ARKANSAS DEPARTMENT OF HUMAN SERVICES
PERFORMANCE BASED CONTRACTING

Pursuant to Ark. Code Ann. 19-11-267 et. seq., the selected DMO shall comply with performance-based standards. Following are the performance-based standards that will be a part of the contract and with which the DMO must comply for acceptable performance to occur under the contract.

I. The DMO must comply with all statutes, regulations, codes, ordinances, and licensure or certification requirements applicable to the DMO or to the DMO's agents and employees and the subject matter of the contract. Failure to comply shall be deemed unacceptable performance.

II. Except as otherwise required by law, the DMO agrees to hold the contracting Division/Office harmless and to indemnify the contracting Division/Office for any additional costs of alternatively accomplishing the goals of the contract, as well as any liability, including liability for costs or fees, which the contracting Division/Office may sustain as a result of the DMO's performance or lack of performance.

III. During the term of the contract, the division/office will complete sufficient performance evaluation(s) to determine if the DMO's performance is acceptable. The damages set forth below are not exclusive and shall in no way exclude or limit any remedies available at law or in equity.

IV. 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 DMO to establish reasonably achievable standards.

V. The contract program deliverables and performance indicators to be performed by the DMO are:

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General and Miscellaneous Requirements The DMO shall perform all services described in the RFP and resulting Contract 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 DMO shall immediately notify the Contract Monitor, by a method to be determined by DHS, of any liabilities that threaten its financial ability	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. In addition to the above, DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is

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to perform the duties of the Contract and of any discussions of filing for bankruptcy by it or by any entity that has a financial interest in the DMO. The DMO shall comply with the requirements of §§ 1903(m), 1905(t), and 1932 of the Social Security Act, as well as 42 CFR Part 438.		corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.
QUALIFICATIONS The DMO must meet and maintain throughout the life of the Contract term the following requirements: 1. The DMO shall obtain a certificate of authority from AID and all other qualifications necessary to conduct business in the State no later than 90 days after Contract Commencement. 2. The DMO must meet all criteria required to enroll as a Medicaid provider, as found in 42 CFR Part 455.	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. In addition to the above, DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10)

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		business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.
Service Requirements **General Service Requirements** In accordance with Section 2.8.6 of the RFP, A. The Contractor must provide services to all Enrolled Members per the terms of the RFP, any amendments to the Contract, and any other applicable federal and state laws and regulations. B. The Contractor must ensure that services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. C. The Contractor shall arrange for and pay for all covered services rendered to Enrolled Members, and be capable of performing the following functions: 1. Credentialing and contracting with an adequate Network of Providers meeting the access requirements specified in the RFP. All Network Providers must be enrolled in 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.	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	If the DMO fails to substantially provide medically necessary services to an Enrolled Member that the DMO is required to provide under law or the Agreement, DHS may seek a remedy under the regulation or this Agreement. DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be

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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. D. The DMO shall monitor and comply with all CMS Managed Care regulations (42 CFR Part 438) that apply to the Contractor. E. 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. F. The Contractor shall cooperate with all other DHS contractors (e.g., MMIS contractor) involved in implementing and operating the program proposed in this RFP. **Medically Necessary Covered Services And Value-Added Services** **Covered Services** As outlined in Section 2.8.6 of the RFP: 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,		imposed by DHS pursuant to the Agreement or by law.

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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. **Value-Added Services** B. Value-Added Services 1. The Contractor may propose to offer		

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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. a. 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. b. 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. **In Lieu of Services** A. 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:		

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DHS determines that the alternative service or setting is a medically appropriate substitute for the covered service or setting under the State plan. a. DHS determines that the alternative service or setting is a cost-effective substitute for the covered service or setting under the State plan. b. The enrollee is not required by the Contractor to use the alternative service or setting. c. The approved in lieu of services are authorized by DHS and identified in the contract. d. 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. **Coordination of Non-Capitated Services** 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.		
Eligibility & Enrollment, Transition, Disenrollment, and Anti-Discrimination **Eligibility & Enrollment** As outlined in Section 2.7.1 of the RFP, 1. A. The Contractor shall maintain and utilize an enrollment system that shall accept, and process daily eligibility files	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance	If the DMO discriminates among Enrolled Members based on their health status or need for health services, DHS may impose a fine as outlined within the federal regulation.

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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. 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. b. 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. 1. Operate a system that electronically accepts and processes Arkansas Medicaid eligibility files from the Arkansas MMIS daily, as well as a full replacement file when deemed necessary by DHS. 2. Determine whether a person requesting assistance, or for whom prior authorization is requested, is eligible for a specific service, pursuant to Arkansas Medicaid policies. 3. Refer individuals who have lost eligibility to the Division of County Operations for assistance. 4. Verify during Claims adjudication that the Enrolled Member was eligible for	throughout the contract term as determined by DHS.	DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. In addition to the above, DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

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Dental Services on the date of service. 5. Submit a daily report of Enrolled Member eligibility daily update statistics to DHS in a method and format as approved by DHS. **Transition** As outlined in RFP Section 2.7.7.A.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 Are consistent with the federal requirements outlined in 42 CFR § 438.62. **Disenrollment** 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 in RFP section 2.7.5 B. **Anti-Discrimination Policy** As outlined in Section 2.7.4 of the RFP, 1. 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. 2. The DMO is prohibited from discriminating against Potential Members eligible to enroll based on health status or need for health care services. 3. The DMO is prohibited from discriminating against Potential Members eligible to enroll based on 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 based on race, color, national origin, sex, sexual orientation, gender identity or disability.		
Member Rights Policy As outlined in Section 2.8.2 of the RFP the following Service Criteria must be met:	Acceptable performance is defined as one hundred percent (100%) compliance with	DHS may impose sanctions provided for under state or federal statutes, rules, or

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A. The DMO must develop and implement a written policy, in clear and understandable language, to protect Enrolled Member's rights. B. The DMO must take reasonable action to inform Enrolled Members of their rights and responsibilities by dissemination of the DMO's Member Handbook. C. 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. D. The DMO, its subcontractors, and Network Providers are prohibited from treating an Enrolled Member adversely for exercising his or her rights, as outlined above.	all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. In addition to the above, DHS may also require a Corrective Action Plan (CAP), may withhold or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.
Enrolled Member Liability As outlined in Section 2.17.1 of the RFP: A. Enrolled Members shall not be held liable for the DMO's debts in the event the DMO becomes insolvent. B. Enrolled Members shall not be liable for Covered Services provided to them, for which Medicaid does not pay the DMO, or for which neither Medicaid nor the DMO	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by	If the DMO imposes charges on Enrolled Members that are more than those permitted in the Medicaid program or under this scope, DHS may impose a fine of up as outlined in the federal regulations.

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pays the provider that furnished the service under a contractual, referral, or other arrangement, including a Provider Agreement. C. Enrolled Members shall not be liable for Covered Services provided under a contract, referral, or other arrangement to the extent that those payments are more than the amount the Enrolled Member would owe if the DMO covered the services directly.	DHS.	DHS may impose any sanctions provided for under state statutes, rules, or regulations to address noncompliance, including but not limited to requiring a Corrective Action Plan (CAP), monetary damages, withholding or reducing payment until noncompliance is corrected, maintaining a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other sanctions that may be imposed by DHS pursuant to the Agreement.
Cultural Competency Plan As outlined in Section 2.8.3 of the RFP, 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.	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. In addition to the above, DHS may also require a Corrective Action Plan (CAP), may withhold or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP,

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		and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.
Dental Records A. As outlined in Section 2.17.2 of the RFP: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. B. 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. **C.** 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 ten (10) years from the final date of the Contract period or the date of completion of any audit, whichever is later.	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. In addition to the above, DHS may also require a Corrective Action Plan (CAP), may withhold or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

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Enrolled Member Information Services The DMO must meet and maintain throughout the life of the Contract term the following requirements listed in Section 2.8.1 of the RFP: **A. General Requirements** 1A. 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	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	If the DMO distributes marketing materials that have not been approved by DMS or that contain false or misleading information, either directly or indirectly through any agent or Subcontractor, DHS may impose a fine of up to $25,000 for each distribution. In addition, DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. In addition to the above, DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

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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		

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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		

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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		

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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		

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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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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:		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
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.		
Access to Care	Acceptable performance is defined	DHS may impose sanctions provided for

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
The DMO must meet and maintain throughout the life of the Contract term the following requirements listed in Section 2.9.2 of the RFP: 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	as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS. 1. At least 95% of Enrolled Members must have access to two or more Primary Care Dentists who are accepting new patients within thirty (30) miles of the Enrolled Member's residence in Urban counties and sixty (60) miles of the Enrolled Member's residence in Rural counties. 2. At least 85% of all Enrolled Members must have access to at least one specialty provider within thirty (30) miles of the Enrolled Member's residence in urban counties and 60 miles of the Enrolled Member's residence in rural counties. 3. 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 thirty (30) miles of the Enrolled Member's residence in Urban counties and sixty (60) miles of the	under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. In addition to the above, DHS may also require a Corrective Action Plan (CAP), may withhold or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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	Enrolled Member's residence in Rural counties. 4. Emergency Care must be provided within twenty-four (24) hours. 5. Urgent care, including urgent specialty care, must be provided within forty-eight (48) hours. 6. Therapeutic and diagnostic care must be provided within fourteen (14) days. 7. 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 thirty (30) days. 8. Non-urgent specialty care must be provided within sixty (60) days of authorization.	

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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. **Assigning a Primary Care Dentist** 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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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)		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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. 1. 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. **Out-of-Network Referrals** 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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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. **Monitoring Access** 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		

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
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. 1. 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.		
Network Adequacy A. Network Adequacy Standards 1. The DMO's network must be supported by written Provider Agreements as described in Section 2.9.1 of the RFP.. 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	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	1st Incident: $250 for each tenth of a percentage point below 99.0% (excluding maintenance time during the specified window) during the month. 2nd incident: A five percent (5%) penalty will be assessed in the following months' payment to the DMO for each thirty (30) day period the DMO is not in full compliance with all requirements of the contract. The five percent (5%) penalty will be calculated from the total payment for the identified month in which the deficiency took place. In addition to the above, DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
for good cause from both the DMO and the Healthy Smiles Dental Managed Care Program in accordance with 42 CFR § 438.56(c). Provider Contracting 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.		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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,		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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. Provider Credentialing and Enrollment B. 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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
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. Provider Re-Credentialing and Re-Validation 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. Network Provider Agreements 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.		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
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. a. Provider Relations and Education 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 shall be able to visit Provider offices a minimum of		

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
one visit per year, and when necessary additional visits as needed, but no visits l less than once a year 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.		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		

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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. Provider Manual 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		

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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		

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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.		
Call Center As outlined in Section 2.8.7 of the RFP, A. 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. **Call Center Requirements** B. 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	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS. 1. 95% of all calls must be answered within three (3) rings or fifteen (15) seconds for any month. 2. Number of busy signals shall not exceed 5% of total incoming calls for any month. 3. The wait time in queue should not be longer than two (2) minutes for 95% of the incoming calls for any month. 4. All calls requiring a	1st Incident: • For criteria 1 – 4, $500.00 for each percentage point for each criterion that falls below the standard during each one- month reporting period. • For criteria 5 – 6, $500 per telephone call that the DMO fails to return during each one-month reporting period. • For any performance criteria, a Corrective Action Plan (CAP) acceptable to DHS shall be due to DHS within ten (10) business days of request. 2nd incident: A five percent (5%) penalty will be assessed in the following months' payment to the DMO for each thirty (30) day period the DMO

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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.	call back to the Enrolled or Potential Member or Provider should be returned within one (1) Business Day of receipt. 5. The abandoned call rate shall not exceed 3% for any month. 6. For calls received during non-Business hours, return calls to Enrolled or Potential Members and Providers must be made on the next Business Day.	is not in full compliance with all requirements of the contract. The five percent (5%) penalty will be calculated from the total payment for the identified month in which the deficiency took place. DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. In addition to the above, DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

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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		

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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		

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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		
Website Requirements The DMO must meet and maintain throughout the life of the Contract term the following requirements listed in Section 2.8.4 of the RFP: D. 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.	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	1st Incident: $250 for each tenth of a percentage point below 99.0% (excluding maintenance time during the specified window) during the month. 2nd incident: A five percent (5%) penalty will be assessed in the following months' payment to the DMO for each thirty (30) day period the DMO is not in full compliance with all requirements of the contract. The five percent (5%) penalty will be calculated from the total payment for the identified month in which the deficiency took place. In addition to the above, DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address

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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		noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

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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.		
Grievances and Appeals The DMO must meet and maintain throughout the life of the Contract term the following requirements listed in Section 2.8.4 of the RFP: A. 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	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	1st Incident: $500 for each Grievance the DMO fails to administer in accordance with the standards during each one-month reporting period. 2nd incident: A five percent (5%) penalty will be assessed in the following months' payment to the DMO for each thirty (30) day period the DMO is not in full compliance with all requirements of the contract. The five percent (5%) penalty will be calculated from the total payment for the identified month in which the deficiency took place. In addition to the above, DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP,

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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 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. **Appeals**		

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
B. 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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
§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:** 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 **Provider Appeals:** 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. **Grievance Procedure** C. 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		

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
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		

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
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.		
Claims Processing The DMO must meet and maintain throughout the life of the Contract term the following requirements listed in Section 2.10.1 of the RFP: 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 Part 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 which 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 in accordance with Section 6.3 of this	Acceptable Performance shall comply with the following quantitative metrics: 1. 100% of clean paper claims shall be adjudicated as approved or denied within 30 calendar days of receipt. 2. 100% of clean electronic claims shall be adjudicated as approved or denied within 14 calendar days of receipt. 3. 100% of approved claims shall be paid within 14 calendar days.	1st Incident: $250.00 for each percentage point for each criterion that falls below the standard during each one-month reporting period, as identified in each quarterly report. 2nd incident: A five percent (5%) penalty will be assessed in the following months' payment to the DMO for each thirty (30) day period the DMO is not in full compliance with all requirements of the contract. The five percent (5%) penalty will be calculated from the total payment for the identified month in which the deficiency took place. In addition to the above, DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. , DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
Amendment. 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		discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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 prior to 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 a rate negotiated between the DMO and the IHCP that is not less than the amount required by FFS, or i. In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the Arkansas Medicaid program would reimburse the IHCP for services; 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		

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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 or not, 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: a. Registers the date a Claim is received by a Provider. b. Records the details of each Claim transaction. c. Has the capability to report each Claim transaction by date and type. d. Maintains information at the Claim and line detail levels. e. 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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
of Claims, allowing Providers to: a. Verify Enrolled Member eligibility. b. Submit and view prior authorization requests. c. Provide functionality for claims appeals and reconsiderations. d. 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. e. 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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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 which is denied in whole or in part.		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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 Monitor and the Contractor, to pay claims from medical Providers that offer Dental Services. s. Have a program to detect and promptly report suspected fraud and abuse to OMIG, 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 Monitor: a. A quarterly report to the Contract Monitor showing, for each month's paper and electronic Claims, average adjudication time and disposition. b. A monthly file to the Contract Monitor, 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.		

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
Encounter Data As outlined in Section 2.10.1 of the RFP, 1. The DMO is required to submit all Encounter Data for all services provided to Enrolled Members, including allowed and paid amounts, 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.	Acceptable Performance shall comply with the following quantitative metrics: 1. At least 99% of all encounter data must be accurate. 2. All encounter data must submitted in accordance with the timeframes established in the Contract.	1st Incident: • For criteria 1, $1,000 for each percentage point below the standard during the reporting period. • For criteria 2, $1,000 for each day past the deadline. In addition to the above penalties, DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

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5. Encounter Data must follow the format and include the data elements described in the most current version of HIPAA- compliant X 12 837D 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 jointly by the Contractor and 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.		
2.11.1 PREAUTHORIZATION AND UTILIZATION MANAGEMENT A. 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 to		DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. In addition to the above, DHS may also require a Corrective Action Plan (CAP), may withhold or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP,

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
meet the EPSDT standard. See 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 Monitor, by a method and format approved by the Contract Monitor, 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. B. Prior Authorization 1. The DMO may require prior authorization for Covered Services in accordance with the requirements of this Solicitation 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		and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

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that conduct utilization management activities, including prior authorization reviews, must NOT be structured 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 defined timeframes 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 Monitor 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 Monitor 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		

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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 Monitor 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. Not require prior authorization for: i. Any Medically Necessary preventive services. ii. Diagnostic Dental Services.		

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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. 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, except for 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.		

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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 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 Monitor 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 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		

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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 amount 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		

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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. C. 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:		

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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 Monitor, 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		

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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 within ten (10) Business Days after anniversary of Go-Live Date as well as fulfill ad hoc requests from DHS within ten (10) Business Days of request. D. Continuity of Care and Non-Network Providers 1. The Contractor must ensure that the care of newly enrolled Beneficiaries 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 Beneficiaries 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-		

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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, Continuity of Care and Non-Network Providers, does not require the Contractor to reimburse the Beneficiary's existing non-network providers for ongoing care for: a. More than ninety (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. (1)		
1.25 CONTRACTOR OFFICE, STAFFING, AND SUBCONTRACTING A. Office Location 1. The Contractor must maintain a physical office in Pulaski County, Arkansas. a. At minimum, the following staff shall be in the Pulaski County, Arkansas office: Project Director, Dental Director, Provider relations staff, and outreach 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	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	$750 per each day after the 15th day that a suitable Replacement has not been submitted. The suitability of the Replacement is at the sole discretion of the State. $2,000 for each day past the deadline for each report. In addition to the above penalties, DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. DHS may also require a Corrective Action Plan (CAP), may withhold or reduce payment until noncompliance is corrected, file and maintain a negative

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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 always 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 Monitor. 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. 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 reporting staffing rates, the Contractor shall submit to the Contract Monitor by the fifteenth (15th) of each month a list of all Contract Personnel with associated full-time equivalencies (forty (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 Monitor 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		Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

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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. Enough 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.		

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7. A Quality Assurance Coordinator who shall coordinate requirements and monitor the quality of care, as described in Section 3.9 of this RFP. 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 Beneficiaries 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		

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"Officer" shall be considered Key Personnel under this Contract. 14. The Contractor shall submit to the Contract Monitor 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		

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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 Monitor'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 Monitor 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		

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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 Monitor shall have the right to require additional information concerning the proposed substitution. d. The Contract Monitor 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 Monitor 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 Monitor 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 Monitor 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		

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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 Monitor. 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 Monitor, at the option and sole discretion of the Contract Monitor, the original personnel may continue to work under the Contract, or the replacement personnel will be authorized to replace the original personnel, notwithstanding the		

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original personnel's ability to return. d. Directed Personnel Replacement: i. The Contract Monitor 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, or 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 Monitor, the Contract Monitor 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 Monitor. iv. If the Contract Monitor rejects the Remediation Plan, the Contractor shall revise and resubmit the plan to the Contract Monitor within five (5) days, or in the timeframe set forth by the Contract Monitor in writing. • Should performance issues persist despite the approved Remediation Plan, the Contract Monitor 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		

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requiring the immediate removal of the key personnel at issue. • If possible, the Contract Monitor will provide at least fifteen (15) days notification of a directed replacement. However, if the Contract Monitor deems it necessary and in DHS' best interests to remove the personnel with less than fifteen (15) days' notice, the Contract Monitor 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 Monitor 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 Contract Monitor 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:		

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i. Key Personnel: • Project Director • Dental Director • Provider Relations Director • Chief Financial Officer • Information Technology Director • Outreach and Education Coordinator • Compliance Officer • 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 F. Debarred Individuals 1. 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. 2. The Contractor shall be required to disclose to the Contract Monitor 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. 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 delegation 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		

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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 delegation agreements for compliance with the terms of the Contract. 2. A subcontract or delegation agreement does not relieve the DMO of any responsibilities under the requirement of any resulting Contract, and the DMO is ultimately 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 delegation 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		

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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		

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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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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 delegation 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 delegation agreement. 13. The DMO shall not include provisions in any Subcontract or delegation agreement that contain compensation terms that discourage Network Providers from serving any specific eligibility category.		

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14. The DMO shall maintain a fully executed original or electronic copy of all Subcontracts or delegation agreements, which shall be available to DHS within five (5) business days of a request by DHS to inspect. 15. Subcontract or delegation 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 delegation agreement to make a specific payment directly or indirectly under a Provider Incentive Plan, as described in Section 8.3.1, 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 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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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 delegation 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 which 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 delegation agreement the activities and reporting responsibilities delegated to the Subcontractor or delegate; 3. The subcontract or delegation agreement must include language for revoking delegation or imposing other sanctions if the Subcontractor's or		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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 meets Contract requirements; 5. The DMO will 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 Monitor 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		

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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 which 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:		

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
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. Consistent with Section 6.2.7 of this Amendment, 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		

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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: g. The arrangement must be for a fixed period; h. Performance must be measured during the rating period under the contract in which the withhold arrangement is applied; i. The arrangement may not be renewed automatically; j. The arrangement must be made available to both public and private contractors under the same terms of performance; k. The arrangement must not condition DMO participation in the withhold arrangement on the DMO entering into or adhering to intergovernmental transfer agreements; and l. 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. m. 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. n. At least ninety (90) days prior to the Go-Live Date, and in a method and format approved by the Contract Monitor, the Contractor shall submit to the Contract Monitor for review and approval a written plan which shall		

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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. o. 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 Monitor's approval. p. The Contractor shall implement and maintain all necessary processes and procedures, including timeliness, to support its quality assurance and improvement plan. q. On an ongoing basis, the Contractor shall look for opportunities for quality improvement and implement timely corrective action. r. The Contractor shall be required to meet a set of performance measures outlined in Attachment C. s. 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. t. Failure to meet the Quality Measures, as outlined in the attachment to the Contract, will result in corrective action or sanctions being taken, up to and including recoupment or capping enrollment, u. The DMO must submit quarterly 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. v. These reports, as specified in the deliverables section below, will be		

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monthly for the first year of the Contract but, if requested by the Contract Monitor, must move to quarterly submissions. w. The Contractor shall cooperate with the State's External Quality Review Organization. x. 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. y. To ensure that the Contractor receives ongoing feedback on its administration of the dental program from Beneficiaries 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 Beneficiaries 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. 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 Monitor must approve all appointments to the groups.		

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
z. During the Contract Term, the Contractor shall submit monthly reports to the Contract Monitor on the status of the quality of the dental program by the 10th of the following month. i. The Contractor shall submit for the Contract Monitor's approval a reporting template by the Readiness Review. ii. After the first year of the Contract, the Contract Monitor may reduce the frequency of these reports. These reports shall include, at a minimum, the following information: (2) 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. (3) The status of the Contractor's goals and objectives; (4) All quality improvements that were implemented during the month; and All corrective actions that were implemented during the month.		
COORDINATION OF BENEFITS & THIRD-PARTY LIABILITY A. 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	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	1st Incident: $250 for each tenth of a percentage point below 99.0% (excluding maintenance time during the specified window) during the month. 2nd incident: A five percent (5%) penalty will be assessed in the following months' payment to the DMO for each thirty (30) day period the DMO is not in full compliance

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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 MCO, PAHP, or PIHP (as those are defined by CMS); and c. Medicaid in the FFS environment. 5. DHS will provide 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' 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. 9. 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. 10. A “total plan case” is a case where payments for services rendered to the Enrolled Member are exclusively the		with all requirements of the contract. The five percent (5%) penalty will be calculated from the total payment for the identified month in which the deficiency took place. DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

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responsibility of the DMO; no reinsurance or Fee-For-Service payments are involved. 11. 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. 12. 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 regarding casualty recovery. The DMO may retain up to 100% of its recovery collections if all 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. 13. 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. 14. The DMO must report settlement information to DHS within ten (10) business days from the settlement date. B. 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		

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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. a. If the Contractor later establishes, 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. b. 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. C. 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		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
recovered. **3.** The Contractor shall provide a quarterly report detailing claims cost-avoided and claims recovered.		
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 MMIS and other systems (e.g., eligibility, data warehouse, pharmacy) as necessary to carry out 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 Monitor 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 Department; 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 Program's general business practices, 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		DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. , DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

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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 HITECH standards for data and document management. 3. This includes the ability to transmit, receive and process data in HIPAA compliant formats that are in use as of the Contract start date. 4. 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. 5. 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.		

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
6. 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. 7. 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. 8. The DMO must make DHS aware of the nature and availability of these functions prior to extending access to these functions to Enrolled Members and/or providers. 9. 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 CAP that describes how problems with critical systems functions will be restored and prevented from occurring again. 10. The CAP must be delivered to DHS within five (5) business days of the critical systems function problem or failure. 11. 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_. 12. The DMO must develop a Business Continuity-Disaster Recovery Plan (BC-DR) that is continually ready to be invoked. 13. The BC-DR must be reviewed and approved by DHS prior to implementation. 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. 14. 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;		

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
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 f. Malicious acts, including malware or manipulation. 15. 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 Monitor; f. Recovery procedures; g. Procedures for deactivating the Plan. 16. 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. 17. The DR plan will have a Recovery Time Objective (RTO) of twenty-four (24) hours and a Recovery Point Objective (RPO) of twenty-four (24) hours. 18. 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		

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outlined 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. 19. 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 RTO of twenty-four (24) hours and a RPO of twenty-four (24) hours within forty-eight (48) 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. 20. 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. 21. 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. 22. Any app must be approved by DHS prior to utilization by the DMO. 23. 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. 24. DHS will monitor all social networking		

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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___. C. Disaster Recovery Plan 1. The Contractor shall provide a Disaster Recovery Plan for the claims processing system. 2. 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. D. Other Security Measures 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 H for sample 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 Monitor 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		

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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. d. DHS shall have the right to refuse any individual employee to work on State premises, based upon information provided in a background check. e. 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. f. 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 Vendors' Library), or other State security regulations or policies about which they may be informed from time to time. E. 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. 1. The Contractor shall perform system updates as requested by the Contract Monitor. 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 Monitor that a deficiency exists within the Contractor's system. c. Should the Contractor feel that changes, corrections, or enhancements are needed to the		

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system, the Contract Monitor must be advised of the changes, corrections, or enhancements and must approve before implementation. 2. The Department shall advise the Contractor of changes to MMIS throughout the Contract Term. **3.** The Contractor shall adapt to all changes to fulfill all the tasks outlined in this RFP.		
Payment to Contractor A. Capitation Payments 1. DHS will make Capitated Payments to the DMO for all Medicaid-eligible Enrolled Members in accordance with Attachment O. 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 to the rates; however, the DMO will be required to accept the DHS proposed Capitated Payments to participate in the Healthy Smiles program. B. 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. C. All disputes regarding the amount owed shall be addressed in accordance with the process determined in contract negotiations. D. If an Enrolled Member qualifies for retroactive coverage prior to the date of application for Medicaid coverage, Contractor will receive a capitation payment for each month during the retroactive eligibility period. E. If 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. F. At the end of each year, the Contractor shall submit reports on its Medical Loss Ratio calculated in accordance with the		DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. In addition to the above, DHS may also require a Corrective Action Plan (CAP), may withhold or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

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requirements established under federal regulations,		
MEDICAL LOSS RATIO (MLR) A. The DMO shall track and report to DHS actual medical expenditures against an MLR of eighty-five percent (85%). The report shall be made as outlined within the Scope. B. 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. C. 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 because of subrogation. • Incurred but not reported claims based on experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	1st incident: $500 penalty for failure to report actual medical expenditures against an MLR of eighty-five percent (85%) in accordance with the standards outlined in Service Criteria. 2nd incident: A five percent (5%) penalty will be assessed in the following months' payment to the DMO for each thirty (30) day period the DMO is not in full compliance with all requirements of the contract. The five percent (5%) penalty will be calculated from the total payment for the identified month in which the deficiency took place. DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be

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• 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		due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

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reimbursement for State Plan services or Value-Added Services or In Lieu of Services and provided to an Enrolled Member. o 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 is 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 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		

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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)		

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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. 3. 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. D. 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. E. 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		

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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. 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 aggregate. a. Allocation to each category should be based on a generally 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 generally 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. Expenses, adjustments, and calculations must be done in accordance with the corresponding section in the RFP and resulting Contract or as allowed under current federal regulations. Shared expenses, including expenses under the terms of a management or administrative contract, must be apportioned pro rata to the entities incurring the expens b. e. Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special		

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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 grou c. p. 3. of allocation methods. The DMO must identify in the MLR report required in 42 CFR § 438.8, the specific basis used to allocate expenses reported. 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 M eportprt 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. 4. 8. 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. The credibility adjustment shall be added to the MLR calculation before the MLR report is submitte 5. d. The DMO must aggregate data for all Medicaid eligibility groups covered under the Contract, unless separate reporting is otherwise require 6. d. 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 thirty (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		

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accurately incorporate the expenditures associated with the subcontractor's activities into the DMO's overall MLR calculation 7. . a. 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. 8. The DMO and its Subcontractors must calculate all components of and adjustments to incurred claims, expenditures for activities that improve health care quality, and fraud prevention activities 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. 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: a. Re-calculate the MLR for all MLR reporting years affected by the change; and b. Submit a new MLR report meeting the applicable requirements in this RFP and the resulting Contract. F. Attachment A3 illustrates the Risk Corridor parameters relevant to this contract. If the Contractor's profits or losses exceed the amounts listed in Attachment A3, the State will receive a portion of the profits or refund the Contractor a portion of the losses in the proportion indicated in Attachment A3. The State shall reserve the right to independently verify these calculations prior to the State issuing any refunds in accordance with this section. 1. The methodology shown in the Risk Corridor Examples Attachment A3 shall remain the same during the first year of service provision after Go-Live. However, DHS shall retain the right to re-negotiate		

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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 (attached to this agreement). 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. 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 ten (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. G. 2024 Risk Corridor Settlement a. The CY 2024 risk corridor settlement shall include all claims and revenue incurred between January 1, 2024, and December 31, 2024, with allowable		

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claims runout for CY 2024 submitted by providers to the Dental MCO through March 31, 2026. b. 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. c. The CY 2024 risk corridor settlement will be paid in the manner mutually agreed upon by parties no later than June 30, 2026. d. This section shall survive the termination or replacement of this Agreement. H. Pay-for-performance arrangements the bidder has in place with contracted entities shall be included in the risk corridor calculation, subject to the requirements in 3.4.C.2.		
Reporting Requirements A. General Reporting Requirements 1. The DMO shall submit reports as outlined in the scope of work. 2. The reporting requirements set out in this Section are in addition to other reporting requirements found this RFP and the resultant Contract and do not supplant or supersede those other requirements. 3. Reports shall be submitted in a manner and format agreed upon by the parties, unless otherwise specified herein. B. Call Center reports required under the Contract must be submitted for both the Enrolled Member Support Call Center and the Provider Support Call Center. **Medical Loss Ratio (MLR) Reporting** A. The DMO must submit a report detailing the calculation of its MLR according to Section 12.2 of this RFP. This report must be submitted on the 15th day of August in the year following the completion of each calendar year. B. In accordance with 42 CFR § 438.8(k), the MLR Report submitted to DHS must include: 1. Total Incurred Claims. 2. Expenditures on quality improving activities. 3. Expenditures related to activities compliant with program integrity	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	1st Incident: $2,000 for each day past the deadline for each report. In addition to the above penalties, DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request.

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requirements (Fraud Prevention Activities). 4. Non-claims costs. Non-Claims Costs as referenced in Section 9.3, 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. 5. Premium Revenue. 6. Taxes. 7. Licensing fees. 8. Regulatory fees. 9. 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. 10. Any credibility adjustment applied. Credibility adjustment, as referenced in Section 9.3, 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, as referenced in Section 9.3, 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. 11. 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. 12. 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 eighty-five percent (85%) or higher set by DHS. When applicable, DHS or its contracted		Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

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actuaries will specify the methodology to be used when determining the remittance calculation. 13. 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. 14. 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. 15. The number of member months. Member months, as referenced in Section 9.3 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. 16. Other metrics or information required by DHS. C. 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. D. 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.		
Quality Metrics DMO shall strive to achieve the following goals: • **At least 16.8% of Enrolled Members over the age of 21 received an oral evaluation for dental service during the contract year.** • **At least 57.2% of Enrolled Members under the age of 21 received at least**	Minimum Acceptable Performance for this Service Criteria shall comply with the following quantitative metrics: 1. At least 15% of Enrolled Members	For failure to meet all of the two-point performance targets, the following damages may be assessed based on the total point value receive for all four, quality metrics: • If 6-7 points are

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one oral evaluation for dental service during the contract year. • **At least 28.9% of Enrolled Members under the age of 21 received topical fluoride treatment during the contract year.** • **At least 51.3% of Enrolled Members received sealants on permanent first molar teeth by their 10th birthday.** Notwithstanding the goals outlined above, DMO shall meet certain minimum quality metrics during the contract year. Details about the calculation, reporting, and supporting data for these measures will be specified by DHS.	over age 21, shall have had at least one (1) oral evaluation or preventative dental service during the contract year to receive one point towards the eight total points available; 15.2% to receive two points: i. Enrolled Members who have been enrolled for less than nine (9) months of the contract year shall be excluded from this measure. 2. At least 50% of Enrolled Members under age 21, shall have had at least one (1) oral evaluation during the contract year to receive one point towards the eight total points available; 51.9% to receive two points. i. The following Enrolled Members shall be excluded from this measure: a. Enrolled Members who have been enrolled for less than nine (9) months of the contract year. b. Enrolled Members under on (1) year of age at the midpoint of the contract	earned, damages equal to one-tenth of one percent (0.10%) of the total capitated payments made during the contract year. • If 4-5 points are earned, damages equal to three-tenths of one percent (0.30%) of the total capitated payments made during the contract year. • If 0-3 points are earned, damages equal to five-tenths of one percent (0.50%) of the total capitated payments made during the contract year. • For failure to meet any of the enumerated minimum performance criteria, DHS may require a CAP acceptable to DHS, which shall be due to DHS within ten (10) business days of request. • DHS may also suspend all new enrollments to the DMO, pending remediation of the deficient criteria. In addition to the above penalties, DHS reserves the right to impose additional penalties including without limitation, monetary damages, withholding payment on future invoices until DMO is in full compliance, maintaining a below standard Vendor Performance Report (VPR) in the DMO file, or contract termination.

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	year. 3. At least 25% of Enrolled Members under age 21, shall have had at least one (1) topical fluoride treatment during the contract year to receive one point towards the eight total points available; 26.3% to receive two points. i. The following Enrolled Members shall be excluded from this measure: a. Enrolled Members who have been enrolled for less than nine (9) months of the contract year. b. Enrolled Members under on (1) year of age at the midpoint of the contract year. ii. Data in support of this measure shall align with TFL-CH Child Core Set Specifications (2025). 4. At least 45% of Enrolled Members who turn 10 years of age during the contract year shall have received at least one sealant on permanent first molar teeth by their 10th birthday to receive one point towards the eight	

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	total points available; 46.5% to receive two points. i. The following Enrolled Members shall be excluded from this measure: a. Enrolled Members who have been enrolled for less than nine (9) months of the contract year. b. Enrolled Members under on (1) year of age at the midpoint of the contract year. c. Enrolled Members who have received treatment (restorations, extractions, endodontic, prosthodontic, and other dental treatments) on all four (4) permanent first molars in the 48 months prior to their 10th birthdate. ii. Data in support of this measure shall align with SFM-CH Child Core Set Specifications (2025). DHS has the discretion to allow a variance of any of the quality metrics performance criteria. The DMO may request a variance of these standards on a	

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	metric-by-metric basis if extenuating circumstances beyond the DMO's control prohibit compliance with the specified threshold. A comprehensive analysis of the extenuating circumstances must be documented and submitted to DHS for review.	
Program Integrity A. 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 DMO shall work collaboratively with these agencies and units as described below. B. Required Disclosures 1. The Contractor, as well as its Subcontractors, and any Providers, whether contract or non-contract 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	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	If the DMO fails to timely submit an acceptable FAPP or fails to timely submit the reports referenced in the Scope, a sanction of up to $2,000 per day, from the date the report is due to DHS or OMIG, until DHS or OMIG deems the DMO to be in compliance. If the DMO fails to implement an FAPP or create an investigative unit, a sanction of up to $10,000 may be imposed. If the DMO fails to timely report or fully report to DHS and OMIG all required information for suspected or confirmed instances of provider, recipient, or internal Fraud within fifteen (15) business days after detection or fails to timely file quarterly reports of Fraud, Abuse, Waste or Overpayments due to suspected Fraud, a sanction of up to $1,000 per day may be imposed until DHS and OMIG deems the DMO to be in compliance.For other violations of the corresponding Service Criteria, DHS may impose sanctions provided for

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any Provider which 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 (a copy of which is included in the Vendors' Library). C. Prohibited Relationships 1. 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. 2. 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; 3. For purposes of this Section, "have a relationship" includes: a. A director, officer, owner, or partner of the DMO; b. A SubDMO 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		under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

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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. 4. If the DMO determines it has a relationship, with someone who is excluded from DMO participation according to 42 CFR 438.600 et.seq. the DMO must disclose such relationship immediately to DHS and OMIG, in writing, along with any remedial actions being taken by the DMO. 5. On at least a monthly basis and at the time that the DMO engages the individual or during renewal of agreements, the DMO must disclose individuals they have a relationship with, as defined above, against 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: i. https://dhs.arkansas.gov/dhs/portal/Exclusions/PublicSearch/ . 6. The DMO must not be controlled by a sanctioned individual who is excluded under Section 42 CFR 438.600 et.seq. 7. 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. 8. 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		

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Vendors' Library). 9. Any services provided by excluded individuals shall be refunded to and/or obtained by the State and/or the DMO as prescribed in Section 3.18.J - Program Integrity Overpayment Recovery. 10. 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. 11. Any Provider listed on any of these excluded or disbarred entity databases shall not be included in the Contractor's Network. D. Fraud and Abuse Prevention 1. The DMO must have a written 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,		

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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. 2. The DMO must have a written compliance and antifraud plan (compliance plan), including its fraud, waste, and abuse policies and procedures. The compliance 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 compliance 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 which were conducted during the previous fiscal year by the DMO's fraud investigative unit; c. Enforcement of standards through well-publicized statutory requirements, the Agreement 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		

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frequently if required by DHS or OMIG. 4. The FAPP and/or updates to the PI Plan shall be submitted to the Contract Monitor ten (10) business days prior to scheduled meetings discussing the Plan. The Plan shall include provisions enabling the efficient identification, investigation, and resolution of waste, fraud and abuse issues of Providers and any Subcontractors, including but not limited to: a. Written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all applicable State and federal standards. b. The designation of investigatory and program integrity staff. c. The type and frequency of training and education of DMO employees on the detection of fraud, waste, and abuse. Training must be annual and address the False Claims Act, Arkansas laws and requirements governing Medicaid reimbursement and the utilization of services – particularly changes in rules, and other Federal and State laws governing Medicaid provider participation and payment as directed by CMS, DHS and OMIG. Training should also focus on recent changes in rules when there have been changes. d. A risk assessment of the DMO's various fraud and abuse/program integrity processes. • A risk assessment shall also be submitted on an 'as needed' basis and updated after program integrity-related actions, including financial-related actions (such as overpayment, repayment, and fines), are taken. • The DMO shall inform DHS and OMIG of such actions in its audit plan. • The assessment shall also include a listing of the DMO's top three (3) vulnerable areas and shall outline action plans mitigating such risks. 5. Provision for internal monitoring and auditing. 6. Procedures designed to prevent and		

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detect abuse and fraud in the administration and delivery Dental Services under the Contract. 7. A description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to: a. A list of automated pre-payment claims edits. b. A list of automated post-payment claims edits. c. A list of types of desk audits on post-processing review of claims. d. A list of reports for Provider profiling and credentialing used to aid program and payment integrity reviews. e. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services. f. A list of provisions in the SubDMO and Provider agreements that ensure the integrity of Provider credentials. g. A list of references in Provider and Enrolled Member material regarding fraud and abuse referrals. h. A list of provisions for the confidential reporting of PI Plan violations to the designated person. i. A list of provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports. 8. Provisions ensuring that the identities of individuals reporting violations of the DMO are protected and that there is no retaliation against such persons. 9. Specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating fraud and abuse compliance PI Plan violations. 10. Requirements regarding the reporting of any confirmed or suspected provider fraud and abuse under State or federal law to the DHS. 11. Assurances that no individual who reports Contractor's potential violations		

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or suspected fraud and abuse is retaliated against. 12. Policies and procedures for conducting both announced and unannounced site visits and field audits of Providers to ensure services are rendered and billed correctly. 13. Provisions for prompt response to detected offenses, and for development of corrective action initiatives. 14. Program integrity-related goals, objectives, and planned activities for the upcoming year. E. At a minimum, the DMO must ensure that: 1. 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, subDMOs, vendors, or members under state and/or federal law be reported to DHS and OMIG within five business days; 2. All Provider Agreements entered into 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 Section of the Amendment Scope of Work and the resultant Contract; 3. 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 4. 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: a. 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		

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medical/case records and data relating to the delivery of items or services for which Medicaid monies are expended, and b. 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 circumstance. **Program Integrity Operations** A. The DMO 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. B. The DMO 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. C. DMO shall have operations sufficient to enable the efficient identification, investigation, and resolution of waste, fraud, and abuse issues of Network Providers. D. DMO 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. E. The DMO 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. F. The DMO shall also have effective procedures for timely reviewing, investigating, and processing such referrals.		

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G. DMO shall conduct and maintain at a minimum the following operations and capabilities: 1. Data mining, analytics, and predictive modeling for the identification of potential overpayments and aberrant payments/providers warranting further review/investigation. 2. 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. 3. Onsite audit capability and protocols identifying how and when the DMO or State shall conduct such onsite audits of providers. 4. Medical claim audit capabilities sufficient to enable the DMO 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. 5. Member service utilization analytics to identify Enrolled Members that may be abusing services. **Preliminary Investigation of Suspected Waste, Fraud or Abuse** A. The DMO 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 DMO shall report the suspected incident to DHS and OMIG. B. Unless prior written approval is obtained from DHS, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the DMO shall not: 1. Contact the subject of the investigation about any matters related to the investigation; 2. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or 3. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.		

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C. The DMO shall cooperate with all appropriate State and federal agencies, including the Arkansas MFCU, OMIG and DHS, in investigating fraud and abuse. The DMO shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §§ 455.13, 455.14, 455.21). **Reporting Suspected or Confirmed Incidences of Waste, Fraud or Abuse** A. After a preliminary investigation, the DMO shall immediately report all suspected or confirmed instances of waste, fraud and abuse to the State and DHS. B. The DMO 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. **Quarterly Audit Activity Report** A. On a quarterly basis, or as otherwise directed by DHS or OMIG, and in a method and format approved by DHS or OMIG, the DMO shall submit a detailed Audit Report to DHS and OMIG which 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. B. The Audit Report should also specify individual Provider recoupment, repayment schedules, and actions taken for each audit or investigation. 1. The quarterly progress report must identify recoupment totals for the reporting period. 2. 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. C. DHS shall review and approve, approve with modifications, or reject the Audit		

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Report and specify the grounds for rejection. D. Recoupment totals and summaries for each reporting period (quarterly unless otherwise specified by DHS) must be submitted in the Audit Report. **Cooperation with Further Investigation and/or Prosecution** A. The DMO shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. B. Such cooperation shall include providing, upon request, information, access to records, and access to interview DMO 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. **Auditing Program Integrity Operations** A. 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 SI Unit's performance metrics. B. 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 damages.		
INSURANCE REQUIREMENTS The DMO must meet and maintain throughout the life of the Contract term the following requirements as outlined in Section 2.12.2 of the RFP. A. General Coverage 9. The Contractor **shall** maintain, at Contractor's own expense, during the Contract Term and until final acceptance of all services and	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance	DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. In addition to the above,

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deliverables, the following insurance coverage: c. Business Automobile Liability Insurance for all owned, non-owned, and hired vehicles, for bodily injury and property damage; d. 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. e. 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. f. If Umbrella Liability insurance is provided, it **must** follow the form of the primary coverage. B. Professional Liability Coverage 10. 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	throughout the contract term as determined by DHS.	DHS may also require a Corrective Action Plan (CAP), may withhold or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

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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 11. All exceptions to the Contract's insurance requirements **must** be approved in writing by DHS. 7. The Contractor or Provider **shall** be responsible for all deductibles stated in the policies. 8. Insurance coverage **must** be issued by insurance companies authorized by applicable law to conduct business in the State of Arkansas. 9. 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. 10. 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. 11. 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. 12. Any insurance coverages and limits		

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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. 13. Any insurance maintained by DHS will apply more than and **shall not** contribute to insurance provided by the Contractor under the Contract. 14. 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. 15. 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. 16. 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). 17. The Contractor must require all insurers to waive their rights of subrogation against DHS. D. Proof of Insurance Coverage 12. The Contractor **must** furnish DHS with original Certificates of Insurance evidencing the required insurance coverage on or before the Contract		

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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. 18. 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. 19. 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. 1.		
PROBLEM ESCALATION PROCEDURE The DMO must meet and maintain throughout the life of the Contract term the following requirements as outlined in Section 2.12.7 of the RFP. The Contractor **must** provide and maintain a Problem Escalation Procedure (PEP) for both routine and emergency situations. 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. 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. The Contractor must provide the PEP to the Contract Manager no later than ten (10) Business Days after Contract Commencement. The PEP, including any revisions thereto, must also be provided within ten	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. In addition to the above, DHS may also require a Corrective Action Plan (CAP), may withhold or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be

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(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. 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: 3. The process for establishing the existence of a problem;). 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; . Circumstances in which the escalation will occur in less than the normal timeframe; . The nature of feedback on resolution progress, including the frequency of feedback to be provided to the State; . Identification of, and contact information for, progressively higher levels of personnel in the Contractor's organization who would become involved in resolving a problem; . Contact information for persons responsible for resolving issues after normal business hours (e.g., evenings, weekends, holidays, etc.) and on an emergency basis; and . A process for updating and notifying the Contract Manager of any changes to the PEP. 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. A.		due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.
AUDITS AND ACCESS TO RECORDS The DMO must meet and maintain throughout the life of the Contract term the following requirements as outlined in Section 2.12.4 of the RFP. 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").	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. In addition to the above, DHS may also require a Corrective Action Plan (CAP), may withhold or

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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		reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

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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		

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
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. 1.		

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
Mandated Reporting Pursuant to Ark. Code Ann. §12-18-402 (b)(10) and Ark. Code Ann. §§ 12-12-1708(a)(1)(AA), DMO and all of its employees, agents, and all Subcontractors and Subcontractor's employees and agents shall immediately make a report to the Child Abuse Hotline or the Adult Maltreatment Hotline (based on type of maltreatment) if DMO or any of its employees, agents, or Subcontractors' employees and agents, while performing duties under this contract, have reasonable cause to suspect that: a. A child has been subjected to child maltreatment; b. A child died as a result of child maltreatment; c. A child died suddenly and unexpectedly; or d. Observe a child being subjected to conditions or circumstances that would reasonably result in child maltreatment. or e. An endangered person or an impaired person has been subjected to conditions or circumstances that constitute adult maltreatment or long-term care facility resident maltreatment. A privilege or contract shall not prevent a person from reporting maltreatment when he or she is a mandated reporter and required to report under this section. An employer or supervisor of a mandated reporter shall not prohibit an employee or a volunteer from directly reporting maltreatment to the Hotline. An employer or supervisor of a mandated reporter shall not require an employee or a volunteer to obtain permission or notify any person, including an employee or a supervisor, before reporting maltreatment to the Hotline. Pursuant to Act 531 of 2019, Ark. Code Ann. §12-18-402 (b)(10) and Ark. Code Ann. §§ 12-12-1708(a)(1)(AA), DMO and all of its employees, agents, and all Subcontractors and Subcontractor's employees and agents are mandated reporters.	Acceptable performance is defined as one hundred percent (100%) compliance with all service criteria and standards for acceptable performance throughout the contract term as determined by DHS.	For each failure to report, DHS may impose: 1. A ten percent (10%) penalty, assessed in the following months' payment for each failure to report. The penalty will be calculated from the total payment for the identified month in which the deficiency took place; or 2. A one percent (1%) penalty, assessed in the next payment for each failure to report. The penalty will be calculated from the projected total yearly contract amount for the contract, as determined by DHS. DHS may elect to calculate penalties/damages differently per occurrence. DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. DHS may also require a Corrective Action Plan (CAP), may withhold or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
		due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.
Performance Bonding The DMO **shall** be required to obtain performance bonds to protect the State's interest as follows: 1. The amount of the performance bonds **shall** be one hundred percent (100%) of the annual contract price, unless the State determines that a lesser amount would be adequate for the protection of the State. 2. The State **shall** require additional performance bond protection when a contract price is increased or modified. 3. The additional performance bond **must** be delivered to the Arkansas Department of Human Services Chief Procurement Officer within fourteen (14) calendar days of request. 4. The DMO **shall** notify the State of any changes, modification, or renewals for the performance bond during the term of the contract. The performance bond documentation must be provided to the State with each required notice.	Acceptable performance is always defined as one hundred percent (100%) compliance with Service Criteria throughout the contract term as determined by DHS.	Damages shall be one percent (1%) per day, calculated using the annual contract amount, for each day DMO fails to meet the Performance Bonding Requirements specified in Service Criteria. In addition, DMO's continued failure to meet Service Criteria, may result in a below standard Vendor Performance Report (VPR) maintained in the DMO file and contract termination. Failure to provide is a breach of contract and may result in immediate contract termination.
Conflict of Interest Mitigation During the term of this contract, the DMO shall comply with the terms of the DHS Organizational or Personal Conflict of Interest provisions. The DMO shall disclose all actual, apparent, or potential conflicts of interest to the Department of Human Services (DHS) within five (5) days of having knowledge of them. The DMO shall develop a mitigation plan as requested by DHS which must be approved and accepted by DHS. Any changes to the approved mitigation plan must be approved in advance by DHS.	The DMO must always maintain one hundred percent (100%) compliance with this item throughout the term of the contract.	The DMO will be fined one thousand dollars ($1,000) per day for each day past five (5) days for each actual, apparent, or potential conflict of interest it fails to disclose. The DMO shall be fined ten thousand dollars ($10,000) for the first failure to comply with the mitigation plan developed by the DMO and approved by DHS. Each subsequent violation of the mitigation plan shall be twice the amount of the immediately preceding violation fine.
Transition Planning The DMO must meet and maintain throughout	The DMO must always maintain one hundred	If the DMO fails to meet the acceptable performance

Service Criteria[i]	Acceptable Performance	Damages for Insufficient Performance[ii]
the life of the Contract term the following requirements as outlined in Section 2.12.8 of the RFP. 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	percent (100%) compliance with this item throughout the term of the contract.	standard, DHS may issue a below standard DMO Performance Report (VPR) maintained in the DMO file. Final payment may be withheld from the DMO until all elements of the transition are satisfied as determined by DHS. DHS may impose sanctions provided for under state or federal statutes, rules, or regulations to address noncompliance, including but not limited to, sanctions set forth in 42 CFR Part 438.700 et seq. DHS may also require a Corrective Action Plan (CAP), may withhold, or reduce payment until noncompliance is corrected, file and maintain a negative Vendor Performance Report, or any combination of applicable remedies. DHS shall have discretion to approve, reject, or modify any CAP, and the DMO shall be required to render such CAP acceptable to DHS. Any such CAP shall be due to DHS within ten (10) business days of request. Any DHS-approved CAP may run concurrently with or independently of any other remedies or sanctions that may be imposed by DHS pursuant to the Agreement or by law.

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
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.		
Arkansas Freedom of Information Act (Ark. Code Ann. §25-19-101 et seq.): 1. DMO shall cooperate with DHS requests for information and documents that DHS requires to fulfil an Arkansas Freedom of Information Act (FOIA) request. 2. DMO shall timely provide all documents in its possession or control to DHS that match the request made by DHS. 3. DMO is subject to Arkansas FOIA law pursuant to Ark. Code Ann. §25-19-103(7)(A). DMO shall timely and accurately respond to FOIA requests made directly to DMO. See Ark. Code Ann. §25-19-101 et seq. for specific requirements.	DMO shall respond to FOIA requests timely and accurately one hundred percent (100%) of the time. DMO shall provide information and documents to DHS upon request in the timeframe specified in the request one hundred percent (100%) of the time. DHS shall have sole determination as to the sufficiency	1. For each failure to meet performance standard, DHS may impose: a. A ten percent (10%) penalty, assessed in the following months' payment for each failure to report. The penalty will be calculated from the total payment for the identified month in which the deficiency took place; or b. A one percent

Service Criteria[i]	**Acceptable Performance**	**Damages for Insufficient Performance**[ii]
	of DMO's response and provision of documents.	(1%) penalty, assessed in the next payment for each failure to report. The penalty will be calculated from the projected total yearly contract amount for the contract, as determined by DHS. DHS may elect to calculate penalties/damages differently per occurrence. In addition to the above, DMO shall be responsible for any penalties, fees, and costs imposed on DHS associated with DMO's failure to timely and accurately provide the requested information and documents.

Failure to meet the minimum Performance Standards as specified **may** result in the assessment of damages.

In the event a Performance Standard is not met, the DMO will have the opportunity to defend or respond to, or cure to the satisfaction of the State, the insufficiency. The State **may** waive damages if it determines there were extenuating factors beyond the control of the DMO that hindered the performance of services of it is in the best interest of the State. 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, DMO **shall** follow the direction of the agency regarding the required compensation process.

[i] Nothing in this table is intended to set forth all obligations of the DMO under the contract. These obligations are in addition to any others imposed by the contract and applicable law.
[ii] The damages set forth are not exclusive and shall in no way exclude or limit any remedies available at law or in equity.