 PREAUTHORIZATION AND UTILIZATION MANAGEMENT

N. In arranging for the provision of Medically Necessary Covered Services to Enrolled Members, the Contractor **shall**:

1. Ensure that all Medically Necessary diagnostic, preventive, restorative, surgical, endodontic, periodontic, emergency, and adjunctive Dental Services that are administered by or under the direct supervision of a licensed dentist are provided to children who are eligible for EPSDT services in accordance with the EPSDT federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989, whether or not such services are Covered Services under Arkansas Medicaid.
    a. Services for children shall be approved in accordance with the periodicity standards of the AAPD in order to meet the EPSDT standard. See Attachment F, Bidder's Library, Exhibit 9 for AAPD's Periodicity of Examination, Preventive Dental Services, and Oral Treatment for Children.
    b. Authorize the provision of orthodontics to Enrolled Members under the age of 21 when the orthodontic treatment plan meets all the criteria set by Arkansas Medicaid.
2. Ninety (90) days prior to the Go-Live Date, the Contractor shall submit to the Contract Manager, by a method and format approved by the Contract Manager, policies and procedures for DHS approval that will describe how the Contractor will meet the requirements set forth in this section of the RFP.
3. These policies and procedures shall include all Covered Services, EPSDT and AAPD standards, preauthorization, and the Grievance and Appeal System.

O. Prior Authorization

1. The DMO may require prior authorization for Covered Services in accordance with the requirements of this Solicitation and 42 CFR Part 438. The DMO must make available the list of services requiring prior authorization to Potential and Enrolled Members, as well as Network Providers and out-of-network providers.
2. The DMO must have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services. These written policies and procedures must include:
    a. Mechanisms to ensure consistent application of review criteria for authorizations of services.
    b. Consultation with the requesting provider for Dental Services, when appropriate.
3. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by an individual who has appropriate expertise in addressing the Enrolled Member's service needs. For Dental Services, the decision must be made by a dentist licensed to practice in the State of Arkansas.
4. Compensation to individuals or entities that conduct utilization management activities, including prior authorization reviews, must NOT be structured so as to incentivize denying, limiting, or discontinuing Medically Necessary services to any Enrolled Member.
5. When a requesting provider indicates, or the DMO determines, that following the standard timeframe could seriously jeopardize the Enrolled Member's life, health, or ability to attain, maintain or regain maximum function, the DMO must make an expedited authorization decision and provide notices as expeditiously as the Enrolled Member's condition requires, but no later than seventy-two (72) hours after receipt of the request for services.
6. Service authorization decisions not reached within the defined timeframe specified above constitute a denial and Adverse Benefit Determination. The DMO must provide notice on of the Adverse Benefit Determination and right to Appeal.
7. The Contractor shall make a determination of Medical Necessity on a case-by-case basis for services requiring preauthorization. The Contractor shall:
    a. Provide the proposed list of services requiring preauthorization to the Contract Manager for DHS approval by the Readiness Review and resubmit the list incorporating required changes within five (5) Business Days.

b. Submit all policies and procedures related to preauthorization to the Contract Manager for approval by the Readiness Review and at least thirty (30) days prior to the implementation or effective date of any revision to such policies after the Go-Live Date. These policies and procedures **must** receive DHS approval at least ten (10) days prior to implementation or the effective date of the policy or any revision thereto.

c. Have the ability to place limits on a service; however, such limits **shall** be exceeded for children eligible for EPSDT services when such services are determined to be Medically Necessary based on an Enrolled Member's individual needs.

d. Cover orthodontic care cases for children that meet clinical criteria. The criteria cannot be stricter than that set out in the Arkansas State Plan, which states that the problem must cause dysfunction and score at least 28 points on the Handicapping Labio-Lingual Deviations Index No. 4. The Contractor **shall**:

   i. Submit all criteria and preauthorization process policies and procedures to the Contract Manager for approval by the Readiness Review.

   ii. Pay Providers for the orthodontia by either:

      - Remitting the total reimbursement for comprehensive orthodontia after the corrective appliances are installed in the Enrolled Member's mouth, or
      - Paying for the orthodontia in regular installments, as agreed to by Contractor and Provider.

   iii. Ensure that treatment is completed, despite the loss of eligibility, provided the Enrolled Member was eligible on the date the banding occurred.

      - It is a requirement of the State that any orthodontic services initiated while a beneficiary is eligible for service be followed through to the completion of the treatment plan even if dental eligibility is lost for any reason including when the beneficiary moves to another Contractor
      - In addition to ensuring completion of the authorized treatment plan and removal of the appliance, the Contractor **must** ensure that the treatment plan is completed if the Enrolled Member moves, or the original dental provider is otherwise unable to complete the approved treatment plan.
      - The Enrolled Member PMPM payments to the Contractor will stop as soon as a Beneficiary loses eligibility.
      - The Enrolled Member that lost eligibility is not specifically captured in the present system.

e. Prior Authorization not required for:

   i. Any Medically Necessary preventive services.
   ii. Diagnostic Dental Services.
   iii. Patients who present a specific symptomatic problem such as dental pain.
   iv. Dental emergencies such as trauma or acute infection.

f. Determine Medical Necessity for Dental Services rendered in a non-dental office setting, including in a hospital operating room.

g. Contractor shall serve as the point of contact for the dental Provider, Arkansas Medicaid, and any other required medical Provider.

h. Provide multiple easy-to-use, no-cost methods for Providers to submit pre-authorization requests; such methods can include, but are not limited to, a toll-free phone number, toll-free fax machine, web portal, and email; and all such methods must comply with the following requirements:

   i. All methods must direct Providers immediately to the unit performing the pre-authorizations, with the exception of the toll-free number, which can direct the call to the appropriate unit using simple prompts;

   ii. Providers must be permitted to submit electronic attachments, regardless of the method the Provider uses to submit preauthorization requests; and

   iii. All transmissions must be HIPAA-compliant.

i. Render a decision (approve or deny) in a timely manner so as not to adversely affect the Enrolled Member's health, not longer than the shorter of two (2) Business Days after receiving the required documentation, or seven (7) calendar days from the date of the request;

j. Include all the following requirements in the Contractor's preauthorization process:

i. The dental Provider **must** submit the request for authorization for Covered Services directly to the Contractor.

ii. The Contractor **must** consult with the treating Provider to obtain all necessary information.

iii. All Adverse Benefit Determinations **must** be issued by a Dentist licensed to practice in the State of Arkansas.

iv. The Contractor **shall** ensure that a second qualified reviewer who played no part in the initial denial/down coding decision independently review any Adverse Benefit Determinations.

v. The Contractor **must** ensure that the facility and anesthesia Providers for Dental Services rendered in a non-dental setting are enrolled to participate in Arkansas Medicaid and coordinate the provision of these services with DHS, the enrollee's PASSE, or ARHome insurer, as appropriate. The Contractor shall conduct a performance improvement plan (PIP) in conjunction with all other Contractors in order to develop a coordination process and measures.

vi. The Contractor retains the right to evaluate all Claims for Medical Necessity, except that the Contractor may not deny a Claim for lack of Medical Necessity if the service was prior authorized.

vii. All documentation submitted as part of the preauthorization process **must** be maintained in such a way that it can be retrieved and provided to the Contract Manager upon request.

8. When the DMO makes an Adverse Benefit Determination, the DMO must send notice of the Adverse Benefit Determination to the Enrolled Member and applicable provider as required by the State.

a. The DMO may shorten the period of advance notice from ten (10) to five (5) calendar days before the date of the action, if the DMO has facts indicating that the action should be taken because of probable fraud by the Enrolled Member, and the facts have been verified, if possible, through secondary sources.

b. The DMO may send a notice not later than the date of action, if:

i. The Enrolled Member has died;

ii. The DMO receives a clear written statement, signed by the Enrolled Member or authorized representative, that:

- Requests service termination or
- Has information that requires services termination or deduction and indicates the Enrolled Member understands that service termination or reduction will result;
- The Enrolled Member has been admitted to a service location or enrolled in a service program where he or she is ineligible for enrollment in Healthy Smiles.
- The Enrolled Member's address is determined unknown based on return mail with no forwarding address;
- The Enrolled Member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

c. The notice of Adverse Benefit Determination must contain the following:

i. The type and number of services requested;

ii. The Adverse Benefit Determination taken by the DMO; and

iii. A statement of the basis of the Adverse Benefit Determination, including the facts that support the action/decision and the source of those facts.

iv. The DMO must not terminate or reduce the services until a decision is rendered on appeal and the notice of resolution is sent unless the Enrolled Member requests in writing that the services be terminated or reduced pending a decision on the Appeal.

d. The notice of Adverse Benefit Determination must include:

i. The reasons for the Adverse Benefit Determination, including the right of the Enrolled Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards uses in setting coverage limits;

ii. The Enrolled Member's right to request an Appeal of the DMO's Adverse Benefit Determination, including information on exhausting the DMO's one level of appeal and the right to request a Fair Hearing after receiving notice that the Adverse Benefit Determination is upheld;

iii. The procedures for exercising the Enrolled Member's rights to appeal; and

iv. The circumstances under which an appeal process can be expedited and how to request that

P. Utilization Management

1. The Contractor **shall** establish a system, prior to being deemed ready to take clients, to monitor access to care to ensure that quality metrics goals established by DHS are met.
2. The DMO may conduct pre-payment, concurrent, or post-payment medical reviews of all claims, including outlier claims.
3. All utilization management processes **must** meet Utilization Review Accreditation Commission standards.
4. Any Subcontractor who performs utilization review on behalf of the Vendor must meet all Utilization Review Accreditation Commission standards.
5. Erroneously paid claims are subject to recoupment.
6. When the DMO requires a concurrent medical review for payment of services, if the DMO is unable to determine services are Medically Necessary through its inability to perform a concurrent medical review process, the lack of medical necessity determination shall not constitute a basis for denial of payment or recoupment of paid claims.
7. If the DMO determines services are Medically Necessary through prior authorization, the DMO may not later take the position that the services were not Medically Necessary through post-payment review, unless:
    a. The prior authorization was based upon misrepresentation by act or omission;
        i. The services billed were not provided: or
        ii. An unexpected change occurred that rendered the services not Medically Necessary.
8. The DMO must maintain an electronic record of all Adverse Benefit Determinations.
9. The record must be kept current and be made available to DHS upon request.
10. Each long entry must contain, at a minimum:
    a. Date of the request for services;
    b. Name and Medicaid ID of Enrolled Member;
    c. Name of the provider making the request;
    d. Date of the Adverse Benefit Determination;
    e. Reason for the Adverse Benefit Determination;
    f. Name of DMO employee or contractor who made the Adverse Benefit Determination; and
    g. Date the notice of Adverse Benefit Determination was sent to the requesting provider and Enrolled Member.
11. No later than fifteen (15) days after the end of the quarter, submit a quarterly report to the Contract Manager, including, at a minimum:
    a. Enrolled Member name
    b. Medicaid ID number
    c. Date of request
    d. Date of Adverse Benefit Determination

e. Reviewer's name

f. Service denied.

g. Provider who submitted the request

h. Notation if the service was received as determined through Claims data for dates of service applicable in the preauthorization request

12. Prior to Go-Live, the Contractor **shall**:

a. Develop and implement tools to enable it to routinely assess its progress toward achieving DHS's goal of improving annual utilization of preventive and restorative services.

b. Maintain a tracking system with the capability to identify and report each Enrolled Member's dental utilization; preventive treatment due dates; referrals for corrective treatment; whether treatment was received; and, if so, the date of service.

c. Be prepared to produce and submit reports on EPSDT services delivered and utilization of services by ARKids B Beneficiaries, in the format required and in accordance with the timeline specified by CMS.

d. Be prepared to produce and submit utilization report quarterly after anniversary of Go-Live Date, as well as fulfill ad hoc requests from DHS within ten (10) Business Days of request.

Q. Continuity of Care and Non-Network Providers

1. The Contractor **must** ensure that the care of newly enrolled members is not disrupted or interrupted, especially for Beneficiaries whose health condition has been treated by specialty care Providers or whose health could be placed in jeopardy if Medically Necessary Covered Services are disrupted or interrupted.

2. The Contractor must ensure that Enrolled member receiving Covered Services through a prior authorization receive continued authorization of those services either until the expiration date of the prior authorization, or until the Contractor has evaluated and assessed the Beneficiary and issued or denied a new authorization, whichever is shorter.

3. If a newly enrolled Beneficiary is completing one or more dental procedures initiated prior to joining the Contractor's plan, the Contractor shall only be responsible for payment for the continued course of treatment if such treatment is a Medically Necessary Covered Dental Service and has not already been paid in full by the Beneficiary's previous plan.

4. The Contractor must pay a newly enrolled Beneficiary's existing non-network providers for Medically Necessary Covered Services until the Beneficiary's records, clinical information and care can be transferred to a Network Provider, or until such time as the Beneficiary is no longer enrolled with the Contractor, whichever is shorter.

5. Payment to out-of-network providers must be made within the time period required for Network Providers.

6. This section does not require the Contractor to reimburse the Beneficiary's existing non-network providers for ongoing care for:

a. More than 90 days after a Beneficiary enrolls with the Contractor, or

b. For more than nine (9) months in the case of a Beneficiary who, at the time of enrollment in the Contractor, has been diagnosed with and receiving treatment for a terminal illness and remains enrolled with the Contractor.

2.11.2 REPORTING REQUIREMENTS

A. General Requirements

1. The Contractor shall submit reports as outlined in Attachment F Bidder's Library, Exhibit 6 DMO Reports List.

2. The reporting requirements set out in this Section are in addition to other reporting requirements found in this RFP and the resultant Contract and do not supplant or supersede those other requirements.

B. Reports shall be submitted in a manner and format agreed upon by the parties, unless otherwise specified herein.

C. DHS shall have the right to amend the list of required reports or the reporting schedule at any time during the term of the Contract upon notice to the DMO.

D. DHS shall have the right to request ad hoc reports, as needed to meet the objectives of the Healthy Smiles program and any CMS requirements.

E. Call Center reports required under the Contract must be submitted for both the Enrolled Member Support Call Center and the Provider Support Call Center.

F. Medical Loss Ratio (MLR) Report

1. The DMO must submit a report detailing the calculation of its MLR. This report must be submitted on the 15th day of August in the year following the completion of each calendar year.
2. In accordance with 42 CFR § 438.8(k), the MLR Report submitted to DHS must include:
    a. Total Incurred Claims.
    b. Expenditures on quality improving activities.
    c. Expenditures related to activities compliant with program integrity requirements (Fraud Prevention Activities).
    d. Non-claims costs. Non-Claims Costs means those expenses for administrative services that are not: Incurred claims; expenditures on activities that improve health care quality; or licensing and regulatory fees, or federal and State taxes.
    e. Premium Revenue.
    f. Taxes.
    g. Licensing fees.
    h. Regulatory fees.
    i. Methodologies for allocation of expenditures. A detailed description of all methods used by the DMO or its Subcontractors to allocate expenses, including incurred claims, quality improvement expenses, federal and State taxes and licensing or regulatory fees, and other non-claims costs.
    j. Any credibility adjustment applied. Credibility adjustment means an adjustment to the MLR for a partially credible DMO to account for a difference between the actual and target MLRs that may be due to random statistical variation. Partial credibility means a standard for which the experience of a DMO is determined to be sufficient for the calculation of a MLR but with a non-negligible chance that the difference between the actual and target MLR is statistically significant. A DMO that is assigned partial credibility (or is partially credible) will receive a credibility adjustment to its MLR.
    k. The calculated MLR. The MLR experienced for each DMO in a MLR reporting year is the ratio of the numerator to the denominator. A MLR may be increased by a credibility adjustment, as permitted.
    l. Any remittance owed to the State, if applicable. If required, a DMO must provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85 percent or higher set by DHS. When applicable, DHS or its contracted actuaries will specify the methodology to be used when determining the remittance calculation.
    m. A comparison of the information reported with the audited financial report. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.
    n. A description of the aggregation method used to calculate total Incurred Claims. The DMO will aggregate data for all Medicaid eligibility groups covered under the Contract unless DHS requires separate reporting and a separate MLR calculation for specific populations.
    o. The number of member months. Member months mean the number of months a member or group of members is covered by a DMO over a specified time period, such as a year.
    p. Other metrics or information required by DHS.

3. The DMO must submit audited financial reports specific to the Contract on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. Audited financial reports prepared in accordance with Arkansas statutes and the Arkansas Insurance Code, and accepted by the Arkansas Insurance Department will be deemed to meet the requirements of Section 9.
4. The DMO must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports. The DMO Chief Executive Officer (CEO), Chief Financial Officer (CFO) or his/her designee, is the authorized representative who may attest to the accuracy of the calculation of the MLR.

2.12 ADMINISTRATION AND MANAGEMENT

2.12.1 CONTRACTOR OFFICE, STAFFING, AND SUBCONTRACTING

A. Office Location

1. The Contractor **must** maintain a physical office in Pulaski County, Arkansas.
2. At minimum, the following staff **shall** be located in the Pulaski County, Arkansas office: Project Director, Dental Director, Provider relations staff, outreach staff, and Quality Assurance and Grievances and Appeals staff.

B. Staffing Plan

1. The Contractor **shall** ensure that all persons, whether they are employees, agents, subcontractors, Providers, or anyone acting for or on behalf of the Contractor, are legally authorized to render services under applicable Arkansas law and/or regulations.
2. The Contractor **shall not** have an employment, consulting, or any other agreement with a person that has been debarred or suspended by any federal or State agency for the provision of items or services related to the entity's contractual obligation with the State.
3. The Contractor **shall** implement its staffing plan as proposed in its *Technical Proposal.*
    a. If the Contract necessitates lower staffing levels, the Contractor may request DHS to approve a modified staffing plan.
    b. The Contractor **shall** at all times maintain staffing levels at 90 percent of its proposed staffing plan set forth in its *Technical Proposal* or its modified staffing plan as approved by the Contract Manager.
    c. The staffing for the plan covered by this RFP **must** be capable of fulfilling the requirements of this RFP.
    d. A single individual **shall not** hold more than one position unless otherwise specified in Attachment A Key Personnel.
    e. The DMO must submit an organizational chart to DHS that identifies the staff required in the requirements of this Solicitation. The DMO must notify DHS of any changes to the organizational chart within five (5) business days and submit a new organizational chart reflecting these changes.
    f. For the purpose of reporting staffing rates, the Contractor **shall** submit to the Contract Manager by the 15th of each month a list of all Contract Personnel with associated full-time equivalencies (40 hours equals one (1) full time equivalent position) and the number of days of any vacancies for those positions for the previous month.
    g. The Contract Manager will compare this monthly staffing report to the Contractor’s Staffing Plan for the purposes of calculating compliance with the staffing requirement and damages, if required.

C. The minimum staff requirements shall be as follows:

1. A full-time administrator (Project Director) dedicated 100% to this Contract, **shall** be specifically responsible for the coordination and operation of all aspects of the Contract. This person **shall** be at the Contractor’s officer level and **must** be approved by DHS, including upon replacement.
2. Sufficient numbers of trained and experienced staff who shall conduct daily business in an orderly manner, including such functions as administration, accounting and finance, prior authorizations, Grievance and Appeal System, and Claims adjudication and reporting.

3. Provider Relations Director, and Provider relations staff, whose primary duties shall include development and implementation of the Contractor's ongoing strategies to increase Provider participation and to perform other necessary Provider relation activities.
4. A full-time Outreach and Education Coordinator dedicated 100% to this Contract, and regionally located outreach staff, whose primary duties **shall** include development and implementation of the Contractor's ongoing strategies to increase utilization of Dental Services, lead the Contractor's program for dealing with Non-Compliant Enrolled Members as described, and perform all other necessary outreach and education activities.
5. Dental Director, a dentist who **shall** be licensed by and physically located in the State of Arkansas, who **shall** be responsible for ensuring the proper provision of Covered Services to Enrolled Members.
6. A staff of qualified, clinically trained personnel whose primary duties **shall** be to assist in evaluating Medical Necessity for dental specialty services, as well as represent DHS and the Contractor at dental Administrative Hearings.
7. A Quality Assurance Coordinator who **shall** coordinate requirements and monitor quality of care.
8. An appropriately experienced Information Technology Director who **shall** manage all necessary data functions, including eligibility, Claims, and reporting, and who shall work with DHS' Office of Information Technology (OIT) to ensure compliance with all State and federal data requirements.
9. Sufficiently trained and experienced full-time staff who **shall** maintain Member and Provider Call Center functions and **shall** be responsible for explaining the program, assisting Enrolled member in the selection of dental Providers, assisting Enrolled Members to make appointments and obtain services, and maintaining the Member and Provider Grievance and Appeal Systems.
10. A Chief Financial Officer who **shall** have direct supervisory responsibility for all personnel performing financial functions required for the fulfillment of the Contract.
11. A Compliance Officer who is accountable to the Contractor's executive leadership. This individual **must** maintain a current knowledge of federal and State legislation, legislative initiatives, and regulations that may impact the program. The Compliance Officer, in close coordination with other key staff, has primary responsibility for ensuring all Contractor functions are compliant with the terms of the Contract and the law.
12. Special Investigation Unit staff to review and investigate Contractor's Providers and Enrolled Members that are suspected of engaging in wasteful, abusive, or fraudulent billing or service utilization.
13. Staff members described above with titles of "Director," "Coordinator," or "Officer" shall be considered Key Personnel under this Contract.
14. The Contractor shall submit to the Contract Manager names, qualifications, and resumes of all proposed Key Personnel by the Readiness Review. DHS shall approve Key Personnel or request alternate candidates.
15. Key positions may be filled after award of the contract, but the Project Director and Dental Director position shall be filled within thirty (30) days of contract start date.

D. Substitution of Key Personnel

1. Continuous performance of key personnel: Unless substitution is approved under this section, key personnel **shall** be the same people proposed in the Contractor's *Technical Proposal*, which **shall** be incorporated into the Contract by reference.
2. Such identified key personnel **shall** perform continuously for the Contract Term, or such lesser duration as specified in the *Technical Proposal*.
3. When possible, the Contractor shall provide written notice of removal of Key Personnel through voluntary or involuntary termination, promotion, or demotion, at least two weeks prior to the removal date. If two weeks' notice is not possible, the Contractor shall provide immediate notice.
4. For the purposes of this Section, the following definitions shall apply:
    a. **Extraordinary Personal Circumstance:** Any circumstance in an individual's personal life that reasonably requires immediate and continuous attention for more than fifteen (15) days and that precludes the individual from performing his/her job duties under this Contract. Examples of such circumstances may include, but are not limited to:

i. A sudden leave of absence to care for a family member who is injured, sick, or incapacitated.

ii. The death of a family member, including the need to attend to the estate or other affairs of the deceased or his/her dependents.

iii. Substantial damage to, or destruction of, the individual's home that causes a major disruption in the individual's normal living circumstances.

iv. Criminal or civil proceedings against the individual or a family member.

v. Jury duty.

vi. Military service call-up.

b. **Incapacitating:** Any health circumstance that substantially impairs the ability of an individual to perform the job duties described for that individual's position in the RFP or the Contractor's Technical Proposal.

c. **Sudden:** When the Contractor has less than thirty (30) days' prior notice of a circumstance beyond its control that will require the replacement of any key personnel working under the Contract.

5. The following provisions shall apply to all the circumstances of staff substitution described in this section:

a. The Contractor **shall** demonstrate to the Contract Manager's satisfaction that the proposed substitute key personnel have qualifications at least equal to those of the key personnel for whom the replacement is requested.

b. The Contractor **shall** provide the Contract Manager with a substitution request that **shall** include:

i. A detailed explanation of the reason(s) for the substitution request.
ii. The resume of the proposed substitute personnel, signed by the substituting individual and his/her formal supervisor.
iii. The official resume of the current personnel for comparison purposes; and
iv. Any evidence of any required credentials.

c. The Contract Manager shall have the right to require additional information concerning the proposed substitution.

d. The Contract Manager and other appropriate State personnel involved with the Contract shall have the right to interview the proposed substitute personnel prior to deciding whether to approve the substitution request.

e. The Contract Manager will notify the Contractor in writing of: (i) the acceptance or denial, or (ii) contingent or temporary approval for a specified time limit, of the requested substitution.

f. The Contract Manager will not unreasonably withhold approval of a requested key personnel replacement.

6. Replacement Circumstances:

a. Voluntary Key Personnel Replacement:

i. The Contractor **shall** submit a substitution request at least fifteen (15) days prior to the intended date of change.

ii. A substitution **shall not** occur unless and until the Contract Manager approves the substitution in writing.

b. Key Personnel Replacement Due to Vacancy:

i. The Contractor **shall** replace key personnel whenever a vacancy occurs due to the sudden termination, resignation, leave of absence due to an Extraordinary Personal Circumstance, Incapacitating injury, illness or physical condition, or death of such personnel.

ii. The Contractor **shall** identify a suitable replacement and provide the information or items required for a substitution request within fifteen (15) days of the actual vacancy occurrence or from when the Contractor first knew or should have known that the vacancy would be occurring, whichever is earlier.

iii. A termination or resignation with thirty (30) days or more advance notice **shall** be treated as a Voluntary Key Personnel Replacement.

c. Key Personnel Replacement Due to an Indeterminate Absence:

i. If any key personnel has been absent from his/her job for a period of ten (10) days due to injury, illness, or other physical condition, leave of absence under a family medical leave, or an Extraordinary Personal Circumstance and it is not known or reasonably anticipated that the individual will be returning to work within the next twenty (20) days to fully resume all job duties, before the 25th day of continuous absence, the Contractor **shall** identify a suitable replacement and **shall** provide the information or items required for a substitution request to the Contract Manager.

ii. If this person is available to return to work and fully perform all job duties before a replacement has been authorized by the Contract Manager, at the option and sole discretion of the Contract Manager, the original personnel may continue to work under the Contract, or the replacement personnel will be authorized to replace the original personnel, notwithstanding the original personnel's ability to return.

d. Directed Personnel Replacement:

i. The Contract Manager **shall** have the right to direct the Contractor to replace any personnel who are perceived by DHS as being unqualified, non-productive, unable to fully perform the job duties due to full or partial Incapacity or Extraordinary Personal Circumstance, disruptive behavior, or is known or reasonably believed to have committed a major infraction of legal or Contract requirements.

ii. If deemed appropriate in the discretion of the Contract Manager, the Contract Manager **shall** give written notice of any personnel performance issues to the Contractor, describing the problem and delineating the remediation requirement(s).

iii. The Contractor **shall** provide a written Remediation Plan within ten (10) days of the date of the notice and **shall** implement the Remediation Plan immediately upon written acceptance by the Contract Manager.

iv. If the Contract Manager rejects the Remediation Plan, the Contractor **shall** revise and resubmit the plan to the Contract Manager within five (5) days, or in the timeframe set forth by the Contract Manager in writing.

- Should performance issues persist despite the approved Remediation Plan, the Contract Manager will give written notice of the continuing performance issues and **shall** have the right to either request a new Remediation Plan within a specified time limit or direct the substitution of personnel whose performance is at issue with a qualified substitute, including requiring the immediate removal of the key personnel at issue.

- If at all possible, the Contract Manager will provide at least fifteen (15) days notification of a directed replacement. However, if the Contract Manager deems it necessary and in DHS' best interests to remove the personnel with less than fifteen (15) days' notice, the Contract Manager **shall** have the right to direct the removal in a timeframe of less than fifteen (15) days, including immediate removal.

v. In circumstances of directed removal, the Contractor shall provide a suitable replacement for approval within fifteen (15) days of the notification of the need for removal, or the actual removal, whichever occurs first.

vi. Replacement or substitution of personnel under this section shall be in addition to, and not in lieu of, the State's remedies under the Contract or which otherwise may be available at law or in equity.

E. Approval of Staffing and Facilities

1. During the Start-Up Period, the Contractor **shall**:

a. Provide a completed organizational chart with staffing plan and staff training materials to the Contract Manager for approval by the Readiness Review and **shall** make any requested changes in five (5) Business Days. Key personnel must be identified by the start of the Readiness Review.

b. Provide a Vendor Contract Manager at the office facility location and ensure the functioning of all systems by the Readiness Review.

c. Provide personnel-specific contact information for the following positions and departments by the Readiness Review:

i. Key Personnel:

- Project Director
- Dental Director
- Provider Relations Director
- Quality Assurance Director
- Clinicians for Dental Administrative Hearings
- Outreach Coordinator

ii. Departments:

- Accounting and Finance
- Prior Authorizations
- Claims Processing
- Information Systems
- The Call Center
- Provider Relations
- Member Relations

2. Debarred Individuals

a. The Contractor shall have policies and procedures in place to routinely monitor its own staff positions and subcontractors for individuals debarred or excluded from participation in the Contract by law.

b. The Contractor shall be required to disclose to the Contract Manager information required by 42 CFR 455.106 regarding the Contractor's staff and persons with an ownership/controlling interest in the Contractor that have been convicted of a criminal offense related to that person's involvement in Medicare/Medicaid or Title XIX programs.

F. Delegation of DMO Responsibilities

1. The DMO may delegate performance of work required under the general requirements and/or Scope of Work contained herein through subcontract or agreement with written prior approval by DMS. Any subcontract or agreement must comply with all applicable State and federal laws, including, without limitation, 42 CFR 438.230 and all other applicable Medicaid laws and regulations, other sub-regulatory guidance, and all provisions of the resulting Contract. The DMO must obtain written approval of the subcontract or agreement from DMS prior to implementation of any subcontract or agreement entered after the Effective Date of the Contract. DHS reserves the right to inspect any existing subcontracts or agreements for compliance with the terms of the Contract.

2. A subcontract or agreement does not relieve the DMO of any responsibilities under the requirement of any resulting Contract, and the DMO is responsible for ensuring all activities are performed in accordance with the Contract's terms. The DMO must submit to DHS a monitoring plan for each subcontract or agreement it enters that includes a system for regular and periodic assessment of the subcontractor or delegates compliance with the terms of the subcontract or agreement.

3. The DMO, all Subcontractors, and all network providers must comply with the applicable provisions of federal and State laws, regulations, and policies.

4. The DMO or Subcontractor must, to the extent that the subcontractor is delegated responsibility by the DMO for coverage of services and payment of claims under the Contract, implement and maintain a compliance program that must include:

a. Written policies, procedures, and standards of conduct that articulate the subcontractor's commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and State requirements.

b. A Compliance Officer (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the CEO and the Board of Directors (BoD).

c. A Regulatory Compliance Committee (RCC) of the BoD and at the senior management level charged with overseeing the Subcontractor's compliance with the requirements under the Contract.

d. A system for training and education for the CO, the Subcontractor's senior management, and the Subcontractor's employees for the federal and state standards and requirements, under the Contract.

e. Effective lines of communication between the CO and the Subcontractor's employees.

f. Enforcement of standards through well-publicized disciplinary guidelines.

g. The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of investigation of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.

5. The DMO or Subcontractor, to the extent that the Subcontractor is delegated responsibility by the DMO for coverage of services and payment of claims under the Contract, must implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to DHS, MFCU, and OMIG.

6. The DMO or Subcontractor, to the extent that the Subcontractor is delegated responsibility by the DMO for coverage of services and payments of claims under the Contract, must implement and maintain arrangements or procedures for prompt notification to DHS when it receives information about changes in an Enrolled Member's circumstances that may affect the Enrolled Member's eligibility, including changes in the Enrolled Member's residence or the death of an Enrolled Member.

7. The DMO or Subcontractor, to the extent that the Subcontractor is delegated responsibility by the DMO for coverage of services and payments of claims under the Contract, must implement and maintain arrangements or procedures for notification to DHS, MFCU, and OMIG when it receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the DMO program, including the termination of the Provider Agreement with the DMO.

8. The DMO or Subcontractor, to the extent that the Subcontractor is delegated responsibility by the DMO for coverage of services and payments of claims under the Contract, must implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Enrolled Members and the application of such verification processes on a regular basis.

9. For DMOs that make or receive annual payments under this contract of at least $5,000,000, the DMO or Subcontractor, to the extent that the Subcontractor is delegated responsibility by the DMO for coverage of services and payments of claims under the Contract, must implement and maintain written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act (FCA) and other federal and State laws, including information about rights of employees to be protected as whistleblowers.

10. The DMO or Subcontractor, to the extent that the Subcontractor is delegated responsibility by the DMO for coverage of services and payments of claims under the Contract, must implement and maintain arrangements or procedures that include provision for the timely referral of any potential fraud, waste, or abuse the DMO or Subcontractor identifies to MFCU and OMIG.

11. The DMO or subcontractor, to the extent that the subcontractor is delegated responsibility by the DMO for coverage of services and payments of claims under the Agreement, must implement and maintain arrangements or procedures that include provision for the DMO's suspension of payments to a Network Provider upon prior notice from DHS, MFCU, or OMIG of a determination that there is a credible allegation of fraud, absent a law enforcement exception.

12. A Subcontract or agreement that delegates activities under the Contract or any amendments thereto, must be in writing, signed, and dated prior to work under the subcontract or agreement beginning. The subcontractor or delegate must meet all the requirements and obligations of the DMO related to the activities delegated under the subcontract or agreement.
13. The DMO shall not include provisions in any subcontract or agreement that contain compensation terms that discourage Network Providers from serving any specific eligibility category.
14. The DMO shall maintain a fully executed original or electronic copy of all subcontracts or agreements, which shall be available to DHS within five (5) business days of a request by DHS to inspect.
15. Subcontract or agreement terms, conditions, and other information may be designated as confidential, but must not be withheld or redacted when provided to DHS, OMIG, or MFCU.
16. DHS will not disclose information designated as confidential without the prior written consent of the DMO, except as required by law.
17. The DMO must document compliance certification (business-to-business) testing of transaction compliance with HIPAA for any Subcontractor or delegate that receives Enrolled Member data.
18. The DMO may not use a subcontract or agreement to make a specific payment directly or indirectly under a Provider Incentive Plan, as an inducement to reduce or limit Medically Necessary services to an Enrolled Member. All Subcontractors or delegates, and all employees of the Subcontractor or delegate, must meet the following requirements:
    a. Eligible for participation in the Medicaid program; however, Medicaid participation in Medicaid FFS is not required;
    b. Pass a background check based on the nature and scope of the work the subcontractor or delegate will perform;
    c. Not debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations or guidelines issued under Executive Order 12549; and
    d. Not debarred, suspended, or otherwise excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act or listed on the Arkansas Medicaid Excluded Provider's List.
19. For all subcontracts or agreements that contain a capitated or risk sharing arrangement, the subcontract or agreement must include the following provisions:
    a. A provision requiring the Subcontractor or delegate to provide a “claim for payment" for the capitated amount or risk-sharing payment;
    b. A provision requiring the submission of a claim or encounter that conforms to the Arkansas DHS claim and encounter format for Dental Services provided to a DMO Enrolled Member regardless of whether the pre-paid Capitated Payment amount or shared risk/shared savings payment includes the claim or encounter amount;
20. Subcontractor claims or encounters submitted to the DMO shall be subject to review under federal or State fraud and abuse statutes, rules, and regulations.
21. DHS encourages the use of minority or female-owned business enterprise Subcontractors or delegates.

G. Delegation of Administrative Services

1. The DMO Project Director must retain the authority to direct and prioritize any delegated administrative services functions or responsibilities performed by the Subcontractor or delegate.
2. If the DMO delegates administrative duties or responsibilities, then the DMO shall establish in the Subcontract or agreement the activities and reporting responsibilities delegated to the Subcontractor or delegate.
3. The subcontract or agreement must include language for revoking delegation or imposing other sanctions if the Subcontractor's or delegate's performance is inadequate or below required service levels (see 42 CFR 438.230(c)(1)(iii)).

4. It shall be the DMO's responsibility to evaluate Subcontractor or delegate performance and determine if service level performance meet Contract requirements.
5. The DMO shall notify DHS, within five (5) business days of any deficiencies identified and CAPs developed as a result of ongoing Subcontractor or delegate monitoring or performance reviews.
6. DHS may request the DMO perform additional reviews, if necessary, to assure the subcontractor or delegate maintains adequate service levels and complies with the requirements found in the Contract.
7. If at any time during the contract period, the Subcontractor or delegate is found to be in significant non-compliance with its Subcontract with the DMO, the Healthy Smiles Waiver, the Contract resulting from this RFP, or any other applicable state or federal law, the DMO shall notify DHS.
8. The DMO **must** require Subcontractors and delegates who perform administrative services to adhere to screening and disclosure requirements as required by DHS or the State of Arkansas.
9. The Contractor **shall** submit to the Contract Manager any proposed arrangements with a Subcontractor at least 90 days prior to implementation.
10. DHS will approve or deny Subcontractor requests within 90 days of receipt.
11. While the Contractor may choose to subcontract claims processing functions, or portions of those functions, with a State-approved Subcontractor, the Contractor **shall** demonstrate that the use of such Subcontractors is invisible to Providers, including out-of-network and self-referral Providers, and will not result in confusion to the Provider community about where to submit claims for payments. For example, the Contractor may elect to establish one post office box address for submission of all out-of-network Provider claims. If different subcontracting organizations are responsible for processing those claims, the Contractor **shall** ensure that the subcontracting organizations forward claims to the appropriate processing entity.

H. Quality Assessment and Performance Improvement (QAPI) Strategic Plan

1. The DMO must establish and implement a Quality Assessment and Performance Improvement (QAPI) Strategic Plan for the services it furnishes to Enrolled Members. The QAPI, and any amendments thereto, must be approved by DHS prior to implementation, and must meet the requirements of the Contract and 42 CFR § 438.330.
2. Performance Improvement Projects (PIPs)
    a. The QAPI must include PIPs that must:
        i. Be designed to achieve significant improvement, sustained over time, in dental health outcomes and/or Enrolled Member satisfaction;
        ii. Include measurements of performance using objective quality indicators;
        iii. Implement interventions to achieve improvement in the access to and quality of care;
        iv. Evaluate the effectiveness of the interventions based on the performance measures collected;
        v. Include planning and initiation of activities for increasing or sustaining improvement.
    b. The PIP must address:
        i. The collection and submission of performance measurement data, including any required by CMS or DHS;
        ii. The mechanisms to detect both under and over-utilization of services; and
        iii. Mechanisms to assess the quality and appropriateness of care furnished to Enrolled Members with special health care needs, as defined by the State in the quality strategy.
3. Provider Agreement Arrangements to Improve Quality
    a. The DMO may utilize Provider Incentive Plans to make incentive payments to Network Providers under the Provider Agreement that are based on value. The DMO must make available to DHS, CMS, or their agents any Provider Incentive Plans currently in use.
    b. Incentive payments cannot be based on volume to increase inappropriate utilization (including denial of services).
    c. The incentive payment may not condition participation in the Network on the Network Provider entering or adhering to intergovernmental transfer agreements.

d. Provider Incentive Plans cannot allow for payments directly or indirectly through a subcontractor or delegate to induce a reduction or limit of Medically Necessary services to an Enrolled Member.

e. If the Provider Incentive Plan places the Network Provider at substantial financial risk pursuant to 42 CFR § 422.208(a)(d)) for services that the Network Provider does not furnish itself, the DMO must ensure that all Network Providers at substantial risk have either aggregate or per-patient stop-loss protection in accordance with 42 CFR § 422.208(f).

f. Withhold arrangements may be part of the Provider Agreement. If the DMO utilizes withholding arrangements, the following provisions apply:

   i. The arrangement must be for a fixed period;

   ii. Performance must be measured during the rating period under the contract in which the withhold arrangement is applied;

   iii. The arrangement may not be renewed automatically;

   iv. The arrangement must be made available to both public and private contractors under the same terms of performance;

   v. The arrangement must not condition DMO participation in the withhold arrangement on the DMO entering or adhering to intergovernmental transfer agreements; and

   vi. The arrangement must be necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy.

g. The Contractor shall develop an internal quality assurance and improvement program that is comprehensive and routinely and systematically monitors access, availability, and utilization of services, customer satisfaction, Provider Network adequacy, and any other aspects of the Contractor's operation that affect Beneficiary care.

h. At least ninety (90) days prior to the Go-Live Date, and in a method and format approved by the Contract Manager, the Contractor shall submit to the Contract Manager for review and approval a written plan that shall describe all aspects of its quality assurance and improvement program, which shall, at a minimum,

   i. Include measurable goals and objectives.
   ii. Address both clinical and non-clinical aspects of care.
   iii. Include all demographic and special needs groups, care settings, and types of services.

i. Within ten (10) days of receiving DHS's comments on the draft, the Contractor shall make the required changes and submit the final plan for the Contract Manager's approval.

j. The Contractor shall implement and maintain all necessary processes and procedures, including timeliness, to support its quality assurance and improvement plan.

k. On an ongoing basis, the Contractor shall look for opportunities for quality improvement and implement timely corrective action.

l. The Contractor shall be required to meet a set of performance measures outlined in Attachment C Performance Based Contracting Standards.

m. The State shall reserve the right to re-negotiate the Quality Measures during the Contract Term. All changes made to the Quality Measures, shall become an official part of the contract.

n. Failure to meet the Quality Measures, as outlined in Attachment F Bidder's Library, Exhibit 2, will result in corrective action or sanctions being taken, up to and including recoupment or capping enrollment, as outlined in Attachment C.

o. The DMO must submit quarterly Quality Metric reports on the quality of the DMO's dental program to DHS, as outlined herein in general requirements, Scope of Work, or any relevant attachments.

p. These reports, as specified in the RFP Section 2.17.3, will be monthly for the first year of the Contract but, if requested by the Contract Manager, must move to quarterly submissions.

q. The Contractor shall cooperate with the State's External Quality Review Organization.

r. If requested, the Contractor must submit to and cooperate with any audit of the dental program as determined necessary by the Department. An annual audit shall encompass all major aspects of the administration of the dental program to determine if the Contractor is meeting its contractual responsibilities.

s. To ensure that the Contractor receives ongoing feedback on its administration of the dental program from Enrolled member and Providers, the Contractor shall form two (2) advisory groups within the first three (3) months of the initial Contract year.

i. One group **shall** be composed of Enrolled member, and the other group **shall** be composed of Providers.

ii. Each group **shall** meet at least quarterly and **must** have at least ten (10) members that represent all geographic areas throughout the State. Each group must increase methods for soliciting member feedback in an appropriate and cost-effective manner to allow challenges currently faced with logistics and participation to be identified and addressed,

iii. Meetings should be scheduled in locations and at times that encourage maximum attendance.

iv. The Contractor **shall** be required to keep detailed minutes of each meeting. The Contractor **shall** review and evaluate these minutes as part of its quality assurance and improvement program and, as a result, implement any necessary corrective action.

v. The Contract Manager **must** approve all appointments to the groups.

t. During the Contract Term, the Contractor shall submit quarterly reports to the Contract Manager on the status of the quality of the dental program 30 days after the quarter ends.

i. The Contractor **shall** submit for the Contract Manager's approval a reporting template by the Readiness Review.

ii. After the first year of the Contract, the Contract Manager may reduce the frequency of these reports. These reports **shall** include, at a minimum, the following information:

(1) All quality assurance improvement activities that took place during the month, including:
- A summary of the Beneficiary and Provider advisory group meetings
- An up-to-date list of representatives in each advisory group

(2) The status of the Contractor's goals and objectives;
(3) All quality improvements that were implemented during the month; and
(4) All corrective actions that were implemented during the month.

2.12.2 INSURANCE REQUIREMENTS

A. General Coverage

1. The Contractor **shall** maintain, at Contractor's own expense, during the Contract Term and until final acceptance of all services and deliverables, the following insurance coverage:

a. Business Automobile Liability Insurance for all owned, non-owned, and hired vehicles, for bodily injury and property damage;

b. Comprehensive General Liability insurance of at least $1,000,000.00 per occurrence, and $5,000,000.00 in the aggregate (including Bodily injury coverage of $100,000.00 per each occurrence and Property Damage Coverage of $25,000.00 per occurrence.

c. If the Contractor's current Comprehensive General Liability insurance coverage does not meet the above stated requirements, the Contractor will obtain Umbrella Liability insurance to compensate for the difference in the coverage amounts.

d. If Umbrella Liability insurance is provided, it **must** follow the form of the primary coverage.

B. Professional Liability Coverage

1. The Contractor **must** maintain, at its own expense, or cause its Network Providers to maintain, during the Term of the Contract and until final acceptance of all services and deliverables, the following insurance coverage:

a. Professional Liability Insurance for each Network Provider of $100,000.00 per occurrence and $300,000.00 in the aggregate. The Contractor **must** provide proof of such coverage upon request to DHS.

b. An Excess Professional Liability (Errors and Omissions) Insurance Policy for the greater of $3,000,000.00 or an amount (rounded to the nearest $100,000.00) that represents the number of Beneficiaries enrolled with the Contractor in the first month of the applicable Contract Year multiplied by $150.00, not to exceed $10,000,000.00.

C. General Requirements for All Insurance Coverage

1. All exceptions to the Contract's insurance requirements **must** be approved in writing by DHS.
2. The Contractor or Provider **shall** be responsible for all deductibles stated in the policies.
3. Insurance coverage **must** be issued by insurance companies authorized by applicable law to conduct business in the State of Arkansas.
4. Insurance coverage kept by the Contractor **must** be always maintained in full force during the Contract Term and until DHS's final acceptance of all services and deliverables. Failure to maintain such insurance coverage **shall** constitute a material breach of the Contract.
5. The Contractor **shall** require that any subcontractors providing services under this Contract obtain and maintain similar levels of insurance and **shall** provide the Contract Manager with the same documentation as is required of the Contractor.
6. Except for Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section **must** have an extended reporting period of two (2) years. When policies are renewed or replaced, the policy retroactive date **must** coincide with, or precede, the Contract Commencement.
7. Any insurance coverages and limits furnished by the Contractor **shall** not in any way expand or limit the Contractor's liabilities and responsibilities specified within the Contract documents or by applicable law.
8. Any insurance maintained by DHS will apply more than and **shall not** contribute to insurance provided by the Contractor under the Contract.
9. If the Contractor or its Network Providers desire additional coverage, higher limits of liability, or other modifications for its own protection, the Contractor or its Network Providers **shall** be responsible for the acquisition and cost of such additional protection. Such additional protection **shall not** be an Allowable Expense under this Contract.
10. Insurance coverage **must** name DHS as an additional insured, except for Professional Liability insurance maintained by Network Providers. Insurance coverage **must** name DHS as a loss payee, except for Professional Liability insurance maintained by Network Providers and Business Automobile Liability insurance.
11. Except for Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must provide that prior written notice to be given to DHS at least thirty (30) calendar days before coverage is reduced below minimum DHS contractual requirements, canceled, or non-renewed. The Contractor must submit a new coverage binder to Arkansas Insurance Department (AID).
12. The Contractor must require all insurers to waive their rights of subrogation against DHS.

D. Proof of Insurance Coverage

1. The Contractor **must** furnish DHS with original Certificates of Insurance evidencing the required insurance coverage on or before the Contract Commencement. Such Certificates **must** be submitted prior to Contract award. The failure of DHS or OSP to obtain such evidence from Contractor before permitting the Contractor to commence work **shall not** be deemed to be a waiver by DHS or OSP, and the Contractor **shall** remain under continuing obligation to maintain and provide proof of the insurance coverage.
2. If insurance coverage is renewed during the Contract Term, the Contractor **must** furnish DHS renewal certificates of insurance or such similar evidence within five (5) Business Days of renewal.

3. The insurance specified above **must** be carried until all required services and deliverables are satisfactorily completed. Failure to carry or keep such insurance in force **shall** constitute a violation of the Contract.

2.12.3 SYSTEMS AND SECURITY

A. General Requirements

1. The Contractor **shall** maintain its own management information system throughout the duration of the Contract to perform fully the obligations under this RFP.
2. The Contractor **shall** connect with DHS's Medicaid Management Information System (MMIS) and other systems (e.g., eligibility, data warehouse, pharmacy) as necessary to conduct the obligations under this RFP.
3. The Contractor **shall not** connect any of its own equipment to DHS's LAN/WAN without prior written approval from DHS. The State will provide equipment as necessary for support that entails connection to the State LAN/WAN or give prior written approval as necessary for connection.
4. During the Transition Period, the Contractor shall:
    a. Conduct a Kick-off meeting with Contract Manager and other representatives from the Department within fifteen (15) days of Contract Commencement to present a draft Start-Up Transition Plan that addresses:
        i. A Communication Plan for normal and contingency communication between the Contractor and the DHS, including the State's Organization Change Management and Communications teams;
        ii. Any hardware/software and connectivity requirements and setup of other general office information;
        iii. Training/Orientation of Contractor's staff on State applications, to the extent required;
        iv. Knowledge transfer for current environments and platforms, including a working knowledge of the Healthy Smiles Program's general business practices and all matters concerning DHS functions in support of the system, processes, and procedures for program migrations;
        v. Status reporting and meetings;
        vi. A detailed implementation schedule that **shall** allow for DHS approval of full cycle and performance testing with a start-up date no later than thirty (30) days prior to the Go-Live Date.
        vii. Other matters deemed important for the transition phase by either DHS or the Contractor.
        viii. Training/Orientation Plan for the Contractor and Department staff involved with the dental program.
    b. Submit a final Start-Up and Transition Plan due within ten (10) Business Days of the Kick-off meeting.
    c. Submit, by the time of Readiness Review, security, and Disaster Recovery documentation to include system and processing security and physical security.

B. Information Management and Systems (IT Systems)

1. The DMO must have information management processes and information systems (IT Systems) that comply with Section 6504(a) of the Affordable Care Act (ACA). This means that it must have a claims processing and retrieval system that can collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by DHS to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act.
2. The IT Systems must conform to HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH) standards for data and document management.
3. The DMO must conform to current and updated publications of the principles, standards, and guidelines of the Federal Information Processing Standards (FIPS), the National Institute of Standards and Technology (NIST) publications, including but not limited to Cybersecurity Framework and NIST.SP.800-53r5 moderate.

4. This includes the ability to transmit, receive, and process data in HIPAA-compliant formats that are in use as of the Contract start date.
5. All HIPAA-conforming transactions between DHS and the DMO must be subjected to the highest level of compliance as measured using an industry standard HIPAA compliance checker application.
6. Beginning at Contract Go-Live, any new IT Systems must be approved by DHS prior to implementation or use of the new IT Systems. The DMO must provide details of the test regions and environments of its core production IT Systems, including a live demonstration to DHS representatives, to enable DHS to determine the readiness of the DMO's IT Systems. The DMO must provide a System Implementation Plan.
7. The DMO's IT Systems must conform to future federal and DHS-specific standards for data exchange as of the date stipulated by CMS, or as otherwise agreed to by DHS and the DMO.
8. The DMO must ensure that critical systems functions are available to Enrolled Members and providers 24/7, except during periods of scheduled system unavailability. To the extent possible, the DMO will schedule system unavailability at night (7:00 p.m. to 7:00 a.m.) and/or during the weekend (Friday at 7:00 p.m. to Monday at 7:00 a.m.) to minimize the effects of downtime to Enrolled Members and/or Providers. The DMO shall supply a monthly report of system downtime to DHS.
9. The DMO must make DHS aware of the nature and availability of these critical systems functions prior to extending access to these functions to Enrolled Members and/or providers.
10. If at any point there is a problem with a critical systems function, the DMO must provide to DHS full written documentation that includes a Corrective Actions Plan (CAP) that describes how problems with critical systems functions will be restored and prevented from occurring again.
    a. The CAP must be delivered to DHS within five (5) business days of the critical systems function problem or failure.
    b. Failure to submit a CAP or to show progress in implementing the CAP may subject the DMO to sanctions, in accordance with the Performance Indicators attached hereto as Attachment C.
11. The DMO must develop a Business Continuity-Disaster Recovery Plan (BC-DR) that is continually ready to be invoked.
12. The BC-DR must be reviewed and approved by DHS prior to Readiness Review. Changes in the plan are due to DHS within ten (10) business days after the change and are subject to review and approval by DHS.
13. The DMO shall provide descriptions of the Business Continuity-Disaster Recovery execution plan, the hierarchy of planned events, key roles and responsibilities, and tools for communicating event status to DHS.
14. The DMO shall ensure periodic reviews of the (BC-DR) are conducted to ensure a timely restoration, continuity of services and test them as part of annual DR test execution. Reviews and annual testing are required and must be submitted to the State for approval.
15. At a minimum, the DMO’s BC-DR must address the following scenarios:
    a. The central computer installation and resident software are destroyed or damaged;
    b. System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage;
    c. System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of data maintained in a live or archival system;
    d. Unavailability of critical functions caused by events outside of a DMO’s span of control; and
    e. System interruption or failure resulting from network, operating hardware, software, or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system but do prevent access to the system, i.e., cause unscheduled system unavailability; and
16. The BC-DR Plan shall include:
    a. Plan Objectives;

b. What situations and conditions are covered by the Plan;

c. Technical considerations;

d. Roles and responsibilities of Contractor staff;

e. How and when to notify the Contract Manager;

f. Recovery procedures;

g. Procedures for deactivating the Plan.

This Plan must be provided by the Readiness Review, which shall include backup, and recovery procedures, which will allow recovery of the system and all adjudicated Claims data up to the moment of the disaster and successfully resume data collection within twenty-four (24) hours of any disaster.

The DR plan will have a Recovery Time Objective (RTO) of 24 hours and a Recovery Point Objective (RPO) of 24 hours.

17. The DMO must periodically, but no less than annually, perform comprehensive tests of its BC-DR through simulated disasters and lower-level failures to demonstrate to DHS that it can restore system functions per the standards outlined in the herein, including Attachments. In the event the DMO fails to demonstrate in the tests of its BC-DR that it can restore system functions per the standards outlined herein, including attachments, the DMO must submit to DHS a CAP that describes how the failure will be resolved. The CAP must be delivered within ten (10) business days of the conclusion of the test.
18. When there are unexpected or unscheduled IT Systems outages that are caused by the failure of systems and technologies within the DMO's control, these outages must be corrected, and the IT Systems restored within twenty-four (24) hours of the official declaration of system unavailability. However, the DMO will not be responsible for correcting systems and technologies failures that are outside of its control.
19. The DMO and DHS or its agent must make predominant use of secure file transfer protocol (SFTP) and electronic data interchange (EDI) in their exchanges of data. Additionally, the DMO must encourage Network Providers to participate in DHS's Direct Secure Messaging (DSM) service when it is implemented.
20. If the DMO uses social networking or smartphone/tablet applications (apps), the DMO must develop and maintain appropriate policies and procedures that are submitted to DHS for review and approval.
21. Any app must be approved by DHS prior to utilization by the DMO.
22. If the DMO uses apps to allow Enrolled Members direct access to DHS approved materials, the DMO must comply with the following:
    a. The app must disclaim that use is not private and that no PHI or personally identifying information should be published on the app by the DMO or the end user; and
    b. The DMO must ensure that software applications obtained, purchased, leased, or developed are based on secure coding guidelines.
    c. DHS may monitor social networking activities and apps to ensure compliance with all DMO provider manual and DMO provider agreement terms. The DMO may be subject to sanctions in accordance with the Performance Indicators found in Attachment C Performance Based Contracting Standards
23. The DMO's IT Systems must be able to:
    a. Establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of DHS information and to protect DHS information from unauthorized access, use, modification, or dissemination.
    b. Prohibit the use of unsecured telecommunications to transmit individually identifiable, or deducible, information derived from DHS information.
    c. Transmit DHS information via secure FTP communications protocol approved by the DHS Office of Information Technology (OIT).
    d. Comply with all federal and State laws and regulations regarding the access to, use, modification, or dissemination of personally identifiable information.
    e. Obtain prior written approval from DHS for the use of DHS information for a project other than the one described in the Agreement.

f. Prohibit the reuse or further disclosure of original or derivative data file(s) without prior written approval from DHS.

g. Report any unauthorized access, use, or disclosure of DHS information to the DHS Chief Information Security Officer, at dhs.it.security.team@dhs.arkansas.gov and to the DMO.Compliance@dhs.arkansas.gov within two (2) business days of discovery of such unauthorized access, use, or disclosure.

24. In the event that OIT or the Privacy Office determines or has a reasonable belief that the DMO has or may have accessed, used, reused, or disclosed DHS information that is not authorized by the Agreement, or another written authorization from DHS, the DHS Privacy Office or OIT may require the DMO to perform one or more of the following actions or such other actions as the Privacy Office or OIT deems appropriate:

a. Promptly investigate and report to the Privacy Office determinations regarding any alleged or actual unauthorized access, use, reuse, or disclosure;

b. Promptly resolve any issues or problems identified by the investigation;

c. Submit any formal response to an allegation of unauthorized access, use, reuse, or disclosure;

d. Submit a corrective action plan with steps designed to prevent any future unauthorized access, uses, reuses, or disclosures; and

e. Immediately cease all access to any DHS information and return or destroy all DHS information received under the Agreement.

f. The DMO understands and agrees that as a result of a determination or reasonable belief that an unauthorized access, use, reuse, or disclosure has occurred, DHS may refuse to release further DHS information to the DMO for a period of time to be determined by DHS, OIT, or the Privacy Office.

C. The DMO shall work with a 3rd party vendor for Penetration testing, which must be completed forty-five (45) calendar days prior to operational readiness, upon major System changes, and on an annual basis. Penetration testing results must be delivered to DHS within ten (10) business days of completed testing. Any issues resulting from the Pen testing must be corrected by Vendor within ten (10) business days.

D. Other Security Measures

1. The Contractor shall always comply with the requirements of the Arkansas Personal Information Protection Act and any other State laws, regulations, rules, and policies regarding the privacy and security of information.

2. The Contractor shall provide for physical and electronic security of all Protected Health Information generated or acquired by the Contractor in implementation of the Contract, in compliance with HIPAA, and consistent with the Business Associate Agreement executed between the parties (see Attachment L Business Associate Agreement).

3. The Contractor shall provide within thirty (30) days after Contract Commencement and maintain for the entire Contract term an Information Security Plan for review and approval by DHS.

4. The Contractor must make any changes to the information Security Plan requested by the Contract Manager and resubmit the plan within five (5) Business Days of the request.

5. On-site security requirement(s):

a. To the extent any Contractor or Subcontractor employees are required to provide services on site at any State facility, if requested, the Contractor **shall** be required to provide and complete all necessary paperwork for security access to sign on at the State's site.

b. If requested, this **shall** include conducting and providing to DHS State and/or federal criminal background checks, including fingerprinting, for everyone performing services on site at a State facility.

c. These checks may be performed by a public or private entity and, if required, **shall** be provided by the Contractor to DHS prior to the employee's providing on-site services.

6. DHS **shall** have the right to refuse any individual employee to work on State premises, based upon information provided in a background check.

a. At the discretion of DHS, the Contractor or Subcontractor employees or agents who enter the premises of a facility under DHS or State jurisdiction **shall** be searched, fingerprinted (for the purpose of a criminal history background check), photographed, and required to wear an identification card issued by DHS.

b. The Contractor, its employees and agents, and Subcontractor employees and agents, **shall not** violate Department of Human Services Policy 1002 (a copy of which is enclosed in the Bidders' Library), or other State security regulations or policies about which they may be informed from time to time.

7. At all times, at any facility, the Contractor's personnel **shall** ensure cooperation with State site requirements. The failure of any of the Contractor's or Subcontractor's employees or agents to comply with any security provision of the Contract **shall** be sufficient grounds for the Department to terminate the Contract for default.

8. The Contractor shall perform system updates as requested by the Contract Manager.

a. Changes, corrections, or enhancements to the system **shall** be characterized as a system improvement.

b. These changes may result from a determination by the Contractor or the Contract Manager that a deficiency exists within the Contractor's system.

c. Should the Contractor feel that changes, corrections, or enhancements are needed to the system, the Contract Manager **must** be advised of the changes, corrections, or enhancements and **must** approve before implementation.

9. The Department shall advise the Contractor of changes to MMIS throughout the Contract Term.

10. The Contractor shall adapt to all changes in order to fulfill all the tasks outlined in this RFP in the timeframe set forth by DHS, or as otherwise required by state or federal law.

2.12.4 AUDITS AND ACCESS TO RECORDS

A. Audits

1. The Contractor **shall have** an independent audit firm perform an annual audit of its handling of DHS's critical functions and/or sensitive information, which is identified as Claims processing (collectively referred to as the "Information Functions and/or Processes").

2. Such audits shall be performed in accordance with audit guidance: Reporting on Controls at a Service Organization Relevant to Security, Availability, Processing Integrity, Confidentiality, or Privacy (SOC 2) as published by the American Institute of Certified Public Accountants (AICPA) and as updated from time to time, or according to the most current audit guidance promulgated by the AICPA or similarly- recognized professional organization, as agreed to by the Department, to assess the security of outsourced client functions or data (collectively, the "Guidance") as provided in this section.

3. The type of audit to be performed in accordance with the Guidance shall be a SOC 2 Type II Report.

4. The SOC 2 Report shall be completed annually, submitted by July 31 for the previous State fiscal year.

5. The SOC 2 Report shall report on a description of the Contractor's system and the suitability of the design and operating effectiveness of controls of the Information Functions and/or processes relevant to the following trust principles: Processing Integrity, as defined in the Guidance.

6. The SOC 2 Report shall include work performed by subcontractors that provide essential support to the Contractor for the Information Functions and/or Processes for the services provided to DHS under the Contract. The Contractor shall ensure the performance of the SOC 2 Audits includes its Subcontractor(s).

7. All SOC 2 Audits, including the SOC 2 Audits of Contractor's subcontractors, shall be considered Allowable Expenses.

8. The Contractor shall promptly provide a complete copy of the final SOC 2 Report to the Contract Manager upon completion of each SOC 2 Audit engagement.

9. The Contractor shall provide to the Contract Manager, within thirty (30) calendar days of the issuance of the final SOC 2 Report, a documented corrective action plan that addresses each audit finding or exception contained in the SOC 2 Report.

10. The corrective action plan shall identify in detail the remedial action to be taken by the Contractor along with the date(s) when each remedial action is to be implemented.
11. If the Contractor currently has an annual information security assessment performed that includes the operations, systems, and repositories of the Information Functions and/or Processes services being provided by the Contractor to DHS under the Contract, and if that assessment generally conforms to the content and objective of the Guidance, the Department shall have the determination in consultation with appropriate State government technology and audit authorities, whether the Contractor's current audits are acceptable in lieu of the SOC 2 Report(s).
12. If the Contractor fails during the Contract Term to obtain an annual SOC 2 Report by July 31 for the preceding fiscal year, the Department shall have the right to retain an independent audit firm to perform an audit engagement to issue a SOC 2 Report of the Information Functions and/or Processes being hosted by the Contractor.
13. The Contractor shall allow the independent audit firm to access its facilities for purposes of conducting this audit engagement(s) and provide reasonable support to the independent audit firm in the performance of the engagement. DHS will invoice the Contractor for the expense of the SOC 2 Audit(s) or deduct the cost from future payments to the Contractor.
14. The audit shall be completed at the Contractor's expense.

B. Record Retention and Access

1. Contractor **shall** retain, and **shall** require its Subcontractors to retain, all records related to the Contract for a period of ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.
2. The DMO must retain, and require subcontractors to retain, as applicable, the following information: Enrolled Member Grievance and Appeal records in 42 CFR § 438.416, base data in 42 CFR § 438.5(c), MLR reports in 42 CFR § 438.8(k), and the data, information, and documentation specified in 42 CFR §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years.
3. Permit Entry and Access to Facilities and Records
    a. The DMO must allow access and entry to its premises, facilities, and records, including computer and other electronic systems, to DMS, MFCU, OMIG, HHS, the Comptroller General, or their designees to evaluate, through inspection, audit, or other means, compliance with the requirements for reporting and calculation of data submitted to DMS, and the timeliness and accuracy of rebate payments made.
    b. The DMO must also allow access and entry to the facilities and records, including computer and other electronic systems, of its parent organization, subsidiaries, related entities, contractors, subcontractors, agents, or a transferee that pertain to any aspect of the data reported to DMS or any payment made, or service provided under the DMO Agreement. To the extent that the DMO does not control access to the facilities and records of its parent organization, related entities, or third parties, it will be the responsibility of the DMO to contractually obligate any such parent organization, related entities, or third parties to grant said access.
4. Upon reasonable notice, the Contractor must provide, and cause its subcontractors to provide, reasonable and adequate access by DHS and its authorized representatives to any records that are related to the scope of this Contract.
5. At the determination of DHS, such access may consist of granting DHS access to physical records or responding in a timely manner to requests by DHS for copies of electronic or paper records.
6. Any costs of such access shall be borne by the Contractor and shall not constitute Allowable Expenses under the Contract.

2.12.5 PROJECT GOVERNANCE AND MANAGEMENT

A. Project Steering Committee(s)

B. To manage the Contract and the engagement resulting from this RFP, the State will establish one or more Steering Committee(s). The Steering Committee(s) will be responsible for:

1. Providing strategic oversight, guidance, and direction

2. Reviewing and approving any changes to the Contract (including changes to the scope)
3. Reviewing and resolving issues and risks not resolved at lower levels and providing advice and insight into project management issues
4. Approving any changes to the project scope, schedule, or budget and/or canceling the project

C. The Steering Committee(s) will be comprised of senior management personnel from the State and the Dental Managed Care Vendors, facilitated by a chairperson appointed by State executive leadership. The committee(s) will convene regularly to provide direction or support required for the project and to support the State Project management team.

2.12.6 READINESS REVIEW

A. As required by CMS, the Contractor **must** participate in the Readiness Review process prior to the enrollment of any members in a plan.

B. The Deliverables section of this RFP details the operational documents the vendor **must** submit to DHS as part of the Readiness Review to allow DHS to assess the ability and capacity of the Contractor to perform in key operational areas.

C. The listed documents **must** be submitted to the Contract Manager at least four (4) months prior to planned enrollment, or at a date set by the Contract Manager.

D. DHS **shall** have the right to perform the Readiness Review itself or to procure an outside Vendor to lead the Readiness Review.

E. DHS and the Contractors will finalize the requirements of the Readiness Review, in accordance with 42 CFR 438.66, soon after Contract Commencement at a time which **shall** be determined by DHS. The readiness review may be modified for incumbent contractors.

2.12.7 PROBLEM ESCALATION PROCEDURE

A. The Contractor **must** provide and maintain a Problem Escalation Procedure (PEP) for both routine and emergency situations.

B. The PEP must state how the Contractor will address problem situations as they occur during the performance of the Contract, especially problems that are not resolved to the satisfaction of the State within appropriate timeframes.

C. The Contractor shall provide contact information to the Contract Manager, as well as to other State personnel, as directed, should the Contract Manager not be available.

D. The Contractor must provide the PEP to the Contract Manager no later than ten (10) Business Days after Contract Commencement.

E. The PEP, including any revisions thereto, must also be provided within ten (10) Business Days after the start of each Contract year and within ten (10) Business Days after any change in circumstance which changes the PEP.

F. The PEP shall detail how problems with work under the Contract will be escalated to resolve any issues in a timely manner. The PEP shall include:

1. The process for establishing the existence of a problem;
2. The maximum duration that a problem may remain unresolved at each level in the Contractor's organization before automatically escalating the problem to a higher level for resolution;
3. Circumstances in which the escalation will occur in less than the normal timeframe;
4. The nature of feedback on resolution progress, including the frequency of feedback to be provided to the State;
5. Identification of, and contact information for, progressively higher levels of personnel in the Contractor's organization who would become involved in resolving a problem;

6. Contact information for persons responsible for resolving issues after normal business hours (e.g., evenings, weekends, holidays, etc.) and on an emergency basis; and
7. A process for updating and notifying the Contract Manager of any changes to the PEP.

G. Nothing in this section shall be construed to limit any rights of the Contract Manager or the State that may be allowed by the Contract or applicable law.

2.12.8 TRANSITION AT END OF CONTRACT

A. At the end of this Contract, the Contractor **shall** work cooperatively with DHS and if applicable, any new contractor, to ensure an efficient and timely transition of Contract responsibilities with minimal disruption of service to Beneficiaries and Providers.

B. At least six (6) months prior to the scheduled expiration of the Contract Term, including any option period, the Contractor **shall** develop and provide to the Contract Manager a detailed Full Operations Resources report describing which resources (systems, software, equipment, materials, staffing, etc.) **shall** be required by DHS or another contractor to take over the requirements specified in the RFP/Contract.

C. An Exit Transition Period **shall** begin at least 60 days, but no more than 90 days, prior to the last day the Contractor is responsible for the requirements of the Contract resulting from this RFP.

D. During the Exit Transition Period, the Contractor **shall** work cooperatively with DHS and the new contractor and **shall** provide program information and details specified by DHS.

E. Both the program information and the working relationship between the Contractor and the new contractor **shall** be defined by DHS.

F. Within the Exit Transition Period, the Contractor shall prepare and submit an Exit Transition Plan and Schedule of Activities to facilitate the transfer of responsibilities, information, computer systems, software and documentation, materials, etc., to a new contractor and/or DHS.

G. The Exit Transition Plan shall be submitted by the Contractor within ten (10) days of the date of notification by DHS. The Exit Transition Plan shall include, at a minimum:

1. The Contractor’s proposed approach to the transition;
2. The Contractor’s tasks, subtasks, and schedule for all transition activities;
3. An organizational chart and staffing matrix of the Contractor’s staff (titles, phone, fax) responsible for transition activities;
4. A detailed explanation of how the Contractor will begin work with a new Contractor and/or DHS within ten (10) days of receipt of notice from DHS that another contractor has been selected to provide comprehensive Dental Services.

H. The Contract Manager must approve the Exit Transition Plan before it can be implemented.

I. The Contract Manager and the new contractor will define the information required during this transition period and time frames for submission.

J. The Contract Manager shall have the final authority for determining the information required.

K. The Contractor shall work closely and cooperatively with DHS and the new contractor to:

1. Transfer appropriate software, hardware, records, telephone numbers and lines, equipment, Post Office Box, and other requirements deemed necessary by DHS;
2. Ensure uninterrupted and efficient services to Beneficiaries, Providers, and DHS during the transition period.

L. Thirty (30) days following turnover of operations, the Contractor must provide DHS with a Transition Results Report documenting the completion and results of each step of the Exit Transition Plan.

M. The transition shall not be considered complete until this document is approved by DHS.

N. DHS shall have the right to withhold up to 20% of the last month's Premium Payment until the Turnover activities are complete and the Turnover Plan is approved by DHS.

2.13 PROGRAM INTEGRITY

2.13.1 PROGRAM INTEGRITY

The Arkansas Office of the Attorney General, Medicaid Fraud Control Unit (MFCU) and the Office of the Medicaid Inspector General (OMIG) are the State entities responsible for the investigation of provider fraud in the Arkansas Medicaid program. The Contractor **shall** work collaboratively with these agencies and units as described below.

A. Required Disclosure

1. The Contractor, as well as its Subcontractors, and any Network Providers **shall** comply with all federal requirements (42 CFR Part 455) on disclosure reporting, including but not limited to business transaction disclosure reporting (42 CFR § 455.104) and certain criminal convictions (42 CFR § 455.106) and shall further provide any additional information necessary for the DHS to perform its own exclusion status checks pursuant to 42 CFR § 455.436 if requested.
2. All tax-reporting provider entities that bill and/or receive Arkansas Medicaid funds as the result of this Contract **shall** submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and the terms of this Contract, including at the time of initial contracting, Contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three (3) years, and at any time upon request.
3. Any Provider failing to disclose in accordance with these requirements (or any Provider that otherwise fails any requirement of 42 CFR Part 455) **shall not** be part of the Contractor's Network.
4. Such disclosures **shall** be made on the State's Enrollment Disclosure form Attachment F Bidder's Library, Exhibit 13 DMS-675.
5. The Contractor, as well as its subcontractors, and any Providers, whether contract or non-contract, **shall** comply with all federal requirements (42 CFR § 1002) on exclusion and debarment screening.
6. The DMO must not have a relationship for the administration, management, or provision of Dental Services (or the establishment of policies or provisions of operation support for such Dental Services), either directly or indirectly, with any individual or entity that is:
    a. Excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act:
    b. Listed on the Arkansas Medicaid Excluded Providers List;
    c. Convicted of crimes described in section 1128(b)(8)(B) of the Social Security Act;
    d. Debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order 12549;
7. For purposes of this Section, "have a relationship" includes:
    a. A director, officer, owner, or partner of the DMO;
    b. A Subcontractor or delegate of the DMO;
    c. A person with beneficial ownership of five percent (5%) or more of the DMO entity's equity;
    d. A Network Provider or person with an employment, consulting, or other arrangement with the DMO for the provision of items and services that are significant and material to the DMO entity's obligations under the Contract; and
    e. An employee of the DMO or member of the Board of Directors of the DMO.
8. If the DMO determines it has a relationship, with someone who is excluded from DMO participation, the DMO must disclose such relationship immediately to DHS and OMIG, in writing, along with any remedial actions being taken by the DMO.

9. On at least a monthly basis and at the time that the DMO engages the individual or during renewal of agreements, the DMO must again disclose individuals they have a relationship with, as defined above.
    a. The federal List of Excluded Individuals and Entities (LEIE) and the federal System for Award Management (SAM) (includes the former Excluded Parties List System [EPLS]) or their equivalent, to identify excluded parties; and
    b. DHS listing of suspended and terminated providers at the DHS website below, to ensure the DMO does not include any non-Medicaid eligible providers in its Network: https://dhs.arkansas.gov/dhs/portal/Exclusions/PublicSearch/.
10. The DMO must not be controlled by a sanctioned individual who is excluded under 42 CFR §438.600 et. Seq.
11. The DMO must comply with the conflict-of-interest safeguards described in 42 CFR § 438.58 and with the prohibitions described in section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent contractors.
12. All tax-reporting provider entities that bill and/or receive Arkansas Medicaid funds as the result of this Contract **shall** screen their owners and employees against the federal exclusion databases (such as LEIE and EPLS) as well as the Arkansas database of excluded entities enacted under DHS Policy 1088 (a copy of which is included in the Bidders' Library).
13. Any services provided by excluded individuals shall be refunded to and/or obtained by the State and/or the Contractor as prescribed under Program Integrity Overpayment Recovery.
14. Where the excluded individual is the Provider of services or an owner of the Provider, all amounts paid to the Provider shall be refunded to the State.
15. Any Provider listed on any of these excluded or disbarred entity databases shall not be included in the Contractor's Network

B. Fraud and Abuse Prevention

1. The DMO must develop a Fraud and Abuse Prevention Program (FAPP) designed to reduce the incidence of fraud, waste, and abuse and must comply with all State and federal program integrity requirements, including but not limited to the applicable provisions of the Social Security Act, §§ 1128, 1902, 1903, and 1932; 42 CFR §§ 431, 433, 434, 435, 438, 441, 447, 455; and all applicable State laws.
    a. The FAPP must have internal controls, policies, and procedures in place to prevent, reduce, detect, investigate, correct, and report known or suspected fraud, waste, and abuse activities.
    b. The FAPP must have a clear procedure and policy to report instances of fraud, waste, and abuse.
    c. In accordance with Section 6032 of the federal Deficit Reduction Act of 2005, the DMO must make available to all DMO employees a copy of the written fraud, waste, and abuse policies. If the DMO has an employee handbook, the DMO must include specific information about Section 6032, the DMO's policies, and the rights of employees to be protected as whistleblowers.
    d. The FAPP must have an adequately staffed fraud investigation unit to investigate and report possible acts of fraud, waste, abuse, or overpayment. All fraud, waste, abuse, or overpayments due to suspected fraud must be compiled into a quarterly report to DHS, MFCU, and OMIG, or at the request of DHS, MFCU, or OMIG. Any suspected incidents of fraud must be reported within five (5) business days of discovery to OMIG and DHS.
    e. The Contractor shall have surveillance and utilization control programs and procedures (42 CFR §§ 456.3, 456.4, 456.23) to safeguard Medicaid funds against improper payments and unnecessary or inappropriate use.
2. The DMO must have a written compliance and antifraud plan (Program Integrity Plan), including its fraud, waste, and abuse policies and procedures. The Program Integrity Plan must comply with 42 CFR § 438.608 and include an organizational chart listing DMO's personnel who are responsible for the investigation and reporting of possible overpayment, abuse, waste, or fraud. The Program Integrity Plan must have a description of the DMO's procedures for:
    a. Mandatory reporting of possible overpayment, abuse, waste, or fraud to DHS and OMIG;

b. A summary of the results of the investigations of fraud, waste, abuse, or overpayment that were conducted during the previous fiscal year by the DMO's fraud investigative unit;

c. Enforcement of standards through well-publicized statutory requirements, the scope requirements, and related disciplinary guidelines;

d. A description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to:

i. Prior authorization;
ii. Utilization management;
iii. Subcontract and Provider Agreement provisions;
iv. Provisions from the provider and the member handbooks; and
v. Standards for a code of conduct.

3. The first iteration of the FAPP **shall** be submitted for review and approval by DHS and OMIG 90 days prior to the Go-Live Date. Thereafter, the Program Integrity Plan **shall** be submitted annually and upon request by DHS or OMIG, and updated quarterly, or more frequently if required by DHS or OMIG.

4. Updates to the FAPP and/or Program Integrity Plan **shall** be submitted to the Contract Manager ten (10) business days prior to scheduled meetings discussing the updates. At a minimum, the DMO must ensure that:

a. All suspected or confirmed instances of internal and external fraud, waste, and abuse relating to the provision of, and payment for, Medicaid services, including but not limited to DMO employees/management, providers, subcontractors, vendors, or members, under State and/or federal law be reported to DHS and OMIG within five business days;

b. All Network Provider Agreements entered by the DMO with Network Providers must, at a minimum, require that the Network Provider comply with all applicable State and federal laws, as well as the requirements of this Scope of Work and the resultant Contract;

c. Any final resolution reached by the DMO regarding a suspected case of waste, abuse, or fraud must include a written statement that provides notice to the provider or Enrolled Member that the resolution in no way binds the State of Arkansas nor precludes the State of Arkansas from taking further action for the circumstances that brought rise to the matter; and

d. As required by 42 CFR 438.3(h), the DMO, its subcontractors, and all Network Providers, upon request and as required by DHS, OMIG, MFCU, other State agents, and/or federal law, must:

i. Make available to all authorized federal and State oversight agencies and their agents, including but not limited to DHS, MFCU, and OMIG, all administrative, financial, and medical/case records and data relating to the delivery of items or services for which Medicaid monies are expended, and

ii. Allow access to all authorized federal and State oversight agencies and their agents, including but not limited to DHS, MFCU, and OMIG, to any place of business and all medical/case records and data, as required by State and/or federal laws. Access must be during normal business hours, except under special circumstances when DHS, MFCU, or OMIG must have after hours admission. DHS, OMIG, or MFCU must determine the need for special circumstances.

5. Prohibited Relationships

a. If DHS learns that the DMO has a prohibited relationship, as defined in 42 CFR § 438.600 et.seq., or if the DMO has a relationship with an individual who is an affiliate of such an individual, DHS may continue the Agreement if the DMO terminates the prohibited relationship within thirty (30) calendar days, unless the Secretary of State directs otherwise.

b. If DHS learns that the DMO has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act, DHS may continue the Agreement if the DMO terminates the prohibited relationship within thirty (30) calendar days, unless the Secretary of State directs otherwise.

c. If DHS learns that the DMO has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act, DHS may not renew or extend the Agreement, unless the Secretary pf Stat provides to

DHS and to Congress a written statement describing compelling reasons that exist for renewing or extending the Agreement despite the prohibited affiliation.

C. Program Integrity Operations

1. The Contractor **shall** have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected waste, fraud, and abuse activities.
2. Contractor **shall** have operations sufficient to enable the efficient identification, investigation, and resolution of waste, fraud, and abuse issues of Network Providers.
3. Contractor **shall** conduct all operations and deploy all capabilities described below on a routine basis and as necessary for the effective reduction of Medicaid waste, fraud, and abuse.
4. The Contractor **shall** have the ability to make referrals of suspected malfeasance to DHS and OMIG, and accept referrals from a variety of sources, including directly from Providers (either provider self-referrals or from other providers), Enrolled Members, law enforcement, government agencies, etc.
5. The Contractor **shall** also have effective procedures for timely reviewing, investigating, and processing such referrals.
6. Contractor **shall** conduct and maintain at a minimum the following operations and capabilities:
    a. Data mining, analytics, and predictive modeling for the identification of potential overpayments and aberrant payments/providers warranting further review/investigation.
    b. Provider profiling and peer comparisons of all Network Provider types and specialties – at a minimum annually - to identify aberrant service and billing patterns warranting further review/audit.
    c. Onsite audit capability and protocols identifying how and when the Contractor or State **shall** conduct such onsite audits of providers.
    d. Medical claim audit capabilities sufficient to enable the Contractor to audit any payment issued to any provider, including the ability to audit payments before they are made for newly enrolled Network Providers, providers suspected of improper practices, or providers with a history of payment issues.
    e. Member service utilization analytics to identify Enrolled Members that may be abusing services.

D. Preliminary Investigation of Suspected Waste, Fraud or Abuse

1. The Contractor **shall** promptly perform a preliminary investigation of all incidents of suspected and/or confirmed waste, fraud, or abuse. If the preliminary investigation determines that further investigation is warranted, the Contractor **shall** report the suspected incident to DHS and OMIG.
2. Unless prior written approval is obtained from DHS, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the Contractor **shall not**:
    a. Contact the subject of the investigation about any matters related to the investigation;
    b. Enter or attempt to negotiate any settlement or agreement regarding the incident; or
    c. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
3. The Contractor **shall** cooperate with all appropriate State and federal agencies, including the Arkansas MFCU, OMIG and DHS, in investigating fraud and abuse. The Contractor **shall** have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §§ 455.13, 455.14, 455.21).

E. Reporting Suspected or Confirmed Incidences of Waste, Fraud or Abuse

1. After a preliminary investigation, the Contractor **shall** immediately report all suspected or confirmed instances of waste, fraud and abuse to the State and DHS.
2. The Contractor **shall** be subject to non-compliance remedies under the Contract for willful failure to report fraud and abuse by Providers, Beneficiaries, or applicants to DHS as appropriate.

F. Quarterly Audit Activity Report

1. On a quarterly basis, or as otherwise directed by DHS or OMIG, and in a method and format approved by DHS or OMIG, the Contractor **shall** submit a detailed Audit Report to DHS and OMIG that outlines the Contractor's program integrity-related activities, as well as identifies the Contractor's progress in meeting program integrity-related goals and objectives, if any. The Audit Report **shall** specify current audits, reviews, claim denials, and investigation activity of the unit, a summary of the reason for the audit/investigative activity, the disposition of any such completed activity (including detailed overpayment amounts identified or recouped), and projected upcoming activity for the following quarter.
2. The Audit Report should also specify individual Provider recoupment, repayment schedules, and actions taken for each audit or investigation.
    a. The quarterly progress report **must** identify recoupment totals for the reporting period.
    b. The Audit Report **shall** identify projected upcoming activity, including the top five (5) Providers on Contractor's list for audit, and the type(s) of audit(s) envisioned.
3. DHS **shall** review and approve, approve with modifications, or reject the Audit Report and specify the grounds for rejection.
4. Recoupment totals and summaries for each reporting period (quarterly unless otherwise specified by DHS) **must** be submitted in the Audit Report.

G. Cooperation with Further Investigation and/or Prosecution

1. The Contractor **shall** cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal.
2. Such cooperation **shall** include providing, upon request, information, access to records, and access to interview Contractor employees and consultants, including but not limited to those with expertise in the administration of the program and/or any matter related to an investigation.

H. Program Integrity Overpayment Recovery

1. DHS or OMIG will have the right to take disciplinary action against any Provider identified by the DMO, DHS, or OMIG as engaging in inappropriate or abusive billing or service provision practice.
2. The Contractor **shall** have primary responsibility for the identification of all potential waste, fraud and abuse associated with Dental Services and billings generated as a result of the Contract.
3. In cases involving wasteful or abusive provider billing or service practices (including overpayments) identified by DHS or OMIG, DHS **shall** have the right to recover any identified overpayment directly from the Provider or to require Contractor to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by DHS. DHS **shall** have the right to take disciplinary action against any Provider identified by Contractor or DHS as engaging in inappropriate or abusive billing or service provision practices.
    a. If a fraud referral from Contractor generates an investigation and/or corresponding legal action results in a monetary recovery to DHS, the reporting Contractor will be entitled to share in such recovery following final resolution of the matter (settlement agreement/final court judgment) and following payment of recovered funds to the State of Arkansas.
4. The Contractor's share in the recovery **shall** be as follows:
    a. If a fraud referral from the DMO generates an investigation, and corresponding legal action results in a monetary recovery to DHS, the reporting DMO will be entitled to share in such recovery following final resolution (settlement agreement/final court judgment). The State will retain its costs of pursuing the action, including any costs associated with DHS, OMIG, or MFCU operations associated with the investigation and its actual documented loss (if any). The State shall pay to the DMO the remainder of the recovery, not to exceed the DMO's actual documented loss. Actual documented loss of the DMO may be determined by paid false or fraudulent claims, canceled checks, or other similar documentation which objectively verifies the dollar amount of loss.
    b. If the State determines it is in its best interest to resolve the matter under a settlement agreement, the State **shall** have final authority concerning the offer, or acceptance, and terms of a settlement. The State will exercise its best efforts to consult with the Contractor about potential settlement. The State

may consider the Contractor's preferences or opinions about acceptance, rejection, or the terms of a settlement, but they **shall** not be binding on the State.

c. If final resolution of a matter does not occur until after the Contract has expired, the preceding terms concerning disposition of any recovery and consultation with the Contractor **shall** survive expiration of the Contract and remain in effect until final resolution of a matter referred to the MFCU by the Contractor under this section.

d. If the State makes a recovery from a fraud investigation and/or corresponding legal action where the Contractor has sustained a documented loss, but the case did not result from a referral made by the Contractor, the State **shall not** be obligated to repay any monies recovered to Contractor but may do so at its discretion. Funds recovered as a result of a multi-state fraud investigation/litigation, however, will be shared with Contractor as prescribed for funds recovered as a result of Contractor's fraud referral absent extenuating circumstances.

5. The Contractor **shall** be prohibited from the repayment of State-, federally-, or Contractor-recovered funds to any provider when the issues, services, or claims upon which the repayment is based meet one or more of the following:

a. The funds from the issues, services, or claims have been obtained by the State or federal governments, either by the State directly or as part of a resolution of a State or federal audit, investigation and/or lawsuit, including but not limited to false claims act cases;

b. When the issue, services, or claims that are the basis of the repayment have been or are currently being investigated by DHS, OMIG, the Federal Medicaid Integrity Contractor (MIC), Contractor, Arkansas MFCU, or Assistant United State Attorney (AUSA) are the subject of pending federal or State litigation or have been/are being audited by the State's Recovery Audit Contractor (RAC).

6. This prohibition described above **shall** be limited to a specific Provider(s), for specific dates, and for specific issues, services, or claims. The Contractor **shall** check with DHS before initiating any repayment of any program integrity related funds to ensure that the repayment is permissible.

7. If required, Contractor **shall** correct Federal Financial Participation (FFP) from MMIS in accordance with any overpayment recovery.

I. Auditing Program Integrity Operations

1. DHS or OMIG **shall** have the right to conduct audits of Contractor's program integrity activities to determine the effectiveness of Contractor's operations. Such audit activities may include conducting interviews of relevant staff, reviewing all documentation and systems used for Special Investigation Unit activities, and reviewing the Special Investigation Unit's performance metrics.

2. DHS or OMIG **shall** have the right to issue a corrective action or performance improvement plan and outline timelines for improvement measures. The failure to adhere to operational improvement measures may result in the State's imposing damages up to the amount of overpayments recovered from Contractor's providers by DHS or OMIG audits for the preceding calendar year or imposing other non-compliance remedies including damage

2.14 CALCULATING AND REPORTING COSTS, PROFITS, LOSSES

2.14.1 MEDICAL LOSS RATIO (MLR)

J. The DMO shall track and report to DHS actual medical expenditures against an MLR of eighty-five percent (85%).

K. The DMO must calculate and report to DHS a MLR for each reporting year. The DMO shall calculate and report the MLR, including all related underlying data provided by its subcontractors. The DMO and its Subcontractors shall classify and report revenues and expenditures for all Medicaid covered services in a manner consistent with federal and State laws, regulations, and guidance.

L. The MLR is the ratio of the numerator to the denominator as defined in 42 CFR § 438.8:

1. Numerator — Required elements. The numerator of a DMO's MLR for a MLR reporting year is the sum of the DMO's incurred claims; expenditures for activities that improve health care quality; and fraud prevention activities.

a. Incurred claims

i. Incurred claims must include:

- Direct claims that the DMO paid to providers (including under capitated contracts with network providers) for Covered Services or contractually covered supplies and services meeting the requirements of § 438.3© provided to enrollees.
- Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported.
- Withholds from payments made to Network Providers.
- Claims that are recoverable for anticipated coordination of benefits.
- Claims payments recoveries received as a result of subrogation.
- Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.
- Changes in other claims-related reserves.
- Reserves for contingent benefits and the medical claim portion of lawsuits.

ii. Amounts that must be deducted from incurred claims include the following:

- Overpayment recoveries received from Network Providers.

iii. Expenditures that must be included in incurred claims include the following:

- The amount of incentive and bonus payments made, or expected to be made, to Network Providers.
- The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include Fraud Prevention activities specified herein.

iv. Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to State mandated solvency funds. The DMO shall explicitly report whether these amounts were:

- Included in; or
- Deducted from incurred claims.

v. Amounts that must be excluded from incurred claims:

- Non-claims costs, as defined in 42 CFR 438.8(b), which include the following:
  - Amounts paid to Subcontractors for secondary network savings.
  - Amounts paid to Subcontractors for network development, administrative fees, claims processing, and utilization management.
  - Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State Plan services or Value-Added Services or In Lieu of Services and provided to an Enrolled Member.
  - Fines and penalties assessed by regulatory authorities.
- Amounts paid to the State as remittance under 42 CFR § 438.8(j).
- Amounts paid to Network Providers under 42 CFR § 438.6(d).

vi. Incurred claims paid by one DMO that are later assumed by another entity must be reported by the assuming DMO for the entire MLR reporting year, and no incurred claims for that MLR reporting year may be reported by the ceding DMO.

b. Activities that improve health care quality. Activities that improve health care quality must be in one of the following categories:

i. A DMO activity that meets the requirements of 45 CFR 158.150(b) and is not excluded under 45 CFR 158.150(c).

ii. A DMO activity related to any External Quality Review (EQR)-related activity as described in 42 CFR § 438.358(b) and (c).

iii. Any DMO expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 CFR 158.151, and is not considered incurred claims, as defined herein.

c. Fraud prevention activities. DMO expenditures on activities related to fraud prevention consistent with regulations adopted for the private market at 45 CFR part 158. Expenditures under this paragraph must not include expenses for fraud reduction efforts as described above.

2. Denominator — Required elements. The denominator of a DMO for a MLR reporting year must equal the adjusted premium revenue. The adjusted premium revenue is the DMO's premium revenue minus the DMO's federal, State, and local taxes and licensing and regulatory fees and is aggregated as required by DMS.

   a. Premium revenue. Premium revenue includes the following for the MLR reporting year:

      i. State capitation payments, developed in accordance with 42 CFR § 438.4, to the DMO for all members under a risk contract approved under 42 CFR § 438.3(a), excluding payments made under 42 CFR § 438.6(d).

      ii. DMS-developed one-time payments, for specific life events of members.

      iii. Other payments to the DMO approved under 42 CFR § 438.6(b)(3).

      iv. Unpaid cost-sharing amounts that the DMO could have collected from members under the contract, except those amounts the DMO can show it made a reasonable, but unsuccessful, effort to collect.

      v. All changes to unearned premium reserves.

      vi. Net payments or receipts related to risk sharing mechanisms developed in accordance with 42 CFR § 438.5 or § 438.6. Risk-sharing mechanisms may not be added or modified after the start of the rating period.

   b. Federal, State, and local taxes and licensing and regulatory fees. Taxes, licensing, and regulatory fees that may be deducted for the MLR reporting year include:

      i. Statutory assessments to defray the operating expenses of any State or federal department.

      ii. Examination fees in lieu of premium taxes as specified by State law.

      iii. Federal taxes and assessments allocated to DMOs, excluding federal income taxes on investment income and capital gains and Federal employment taxes.

      iv. State and local taxes and assessments including:

         - Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.
         - Guaranty fund assessments.
         - Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by states.
         - State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.
         - State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.

      v. Payments made by a DMO that are otherwise exempt from federal income taxes, for community benefit expenditures as defined in 45 CFR 158.162(c), limited to the highest of either:

         - Three percent of earned premium; or
         - The highest premium tax rate in the state for which the report is being submitted, multiplied by the DMO's earned premium in the state.

   c. Denominator when DMO is assumed. The total amount of the denominator for a DMO which is later assumed by another entity must be reported by the assuming DMO for the entire MLR reporting year, and no amount under this paragraph for that year may be reported by the ceding DMO.

3. The MLR will be monitored per 42 CFR 438.8., and the MLR will be used to enforce a rebate at the end of the year. Risk-sharing mechanisms may not be added or modified after the start of the rating period.

M. Allocation of Expenses

1. General requirements. Each expense must be reported under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit lines of business or products other than those being reported, including but not limited to those that are for or benefit self-funded plans, must be reported on a pro rata share.
2. Description of the methods used to allocate expenses. The MLR report required in 42 CFR § 438.8 must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, federal and State taxes and licensing or regulatory fees, and other non-claims costs. A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.
    a. Allocation to each category should be based on an accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will be the most accurate method. If a specific identification is not feasible, the Contractor should provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analyses.
    b. Shared expenses, including expenses under the terms of a management or administrative contract, must be apportioned pro rata to the entities incurring the expense
    c. Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios, or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group

N. Allocation methods. The DMO must identify in the MLR report required in 42 CFR § 438.8, the specific basis used to allocate expenses reported.

O. Maintenance of records. The DMO and its Subcontractors must maintain and make available to DHS, upon request, the data used to allocate expenses reported in the Medical Loss Ratio report together with all supporting information required to determine that the methods identified and reported as required under 42 CFR § 438.8(k) were accurately implemented in preparing the report required in 42 CFR § 438.

P. The DMO may add a credibility adjustment, based on the methodology in 42 CFR 438.8(h)(4), to the calculated MLR, if the MLR reporting year experience is partially credible. If the DMO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standard. The credibility adjustment cannot be added to the calculated MLR, if the MLR reporting year is fully credible. DMO must aggregate data for all Medicaid eligibility groups covered under the Contract, unless separate reporting is otherwise required

Q. The DMO must require any Subcontractor providing claims adjudication activities to provide all underlying data associated with MLR reporting to that DMO within 180 days of the end of the MLR reporting year or within 30 days of being requested by the DMO, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting. The level of detail must be sufficient to allow the DMO to accurately incorporate the expenditures associated with the Subcontractor’s activities into the DMO’s overall MLR calculation

3. When a DMO’s Subcontractor is also performing an administrative function not attributable to the direct provision of Medicaid covered services, such as eligibility and coverage verification, claims processing, utilization review, or network development, payments by the DMO to the Subcontractor for such functions are a non-claims administrative expense as described in 42 CFR 438.8(e)(2)(v)(A), and should not be counted as an incurred claim for the purposes of MLR calculations.
4. The DMO and its Subcontractors must calculate all components of and adjustments to MLR in accordance with 42 CFR 438.8 based on claims incurred only during the MLR reporting year and paid through March 31st of the following year. Contract reserves must be calculated as of December 31st of the applicable year.

R. If DMS makes a retroactive change to the Capitation Payment for an MLR reporting year, and the MLR report has already been submitted to DMS, the DMO must:

1. Re-calculate the MLR for all MLR reporting years affected by the change; and
2. Submit a new MLR report meeting the applicable requirements in this RFP and the resulting Contract.

S. Attachment F Bidder's Library, Exhibit 10 illustrates the Risk Corridor parameters relevant to this contract. In the event that the Contractor's profits or losses exceed the amounts listed in Exhibit 10, the State will receive a portion of the profits or refund the Contractor a portion of the losses in the proportion indicated in Exhibit 10. The State shall reserve the right to independently verify these calculations prior to the State issuing any refunds in accordance with this section. It is important to note, the presence of a Risk Corridor will be at DHS' discretion (i.e., it may go away after the PHE unwind is complete), and that each DMO will still be subject to the minimum MLR calculation (after the Risk Corridor).

1. The methodology shown in the Exhibit 10 Risk Corridor Examples **shall** remain the same during the first year of service provision after Go-Live. However, DHS **shall** retain the right to re-negotiate the methodology prior to renewal of the contract for the second year of services or at any-time during the remaining life of the Contract.
    a. The Risk Corridor and Medical Loss Ratio are two separate calculations. Calendar year 2024 includes a risk corridor program. The risk corridor program is based on and calculated within the Financial Data Request in a format required by DHS. The pricing assumptions for CY2024 are contained within the CY2024 Rate Certification (found in Attachment F Bidders Library, Exhibit 7 Milliman Letter). CY2024 Dental rates will be reconciled upon CMS approval.
    b. The risk corridor settlement will occur after the CY 2024 contract period has ended and enough time has passed to collect and validate CY 2024 Dental encounter data and financial data. The final settlement using data with fifteen months of claim runout will be completed as described below in 2.14.1.K.
    c. Reporting of information for purposes of the risk corridor must be consistent with MLR reporting requirements in 42 CFR 438.8.
    d. The Contractor and its Subcontractors must agree that the State of Arkansas, DHS, MFCU, OMIG, HHS, the Comptroller General, or their designees may, at any time, inspect and audit any records or documents of the Contractor, its Subcontractors, or delegates, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. Based on any such inspection, audit, or review, DHS reserves the right to adjust the risk corridor calculation as necessary to reflect market level reimbursement of providers.

T. 2024 Risk Corridor Settlement

1. The CY 2024 risk corridor settlement shall include all claims and revenue incurred between January 1, 2024, and December 31, 2024, with allowable claims runout for CY 2024 submitted by providers to the Dental MCO through March 31, 2026.
2. The CY 2024 risk corridor with fifteen months of claims runout information will be provided by the Dental MCO to DHS no later than April 20, 2026, which DHS will use to calculate the final 2024 Risk Corridor settlement.
3. The CY 2024 risk corridor settlement will be paid in the manner mutually agreed upon by parties no later than June 30, 2026.
4. This section shall survive the termination or replacement of this Agreement.

U. Pay-for-performance arrangements the bidder has in place with contracted entities shall be included in the risk corridor calculation.

2.15 PAYMENT UNDER THE AGREEMENT

2.15.1 PER MEMBER PER MONTH CAPITATION RATES

The Dental Managed Care service is structured through a Capitated Payment Model. Capitation payments for this service are made on a Per Member Per Month (PMPM) basis. All service provision for contracts established by this solicitation will be compensated through PMPM capitation payments. No other compensation will be payable under these contracts.

Distinct Capitation Rates are set for seven (7) categories of program members eligible for PMPM capitation payments:

- Enrolled Members, age 0-1
- Enrolled Members, age 2-5
- Enrolled Members, age 6-18
- Enrolled Members, age 19-20
- Enrolled Members, age 21-54
- Enrolled Members, age 55-64
- Enrolled Members, age 65+

Capitation Payments under an established contract will be made based on the Member Category Rate (MCR) and number of members in each category that are enrolled with a given contractor in each month.

V. Composite Rate Range

1. For the purposes of scoring cost in this solicitation, a Per Member Per Month Composite Rate Range (CRR) has been determined by the State's actuarial service inclusive of all seven (7) member categories. The CRR has been calculated from recent historical data of member distribution in each category (See Attachment F Bidder's Library, Exhibit 7 Milliman Letter *Calendar Year 2024 Dental Capitation Rate Development Report)*.
2. Prospective Contractors will bid a PMPM Composite Rate within the provided range on Attachment E Cost Proposal Template. The PMPM Composite Rate entered will be the scored pricing component of the solicitation.
3. The Per Member Per Month Composite Rate Range for Dental Managed Care Services is $18.29 -$19.25.
4. The *Cost Proposal Template* will also automatically calculate and fill each Member Category Rate based on the Composite Rate provided by the Prospective Contractor. Individual MCRs will not be used to score pricing on this solicitation.

W. Annual Rate Adjustments

Each distinct Capitation Rate is adjusted each calendar year in accordance with the State's actuarial analysis. Contracts established through this solicitation will use awarded PMPM capitation rates through 12/31/2024. The State's actuarial service will determine adjustments to those capitation rates for calendar year 2025 and again for each subsequent calendar year in which services are provided under the Contract.

2.16 SANCTIONS AND DAMAGES

2.16.1 SANCTIONS

X. Failure to meet the requirements set out in the scope may subject the DMO to the sanctions set out in Attachment C, Performance Based Contracting Standards, incorporated herein by reference.

Y. DHS may impose additional sanctions provided for under State or federal statutes, rules, or regulations to address noncompliance, including but not limited to requiring a Corrective Action Plan (CAP), withholding, or reducing payment until noncompliance is corrected, maintaining a negative Vendor Performance Report, or any combination of applicable remedies.

Z. DHS will provide the DMO with timely written notice before imposing any intermediate sanction (other than required temporary management) that explains the basis and nature of the sanction.

2.17 MISCELLANEOUS PROVISIONS

2.17.1 LIABILITY OF ENROLLED MEMBERS

AA. Enrolled Members shall not be held liable for the DMO's debts in the event the DMO becomes insolvent.

BB. Enrolled Members shall not be liable for Covered Services provided to them, for which Medicaid does not pay the DMO, or for which Medicaid or the DMO does not pay the provider that furnished the service under a contractual, referral, or other arrangement, including a Provider Agreement.

CC. Enrolled Members shall not be liable for Covered Services provided under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the Enrolled Member would owe if the DMO covered the services directly.

2.17.2 DENTAL RECORDS

DD. The DMO must use and disclose individually identifiable health information, such as dental records or any other health or enrollment information that identifies a particular Enrolled Member, in accordance with the confidentiality requirements in 45 CFR, Parts 160 and 164; 42 CFR § 438.208(b)(6); and 42 CFR § 438.224.

EE. The DMO must report to DHS consistent with the terms of the HIPAA Business Associate Agreement between the parties, the discovery of any use or disclosure of personal health information (PHI) that is not in compliance with the Contract, or State or federal law, in a manner and format prescribed by DHS.

FF. The DMO must require that the State, DHS, OMIG, MFCU, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the DMO, its Subcontractors, or its providers and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

2.17.3 DELIVERABLES BASED APPROACH

The State will use a deliverables-based approach to determine progress and completion. The State and the DMO Vendor will establish specific expectations for deliverables using the process described below. All deliverables will be reviewed and approved using a structured and controlled process. These processes, structures, and tools will govern any work done on the project. The DMO Vendor shall agree to these processes, and any work done not in compliance with these processes is completely at risk by the DMO Vendor. The DMO Vendor will prepare project deliverables for DHS approval that, at a minimum, conform to industry project management standards.

All deliverables are subject to review by the State before final approval, acceptance, and payment. Where appropriate, the DMO Vendor will perform a walkthrough of a draft version of the deliverable with all appropriate State staff and solicit feedback before submission. The DMO Vendor shall provide complete and comprehensive deliverables to the State. Each deliverable shall offer continuous improvement goals and advise on how to reach those goals.

DHS will have no less than ten (10) State business days to complete its initial review of the deliverable. The State will accept or reject deliverables in writing. In the event of the rejection of any deliverable, the DMO Vendor will be notified of the reason(s) for rejection. Unless agreed by the State due to the complexity of the deliverable, the DMO Vendor will have five (5) State business days to correct the rejected deliverable and return it to the State. Failure by the State to complete activities within the timeframes noted does NOT constitute acceptance, approval, or completion unless otherwise agreed upon by the State and the DMO Vendor. The State's acceptance or rejection of a deliverable or the delay of the due date will be made in writing by an authorized State representative.

All payment requests (e.g., invoices) must include copies of the approval signed by the State stakeholder authorized to approve the deliverable.

GG. Deliverables Summary and Due Dates

The following table summarizes the required Dental Managed Care Vendor deliverables and due

dates. The deliverables are described in the following section of this RFP.

Due dates for Initial deliverables are calendar days from the Contract Start Date unless otherwise specified, to be submitted on the next business day. The DMO Vendor will also update deliverables within 15 business days of a change in content.

Table 3: Deliverables Summary Table

No	Deliverable Name	Initial Due Dates	Operations Due Dates
PHASE I – Transition Period			
2.12.2 D	Certificates of Insurance	Contract Award	Annual
2.13.1 A	Tax Reporting Disclosures	Contract Award	Annual and upon any change
2.12.7 A	Problem Escalation Procedure (PEP)	10 days post Contract Award	Annual. Within 10 Business days after the start of each contract year and within 10 business days after any change in circumstance
2.12.3 A	Kick-off Meeting	15 days post Contract Award	N/A
2.8.2 A	Member Rights Policy	At Readiness Review	Annual
2.9.2 D	Monitoring Access Plan	At Readiness Review	Annual
2.9.1 G	Network Provider Policy	At Readiness Review	Annual
2.8.8 B	Call Center Disaster Recovery Plan Executed and Tested	At Readiness Review	Annual
2.12.1 E	Staffing Plan w/ Organizational Chart	At Readiness Review	Update 15th of following month or within 5 days of any change
2.12.1 F	Subcontractor Monitoring Plan	At Readiness Review	Annual
2.12.1 G	Subcontractor Report	90 days prior to Go-Live	15 days for voluntary change and 15 days for involuntary change
12.12.1 H	Quality Assessment and Performance Improvement Strategic Plan	90 days prior to Go-Live	Annual
2.12.1 H	Provider Incentive Plan(s)	TBD	TBD
2.12.3 B	System Implementation Plan	At Readiness Review	
2.13.1 C	Program Integrity Plan	At Readiness Review	Annual
2.12.3 B	Business Continuity and System Disaster Recovery Plan	At Readiness Review	Annual
2.12.3 D	Information Security Plan	Before Readiness Review	30days before contract renewal or within 5 days of any change
2.8.4 D	Website	Before Readiness Review	Monthly
2.11.1 B	List of Services Requiring Preauthorization	Before Readiness Review	Annual or upon changed

No	Deliverable Name	Initial Due Dates	Operations Due Dates
2.11.1 B	Preauthorization Policies and Procedure	30 days before Go-Live	Annual or upon changed
2.9.1 G	Provider Manual	Before Readiness Review	30 days prior to distribution but no less than 10 days prior to contract renewal annually
2.9.1 E	Network Provider Agreements	Before Readiness Review	At least thirty (30) days prior to implementation of revisions
2.9.1. F	Practice Guidelines	Annual	
2.8.1 A	Outreach Materials	Before Readiness Review	At least 10 days before use, ongoing whenever there are updates
2.8.1 D	Marketing and Advertising Materials	Before Readiness Review	At least thirty (30) days prior to intended use
2.8.1 E	Member Handbook	At Readiness Review	
2.8.1 E	New Member Orientation Packet/Welcome Packet	Mailed to members 15 days prior to Go-Live date and within 10 days of new enrollment	N/A
2.8.1 H	Member Incentive Plan	Annual	
2.9.1 D	Provider Re-Credentialing Review and Approval	At Readiness Review	Once every 3 years
2.9.1 B	Provider Medicaid Enrollment Revalidation	At Readiness Review	Once every 5 years
2.9.1 E	Provider Rate Certification – Capitated Payments Report	30 days before Go-Live	
PHASE II - Operations			
2.8.1 E	Provider Directory/Provider Terminations/Provider Additions	Monthly	15th of the following month
2.10.1 D	Encounter Certification Report	Monthly	15th of the following month
2.8.8 B	Appointment Reminder Report	Monthly	15th of the following month
2.8.1 E	New Member Orientation/Welcome Packet Report	Monthly	15th of the following month
2.8.4 A	Appeals Report	Monthly	15th of the following month
2.8.4 A	Grievances Report	Monthly	15th of the following month
2.9.1 C	Provider Recruitment Report	Monthly	15th of the following month
2.10.3 C	Third Party Liability (TPL) Not Collected Report	Monthly	15th of the following month
2.10.1 C	Denied Claims Report	Monthly	15th of the following month
2.9.1 G	Provider Training Report	Quarterly	30 calendar days after the quarter ends
2.8.1	Outreach Activities Report /	Quarterly	30 calendar days after the quarter ends

No	Deliverable Name	Initial Due Dates	Operations Due Dates
	Outreach to Pregnant Women and Non-Compliant Beneficiaries Report		
2.8.8.B 4	Call Center Metrics Report	Quarterly	30 calendar days after the quarter ends
2.11.1 B	Preauthorization Report	Quarterly	30 calendar days after the quarter ends
2.11.1 C	Adverse Benefit Determination Report	Quarterly	30 calendar days after the quarter ends
2.10.1 A	Claims Report	Quarterly	30 calendar days after the quarter ends
2.10.1 A	Provider Preventable Conditions Report	Quarterly	30 calendar days after the quarter ends
2.12.1 H	Quality Metrics Report	Quarterly	30 calendar days after the quarter ends
2.12.1 H	Provider Advisory Committee Summary with Meeting Minutes/ Member Advisory Committee Summary with Meeting Minutes	Quarterly	30 calendar days after the quarter ends
2.13.1 C	Program Integrity Plan Update	Quarterly	30 calendar days after the quarter ends
2.14.1	Claims Expenditure Template	Quarterly	30 calendar days after the quarter ends
2.12.1 H	Quality Status Report	Quarterly	30 calendar days after the quarter ends
2.13.1 G	Audit Report	Quarterly	30 calendar days after the quarter ends
2.9.1 C	Primary Care Dentist Capacity Report	Bi-annual	End of 2nd and 4th quarter of each calendar year within 10 business days of the end of those quarters
2.9.1 A	Network Adequacy Report	Bi-annual	End of 2nd and 4th quarter of each calendar year within 10 business days of the end of those quarters
2.8.1 J	Outreach Plan	Annual	November 1 for the following calendar year
2.11.1 C	Utilization Report	Annual	Annually on January 10th
2.12.3 B	Business Continuity Disaster Recovery (BC-DR) Certification	Annual	Within 60 calendar days after the year ends
2.11.1 B	Performance Measures Performance Improvement Plan (PIP)	Annual	Within 60 calendar days after the year ends
2.8.1 E	Enrollment Orientation Packet Summary	Annual	Within 60 calendar days after the year ends

No	Deliverable Name	Initial Due Dates	Operations Due Dates
2.9.1.F	Annual Provider Visit Log	Annual	Within 60 calendar days after the year ends
2.11.2 F	Medical Loss Ratio (MLR) Report	Annual	August 15th - year following the completion of each calendar year
2.12.4 A	SOC 2 Audit Report	Annual	July 31st for preceding calendar year
2.8.3	Cultural Competency Plan	Annual	November 1st for the following calendar year
2.11.2 F	Audited Financial Reports	Annual	November 1st for the following calendar year
2.10.2 B	Overpayment Recoveries Report	N/A	Within 30 calendar days of when DMO identifies
2.11.1 C	ARKids B EPSDT Services Report	N/A	Specified by CMS
2.12.1 E	Debarred Individuals Disclosure Report	N/A	Upon occurrence
2.10.1 C	Incidents of Suspected/Confirmed Waste, Fraud or Abuse Report	N/A	Upon occurrence, notification to DHS
2.12.4 B	Records related to Scope of Contract	N/A	Upon reasonable notice
	Disclosure of PHI	N/A	Upon discovery of any use or disclosure of Personal Health Info that is not compliant with the Agreement or state/federal law; Notification to DHS
	Required Disclosures-DMS-675 Form	N/A	Within 35 calendar days after change in ownership
2.10.3 A	Settlement Information (Joint and Mass Tort Cases)	N/A	Upon occurrence, within 10 business days from settlement date
2.10.3	Third Party Liability	N/A	Upon identification within 10 business days
2.10.3	TPL Settlement Information	N/A	Within 10 business days
2.12.3 B	Unauthorized Access, Use, or Disclosure of DHS PHI	N/A	Upon occurrence, within 15 days of suspected incident; Notification to DHS
2.12.1 D	Key Personnel Changes	N/A	Within 15 days of change
2.12.8 G	Exit Transition Plan	Within 10 days of notice of contract end	N/A
2.12.8 I	Transition Results Report	Within 30 days of operations turnover	N/A

3 SELECTION

- ***Do not** provide responses to items in this section.*

3.1 RFP CONTENTS

Table 4: RFP Attachments

Attachment	Name	Description	Bid Submission Requirement
A	Key Personnel	This attachment is Key Personnel requirements	Mandatory
B	Glossary of terms and acronyms	This is a collection of common acronyms and terms used throughout the RFP documents.	Informational
C	Performance Based Contracting Standards	Performance Contracting Standards	Informational
D	Technical Response Packet	This is a template Respondents should use in preparing their Technical Proposals	Mandatory
E	Cost Proposal Template	This is a template Respondents should use in proposing a cost for the project	Mandatory
F	Bidder's Library	This is a collection of files that Respondents should referenceand review to get a better understanding of what is expected bythe RFP.	Informational
G	DHS Standard Security Requirements	Standard Security Requirements	Mandatory
H	Written Questions	Respondent should use this form to submit written questions to the State pursuant to RFP Section 1.10	Non-Mandatory
I	Contract and Grant Disclosure Form	Required Disclosure Form	Mandatory
J	n/a	Attachment J has been removed from the solicitation.	n/a
K	Pro Forma Contract	Pro forma contract	Informational
L	Business Associate Agreement (BAA)	Business Associate Agreement	Informational
M	DHS Organizational or PersonalConflict of Interest Policy	Organizational or Personal Conflict of Interest Policy	Informational
N	Client History Form	This is a template Respondents must use to list all experience align with the time frames and any other pertinent information	Mandatory
O	Official Bid Price Sheet	This is a required sheet Respondents should use to provide pricing information	Mandatory

Attachment	Name	Description	Bid Submission Requirement
P	Terms and Conditions	Required Terms and Conditions contract	Informational
Q	Supplemental Disclosure Form	Required Disclosure Form	Mandatory

3.2 TECHNICAL PROPOSAL SCORE

HH. OP will review each *Technical Proposal Packet* to verify submission Requirements have been met. *Technical Proposals Packets* that do not meet submission *Requirements* **shall** be rejected and **shall** not be evaluated.

II. An agency-appointed Evaluation Committee will evaluate and score qualifying Technical Proposals. Evaluation will be based on Prospective Contractor's response to the *Information for Evaluation* section included in the *Technical Proposal Packet*.

5. Members of the Evaluation Committee will individually review and evaluate proposals and complete an Individual Score Worksheet for each proposal. Individual scoring for each Evaluation Criteria will be based on the following Scoring Description.

Table 5: Proposal Scoring Criteria

Quality Rating	Quality of Response	Description	Confidence in Proposed Approach
5	Excellent	When considered in relation to the RFP evaluation factor, the proposal squarely meets the requirement and exhibits outstanding knowledge, creativity, ability, or other exceptional characteristics. Extremely good.	Very High
4	Good	When considered in the relation to the RFP evaluation factor, the proposal squarely meets the requirement and is better than merely acceptable.	High
3	Acceptable	When considered in relation to the RFP evaluation factor, the proposal is of acceptable quality.	Moderate
2	Marginal	When considered in relation to the RFP evaluation factor, the proposal's acceptability is doubtful.	Low
1	Poor	When considered in relation to the RFP evaluation factor, the proposal is inferior.	Very Low
0	Unacceptable	When considered in relation to the RFP evaluation factor, the proposal clearly does not meet the requirement. Either nothing in the proposal is responsive in relation to the evaluation factor or the proposal affirmatively shows that it is unacceptable in relation to the evaluation factor.	No Confidence

6. After initial individual evaluations are complete, the Evaluation Committee members will meet to discuss their individual ratings in a consensus scoring meeting. At this consensus scoring meeting, each evaluator will be afforded an opportunity to discuss his or her rating for each evaluation criteria.

7. After committee members have had an opportunity to discuss their individual scores recorded on the preliminary Individual Score Worksheet with the committee, the individual committee members will be given the opportunity to change their initial individual score, if they feel that is appropriate.
8. The final individual scores of the evaluators will be recorded on the Consensus Score Sheets and averaged to determine the group or consensus score for each proposal. For purposes of scoring, only the final scores of the evaluators reflected on the Consensus Score Sheet will be used. Each evaluator shall sign the Consensus Score Sheet affirming that the score noted is the score intended by the evaluator.
9. Other agencies, consultants, and experts may also examine documents at the discretion of the Agency.

JJ. The *Information for Evaluation* section has been divided into sub-sections.

10. In each sub-section, items/questions have each been assigned a maximum point value of five (5) points. The total point value for each sub-section is reflected in the table below as the Maximum Raw Score Possible.
11. The agency has assigned Weighted Percentages to each sub-section according to its significance.

Table 6: Evaluation Scoring Methodology

Information for Evaluation Sub-Sections	Maximum Raw Points Possible	Sub-Section's Weighted Percentage	* Maximum Weighted Score Possible
E.1 Company Information and Experience	5	5%	35
E.2 Performance Standards, Contract Services and Coordination of Non-Capitated Services	45	4%	28
E.3 RFP Section 2.7 Eligibility, Enrollment and Disenrollment	50	9%	63
E.4 RFP Section 2.8.4 Grievance and Appeal System and Quality Assurance and Improvement	30	12%	84
E.5 RFP Section 2.9 Services	50	12%	84
E.6 RFP Section 2.10 Network and Provider Requirements	70	12%	84
E.7 RFP Section 2.11 Payment to Providers	35	13%	91
E.8 RFP Section 2.12 Strategic Plan and Utilization Management	50	13%	91
E.9 RFP Section 2.13 Administration and Management	35	4%	28
E.10 RFP Section 2.13.3 Systems and Security	30	4%	28
E.11 RFP Section 2.13.6 Readiness Review	10	4%	28
E.12 RFP Section 2.13.8 Transition at End of Contract	15	4%	28
E.13 RFP Section 2.14 Program Integrity	25	4%	28
Total Technical Score	**455**	**100%**	**700**

*Sub-Section's Percentage Weight x Total Weighted Score = Maximum Weighted Score Possible for the sub-section.

KK. The proposal's weighted score for each sub-section will be determined using the following formula:

(A/B)*C =D

A = Actual Raw Points received for sub-section in evaluation
B = Maximum Raw Points possible for sub-section
C = Maximum Weighted Score possible for sub-section
D = Weighted Score received for sub-section

LL. The proposal's weighted scores for sub-sections will be added to determine the Total Technical Score for the Proposal.

MM. Technical Proposals that do not receive a minimum weighted score/subtotal of 400 may not move forward in the solicitation process. The pricing for proposals which do not move forward will not be scored.

3.3 ORAL PRESENTATION/DEMONSTRATION SCORE

NN. The four prospective Contractors with the top technical proposal scores, after the completion of the technical proposal evaluation, may at the sole discretion of DHS be contacted to schedule an oral presentation/demonstration. Key staff proposed in the Bidder's Technical Proposal must be available to participate in the Demonstration/Oral Presentation.

OO. Should DHS opt to schedule any oral presentations/demonstrations, then after each oral presentation/demonstration is complete, the Evaluation Committee members will have the opportunity to discuss the oral presentation/demonstration and revise their individual scores on the Post-Demonstration Consensus Score Sheet based on the information provided during the oral presentation/demonstration.

PP. The final individual scores of the evaluators on the Post-Demonstration Consensus Score Sheets will be averaged to determine the final technical score for each proposal.

3.4 COST SCORE

QQ. When pricing is opened for scoring, the maximum amount of cost points will be given to the proposal with the lowest grand total as shown on the *Official Bid Price Sheet*. (See *Grand Total Score* for maximum points possible for cost score.)

RR. The amount of cost points given to the remaining proposals will be allocated by using the following formula:

(A/B)*(C) =D
A = Lowest Total Cost
B = Second (third, fourth, etc.) Lowest Total Cost
C = Maximum Points for Lowest Total Cost
D = Total Cost Points Received

3.5 GRAND TOTAL SCORE

The Technical Score and Cost Score will be added together to determine the Grand Total Score for the proposal. The Prospective Contractor's proposal with the highest Grand Total Score will be selected as the apparent successful Contractor (*See Award Process*).

	Maximum Points Possible
Technical Proposal	700
Cost	300
Maximum Possible Grand Total Score	**1,000**

3.6 PROSPECTIVE CONTRACTOR ACCEPTANCE OF EVALUATION TECHNIQUE

SS. Contractor **must** agree to all evaluation processes and procedures as defined in this solicitation.

TT. The submission of a *Technical Proposal Packet* **shall** signify the Contractor's understanding and agreement that subjective judgments **shall** be made during the evaluation and scoring of the Technical Proposals.

4 GENERAL CONTRACTUAL REQUIREMENTS

- ***Do not** provide responses to items in this section unless expressly required.*

4.1 PAYMENT AND INVOICE PROVISIONS

A. All invoices shall be forwarded to:

Division of Medical Services
Financial Activities
PO Box 1437 Slot S420
Little Rock, AR 72203

B. Payment will be made in accordance with applicable State of Arkansas accounting procedures upon acceptance goods and services by the agency.

C. The State **shall not** be invoiced in advance of delivery and acceptance of any goods or services. Payment will be made only after the Contractor has successfully satisfied the agency as to the reliability and effectiveness of the goods or services purchased as a whole.

D. The Contractor should invoice the agency by an itemized list of charges. The agency's Purchase Order Number and/or the Contract Number should be referenced on each invoice.

E. Other sections of this *Bid Solicitation* may contain additional Requirements for invoicing.

F. Selected Contractor **must** be registered to receive payment and future *Bid Solicitation* notifications. Contractors may register on-line at https://www.ark.org/vendor/index.html.

4.2 GENERAL INFORMATION

A. The State **shall not** lease any equipment or software for a period which continues past the end of a fiscal year unless the contract allows for cancellation by the State Procurement Official upon a thirty (30) day written notice to the Contractor/lessor in the event funds are not appropriated.

B. The State **shall not** pay damages, legal expenses or other costs and expenses of any other party.

C. The State **shall not** continue a contract once any equipment has been repossessed.

D. Any litigation involving the State **must** take place in Pulaski County, Arkansas.

E. The State **shall not** agree to any provision of a contract which violates the laws or constitution of the State of Arkansas.

F. The State **shall not** enter a contract which grants to another party any remedies other than the following:

1. The right to possession.
2. The right to accrued payments.
3. The right to expenses of de-installation.
4. The right to expenses of repair to return the equipment to normal working order, normal wear and tear excluded.
5. The right to recover only amounts due at the time of repossession and any unamortized nonrecurring cost as allowed by Arkansas Law.

G. The laws of the State of Arkansas **shall** govern this contract.

H. A contract **shall not** be effective prior to award being made by a State Procurement Official.

I. In a contract with another party, the State will accept the risk of loss of the equipment or software and pay for any destruction, loss or damage of the equipment or software while the State has such risk,

when:

1. The extent of liability for such risk is based upon the purchase price of the equipment or software at the time of any loss, and
2. The contract has required the State to carry insurance for such risk.

4.3 CONDITIONS OF CONTRACT

A. The Contractor **shall** always observe and comply with federal and State of Arkansas laws, local laws, ordinances, orders, and regulations existing at the time of, or enacted subsequent to the execution of a resulting contract which in any manner affect the completion of the work.

B. The Contractor **shall** indemnify and save harmless the agency and all its officers, representatives, agents, and employees against any claim or liability arising from or based upon the violation of any such law, ordinance, regulation, order or decree by an employee, representative, or subcontractor of the Contractor.

C. The Contractor agrees to the Performance Based Contracting standards as presented in Attachment C, the pro forma contract as presented in Attachment K, the Business Associate Agreement as presented in Attachment L, the Organizational or Personal Conflict of Interest policy as presented in Attachment M and the DHS Standard Terms and Conditions as presented in Attachment P., Do not complete and return any of the above-named attachments. They are for your information only.

4.4 STATEMENT OF LIABILITY

A. The State will demonstrate reasonable care but will not be liable in the event of loss, destruction or theft of Contractor-owned equipment or software and technical and business or operations literature to be delivered or to be used in the installation of deliverables and services. The Contractor will retain total liability for equipment, software and technical and business or operations literature. The State **shall** not at any time be responsible for or accept liability for any Contractor-owned items.

B. The Contractor's liability for damages to the State **shall** be limited to the value of the Contract or $5,000,000, whichever is higher. The foregoing limitation of liability **shall not** apply to claims for infringement of United States patent, copyright, trademarks, or trade secrets; to claims for personal injury or damage to property caused by the gross negligence or willful misconduct of the Contractor; to claims covered by other specific provisions of the Contract calling for damages; or to court costs or attorney's fees awarded by a court in addition to damages after litigation based on the Contract. The Contractor and the State **shall not** be liable to each other, regardless of the form of action, for consequential, incidental, indirect, or special damages. This limitation of liability **shall not** apply to claims for infringement of United States patent, copyright, trademark, or trade secrets; to claims for personal injury or damage to property caused by the gross negligence or willful misconduct of the Contractor; to claims covered by other specific provisions of the Contract calling for damages; or to court costs or attorney's fees awarded by a court in addition to damages after litigation based on the Contract.

C. Language in these terms and conditions **shall not** be construed or deemed as the State's waiver of its right of sovereign immunity. The Contractor agrees that any claims against the State, whether sounding in tort or in contract, **shall** be brought before the Arkansas Claims Commission as provided by Arkansas law, and **shall** be governed accordingly.

4.5 RECORD RETENTION

D. The Contractor **shall** maintain all pertinent financial and accounting records and evidence pertaining to the contract in accordance with accepted principles of accounting and as specified by the State of Arkansas Law. Upon request, access **shall** be granted to State or Federal Government entities or any of their duly authorized representatives.

E. Financial and accounting records **shall** be made available, upon request, to the State of Arkansas's designee(s) at any time during the contract period and any extension thereof, and for five (5) years from expiration date and final payment on the contract or extension thereof.

F. Other sections of this *Bid Solicitation* may contain additional Requirements regarding record retention.

4.6 PRICE ESCALATION

G. Price increases will be considered at the time of contract renewal.

H. The Contractor **must** provide to OP a written request for the price increase. The request **must** include supporting documentation demonstrating that the increase in contract price is based on an increase in market price. OP has the right to require additional information pertaining to the requested increase.

I. Increases will not be considered to increase profit or margins.

J. OP has the right to approve or deny the request.

4.7 CONFIDENTIALITY

K. The Contractor, Contractor's subsidiaries, and Contractor's employees **shall** be bound to all laws and to all Requirements set forth in this *Bid Solicitation* concerning the confidentiality and secure handling of information of which they may become aware of during providing services under a resulting contract.

L. Consistent and/or uncorrected breaches of confidentiality may constitute grounds for cancellation of a resulting contract, and the State **shall** have the right to cancel the contract on these grounds.

M. Previous sections of this *Bid Solicitation* may contain additional confidentiality Requirements.

4.8 CONTRACT INTERPRETATION

Should the State and Contractor interpret specifications differently, either party may request clarification. However, if an agreement cannot be reached, the determination of the State **shall** be final and controlling.

4.9 CANCELLATION

N. For Cause. The State may cancel any contract resulting from this solicitation for cause at the discretion of DHS. The State shall give the vendor written notice of cancellation, specifying the terms and the effective date of contract termination.

O. For Convenience. The State may cancel any contract resulting from the solicitation by giving the Contractor written notice of such cancellation no less than thirty (30) days prior to the date of cancellation.

P. If upon cancellation the Contractor has provided commodities or services which the State of Arkansas has accepted, and there are no funds legally available to pay for the commodities or services, the Contractor may file a claim with the Arkansas Claims Commission under the laws and regulations governing the filing of such claims.

4.10 SEVERABILITY

If any provision of the contract, including items incorporated by reference, is declared, or found to be illegal, unenforceable, or void, then both the agency and the Contractor will be relieved of all obligations arising under such provision. If the remainder of the contract is capable of performance, it **shall not** be affected by such declaration or finding and **must** be fully performed.

5 STANDARD TERMS AND CONDITIONS

- ***Do not** provide responses to items in this section.*

1. **GENERAL**: Any special terms and conditions included in this solicitation **shall** override these Standard Terms and Conditions. The Standard Terms and Conditions and any special terms and conditions **shall** become part of any contract entered into if any or all parts of the bid are accepted by the State of Arkansas.
2. **ACCEPTANCE AND REJECTION**: The State **shall** have the right to accept or reject all or any part of a bid or all bids, to waive minor technicalities, and to award the bid to best serve the interest of the State.
3. **BID SUBMISSION**: Original Proposal Packets **must** be submitted to the Office of Procurement on or before the date and time specified for bid opening. The Proposal Packet **must** contain all documents, information, and attachments as specifically and expressly required in the *Bid Solicitation*. The bid **must** be typed or printed in ink. The signature **must** be in ink. Unsigned bids **shall** be disqualified. The person signing the bid should show title or authority to bind his firm in a contract. Multiple proposals **must** be placed in separate packages and should be completely and properly identified. Late bids **shall not** be considered under any circumstances.
4. **PRICES**: Bid unit price F.O.B. destination. In case of errors in extension, unit prices **shall** govern. Prices **shall** be firm and **shall not** be subject to escalation unless otherwise specified in the *Bid Solicitation*. Unless otherwise specified, the bid **must** be firm for acceptance for thirty days from the bid opening date. "Discount from list" bids are not acceptable unless requested in the *Bid Solicitation*.
5. **QUANTITIES**: Quantities stated in a *Bid Solicitation* for term contracts are estimates only and are not guaranteed. Contractor **must** bid unit price on the estimated quantity and unit of measure specified. The State may order more or less than the estimated quantity on term contracts. Quantities stated on firm contracts are actual Requirements of the ordering agency.
6. **BRAND NAME REFERENCES**: Unless otherwise specified in the *Bid Solicitation*, any catalog brand name or manufacturer reference used in the *Bid Solicitation* is descriptive only, not restrictive, and used to indicate the type and quality desired. Bids on brands of like nature and quality will be considered. If bidding on other than referenced specifications, the bid **must** show the manufacturer, brand or trade name, and other descriptions, and should include the manufacturer's illustrations and complete descriptions of the product offered. The State **shall** have the right to determine whether a substitute offered is equivalent to and meets the standards of the item specified, and the State may require the Contractor to supply additional descriptive material. The Contractor **shall** guarantee that the product offered will meet or exceed specifications identified in this *Bid Solicitation*. Contractors not bidding an alternate to the referenced brand name or manufacturer **shall** be required to furnish the product according to brand names, numbers, etc., as specified in the solicitation.
7. **GUARANTY**: All items bid **shall** be newly manufactured, in first-class condition, latest model and design, including, where applicable, containers suitable for shipment and storage, unless otherwise indicated in the *Bid Solicitation*. The Contractor hereby guarantees that everything furnished hereunder **shall** be free from defects in design, workmanship, and material, that if sold by drawing, sample, or specification, it **shall** conform thereto and **shall** serve the function for which it was furnished. The Contractor **shall** further guarantee that if the items furnished hereunder are to be installed by the Contractor, such items **shall** function properly when installed. The Contractor **shall** guarantee that all applicable laws have been complied with relating to construction, packaging, labeling and registration. The Contractor's obligations under this paragraph **shall** survive for a period of one year from the date of delivery, unless otherwise specified herein.
8. **SAMPLES**: Samples or demonstrators, when requested, **must** be furnished free of expense to the State. Each sample should be marked with the Contractor's name and address, bid or contract number and item number. If requested, samples that are not destroyed during reasonable examination will be returned at Contractor's expense. After reasonable examination, all demonstrators will be returned at Contractor’s expense.
9. **TESTING PROCEDURES FOR SPECIFICATIONS COMPLIANCE**: Tests may be performed on samples or demonstrators submitted with the bid or on samples taken from the regular shipment. In the event products tested fail to meet or exceed all conditions and Requirements of the specifications, the cost of the sample used, and the reasonable cost of the testing **shall** be borne by the Contractor.
10. **AMENDMENTS**: Contractor’s proposals cannot be altered or amended after the bid opening except as permitted by regulation.
11. **TAXES AND TRADE DISCOUNTS**: Do not include State or local sales taxes in the bid price. Trade discounts should be deducted from the unit price and the net price should be shown in the bid.

12. **AWARD**: Term Contract: A contract award will be issued to the successful Contractor. It results in a binding obligation without further action by either party. This award does not authorize shipment. Shipment is authorized by the receipt of a purchase order from the ordering agency. Firm Contract: A written State purchase order authorizing shipment will be furnished to the successful Contractor.

13. **DELIVERY ON FIRM CONTRACTS**: This solicitation shows the number of days to place a commodity in the ordering agency's designated location under normal conditions. If the Contractor cannot meet the stated delivery, alternate delivery schedules may become a factor in an award. The Office of Procurement **shall** have the right to extend delivery if reasons appear valid. If the date is not acceptable, the agency may buy elsewhere, and any additional cost **shall** be borne by the Contractor.

14. **DELIVERY REQUIREMENTS**: No substitutions or cancellations are permitted without written approval of the Office of Procurement. Delivery **shall** be made during agency work hours only 8:00 a.m. to 4:30 p.m. Central Time, unless prior approval for other delivery has been obtained from the agency. Packing memoranda **shall** be enclosed with each shipment.

15. **STORAGE**: The ordering agency is responsible for storage if the Contractor delivers within the time required and the agency cannot accept delivery.

16. **DEFAULT**: All commodities furnished **shall** be subject to inspection and acceptance of the ordering agency after delivery. Back orders, default in promised delivery, or failure to meet specifications **shall** authorize the Office of Procurement to cancel this contract or any portion of it and reasonably purchase commodities elsewhere and charge full increase, if any, in cost and handling to the defaulting Contractor. The Contractor **must** give written notice to the Office of Procurement and ordering agency of the reason and the expected delivery date. Consistent failure to meet delivery without a valid reason may cause removal from the Contractors list or suspension of eligibility for award.

17. **VARIATION IN QUANTITY**: The State assumes no liability for commodities produced, processed, or shipped in excess of the amount specified on the agency's purchase order.

18. **INVOICING**: The Contractor **shall** be paid upon the completion of all of the following: (1) submission of an original and the specified number of copies of a properly itemized invoice showing the bid and purchase order numbers, where itemized in the *Bid Solicitation*, (2) delivery and acceptance of the commodities and (3) proper and legal processing of the invoice by all necessary State agencies. Invoices **must** be sent to the "Invoice To" point shown on the purchase order.

19. **STATE PROPERTY**: Any specifications, drawings, technical information, dies, cuts, negatives, positives, data or any other commodity furnished to the Contractor hereunder or in contemplation hereof or developed by the Contractor for use hereunder **shall** remain property of the State, **shall** be kept confidential, **shall** be used only as expressly authorized, and **shall** be returned at the Contractor's expense to the F.O.B. point provided by the agency or by OSP. Contractor **shall** properly identify items being returned.

20. **PATENTS OR COPYRIGHTS**: The Contractor **must** agree to indemnify and hold the State harmless from all claims, damages and costs including attorneys' fees, arising from infringement of patents or copyrights.

21. **ASSIGNMENT**: Any contract entered into pursuant to this solicitation **shall not** be assignable nor the duties thereunder delegable by either party without the written consent of the other party of the contract.

22. **CLAIMS**: Any claims the Contractor may assert under this Agreement shall be brought before the Arkansas State Claims Commission ("Commission"), which shall have exclusive jurisdiction over all claims that the Contactor may have arising from or in connection with this Agreement. Unless the Contractor's obligations to perform are terminated by the State, the Contractor shall continue to provide the Services under this Agreement even in the event that the Contractor has a claim pending before the Commission.

23. **CANCELLATION**: In the event, the State no longer needs the commodities or services specified for any reason, (e.g., program changes; changes in laws, rules, or regulations; relocation of offices; lack of appropriated funding, etc.), the State **shall** have the right to cancel the contract or purchase order by giving the Contractor written notice of such cancellation thirty (30) days prior to the date of cancellation.

    Any delivered but unpaid for goods will be returned in normal condition to the Contractor by the State. If the State is unable to return the commodities in normal condition and there are no funds legally available to pay for the goods, the Contractor may file a claim with the Arkansas Claims Commission under the laws and regulations governing the filing of such claims. If upon cancellation the Contractor has provided services which the State has accepted, the Contractor may file a claim. **NOTHING IN THIS CONTRACT SHALL BE DEEMED A WAIVER OF THE STATE'S RIGHT TO SOVEREIGN IMMUNITY.**

24. **DISCRIMINATION**: In order to comply with the provision of Act 954 of 1977, relating to unfair employment practices, the Contractor agrees that: (a) the Contractor **shall not** discriminate against any employee or applicant for employment because of race, sex, color, age, religion, handicap, or national origin; (b) in all solicitations or advertisements for employees, the Contractor **shall** state that all qualified applicants **shall** receive consideration without regard to race, color, sex, age, religion, handicap, or national origin; (c) the Contractor will furnish such relevant information and reports as requested by the Human Resources Commission for the purpose of determining compliance with the statute; (d) failure of the Contractor to comply with the statute, the rules and regulations promulgated thereunder and this nondiscrimination clause **shall** be deemed a breach of contract and it may be cancelled, terminated or suspended in whole or in part; (e) the Contractor **shall** include the provisions of above items (a) through (d) in every subcontract so that such provisions **shall** be binding upon such subcontractor or Contractor.

25. **CONTINGENT FEE**: The Contractor guarantees that he has not retained a person to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except for retention of bona fide employees or bona fide established commercial selling agencies maintained by the Contractor for the purpose of securing business.

26. **ANTITRUST ASSIGNMENT**: As part of the consideration for entering into any contract pursuant to this solicitation, the Contractor named on the *Proposal Signature Page* for this solicitation, acting herein by the authorized individual or its duly authorized agent, hereby assigns, sells and transfers to the State of Arkansas all rights, title and interest in and to all causes of action it may have under the antitrust laws of the United States or this State for price fixing, which causes of action have accrued prior to the date of this assignment and which relate solely to the particular goods or services purchased or produced by this State pursuant to this contract.

27. **DISCLOSURE**: Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that order, **shall** be a material breach of the terms of this contract. Any Contractor, whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy **shall** be subject to all legal remedies available to the agency.