



STATE OF ARKANSAS
OFFICE OF STATE PROCUREMENT
 1509 West 7th Street, Room 300
 Little Rock, Arkansas 72201-4222

FINAL REQUEST FOR PROPOSAL
BID SOLICITATION DOCUMENT

NOTE: Updates to this final RFP are designated by red font.

SOLICITATION INFORMATION			
Bid Number:	SP-17-0011	Solicitation Issued:	9/2/2016
Description:	Medicaid Dental Managed Care		
Agency:	Department of Human Services (DHS)		

SUBMISSION DEADLINE FOR RESPONSE			
Bid Opening Date:	11/04/2016	Bid Opening Time:	2:00 p.m., Central Time
<p>Proposals shall not be accepted after the designated bid opening date and time. In accordance with Arkansas Procurement Law and Rules, it is the responsibility of Vendors to submit proposals at the designated location on or before the bid opening date and time. Proposals received after the designated bid opening date and time shall be considered late and shall be returned to the Vendor without further review. It is not necessary to return "no bids" to OSP.</p>			

DELIVERY OF RESPONSE DOCUMENTS	
Delivery Address:	<p>Office of State Procurement 1509 West 7th Street, Room 300 Little Rock, AR 72201-4222</p> <p>Delivery providers, USPS, UPS, and FedEx deliver mail to OSP's street address on a schedule determined by each individual provider. These providers will deliver to OSP based solely on the street address.</p>
Proposal's Outer Packaging:	<p>Outer packaging must be sealed and should be properly marked with the following information. If outer packaging of proposal submission is not properly marked, the package may be opened for bid identification purposes.</p> <ul style="list-style-type: none"> • Bid number • Date and time of bid opening • Vendor's name and return address

OFFICE OF STATE PROCUREMENT CONTACT INFORMATION			
OSP Buyer:	Tamara DeBord	Buyer's Direct Phone Number:	501-371-6059
Email Address:	Tamara.DeBord@dfa.arkansas.gov	OSP's Main Number:	501-324-9316
OSP Website:	http://www.dfa.arkansas.gov/offices/procurement/Pages/default.aspx		

SECTION 1 – GENERAL INFORMATION AND INSTRUCTIONS

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

1.1 PURPOSE

- A. The Arkansas Department of Human Services (DHS or the Department), Division of Medical Services (DMS or the Division), is issuing this Request for Proposal (RFP) to obtain two Contractors who will provide through a managed care model comprehensive Dental Services under Arkansas Medicaid. The Contractors will serve, on a capitated basis, all Beneficiaries who receive Dental Services through Medicaid, except for individuals residing in Human Development Centers, individuals enrolled in the Program for All Inclusive Care for the Elderly, and individuals who are eligible for Medicaid only after incurring medical expenses that cause them to “spend down” to Medicaid eligibility levels.
- B. The State is still evaluating the inclusion of the Arkansas Works population. In the event that the State elects to provide Dental Benefits to the Arkansas Works population, certain eligible individuals through Arkansas Works **shall** be Beneficiaries under the Contract. Administration of the Cost Sharing components of the Arkansas Works program would remain the responsibility of the carriers providing Arkansas Works Coverage and not a Contractor awarded under the RFP.
1. Vendors will be evaluated based upon their ability to provide services to all populations listed in this RFP including the ability to service those eligible for and enrolled in Arkansas Works if the State elects to extend dental coverage to that population.
- C. The Contractors **shall** offer a full complement of managed care functions, including:
1. Establishment and management of a Dental Provider Network.
 2. Credentialing and contracting with providers.
 3. Authorization and utilization management.
 4. Identification, investigation, and referral of suspected fraud cases.
 5. Quality assurance and improvement.
 6. Claims processing adjudication and payment.
 7. Management of third party liability.
 8. Education and outreach.
 9. Customer service.
- D. A Vendor, either directly or through its Subcontractor(s), **must** be able to provide all services and meet all of the requirements in this solicitation. The successful Vendors (the Contractors) **shall** remain responsible for Contract performance regardless of Subcontractor participation in the work.

1.2 TYPE OF CONTRACT

- A. A Term contract will be awarded to two (2) Vendors.
- B. The Initial Term of this contract **shall** be from Contract Commencement through December 31, 2019. The anticipated Contract Commencement date is expected to be in the first quarter of 2017.
- C. The implementation of the Plan is anticipated to be through December 31, 2017, with the Go-Live of dental managed care services taking place on January 1, 2018.
- D. Upon mutual agreement by the Vendor and Agency, the contract may be renewed by OSP on a year-to-year basis. The total life of the contract including any renewals, **shall not** be more than seven (7) years.

1.3 ISSUING AGENCY

OSP, as the issuing office, is the sole point of contact throughout this solicitation.

1.4 BID OPENING LOCATION

Proposals submitted by the opening time and date **shall** be opened at the following location:

Office of State Procurement
1509 West Seventh Street, Room 300
Little Rock, AR 72201-4222

1.5 DEFINITION OF REQUIREMENT

- A. The words "**must**" and "**shall**" signify a Requirement of this solicitation and the Vendor's agreement to and compliance with that item is mandatory.
- B. Exceptions taken to any Requirement in this *Bid Solicitation*, whether submitted in the Vendor's proposal or in subsequent correspondence, **shall** cause the Vendor's proposal to be disqualified.
- C. Vendor may request exceptions to NON-mandatory items. Any such request **must** be declared on, or as an attachment to, the appropriate section's *Agreement and Compliance Page*. Vendor **must** clearly explain the requested exception and should reference the specific solicitation item number to which the exception applies. (See *Agreement and Compliance Page*.)

1.6 DEFINITION OF TERMS

A. The State Procurement Official has made every effort to use industry-accepted terminology in this *Bid Solicitation* and will attempt to further clarify any point of an item in question as indicated in *Clarification of Bid Solicitation*. All terms **shall** be defined as shown below and **shall** apply to all solicitation documents.

1. **AAPD:** The American Academy of Pediatric Dentistry.
2. **Administrative Hearing:** A hearing that takes place outside the judicial process before hearing examiners who have been granted judicial authority specifically for the purpose of conducting such hearings.

There are two types of Administrative Hearings:

- a. **Provider initiated** - conducted by administrative law judges from the AR Department of Health and is governed in part by provisions of the AR Medicaid Fairness Act in addition to CMS and AR State Plan policies and regulations.
 - b. **Beneficiary initiated** – conducted by administrative law judges from the AR Department of Human Services and governed by CMS and AR State Plan policies and regulations.
3. **Adverse Benefit Determination:** Any of the following:
 - a. The denial or limited authorization of a requested Covered Service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, health care setting, or effectiveness of a Covered Service;
 - b. The reduction, suspension, or termination of a previously authorized Covered Service, including but not limited to the down-coding of prior authorizations services;
 - c. The denial, in whole or in part, of payment for a Covered Service.
 - d. The failure to provide Covered Services in a timely manner;
 - e. The Contractor's failure to act within the timeframes provided under State and federal law regarding the standard disposition of Grievances and standard disposition and resolution of Appeals. Applicable authority includes this RFP, DHS procedure (see Section 160 of the Arkansas Medicaid Provider Manual), any and all applicable administrative or court orders, and 42 C.F.R. § 438.408(b);

- f. The denial of a request to dispute financial liability, including Cost Sharing, copayments, and Beneficiary financial liabilities.
 - g. Any other occurrence which meets the definition of an “Adverse Decision” under § 20-77-1701 of the Arkansas Medicaid Fairness Act. (A copy of which is included in the Vendors’ Library).
4. **AID:** The Arkansas Insurance Department.
 5. **Allowable Expenses:** All reasonable expenses related to the Contract between DHS and the Contractor that are incurred during the Contract Term and not reimbursable or recovered from another source.
 6. **Appeal:** The process by which the Contractor reviews an Adverse Benefit Determination.
 7. **Arkansas Works:** Medicaid expansion program for adults between the ages of 19 and 64 with an income at or below 138% of the Federal Poverty Level (FPL). The program is operated via an 1115 Demonstration waiver with CMS. As of July 2016, 258,161 newly eligible adults were covered under the 1115 Demonstration waiver.
 8. **Automated Distribution Call System (ADC):** A telephone facility that manages incoming calls and handles them based on the number called and an associated database of handling instructions.
 9. **Beneficiary:** A person certified by DHS as eligible for Dental Benefits through Arkansas Medicaid, including through ARKids B and including during any retroactive eligibility period, except individuals who are members of the Spend Down Population, who reside in Human Development Centers, or who are enrolled in the PACE program.
 10. **Benefits or Dental Benefits:** A schedule of Dental Services to which Beneficiaries are entitled and to be administered by the Contractor pursuant to this RFP.
 11. **Bid Solicitation:** A term used synonymously with the terms “Request for Proposal” and “RFP.”
 12. **Business Day:** Any day other than a Saturday, Sunday, or a State or federal holiday on which DHS’s offices are closed, unless the context clearly indicates otherwise.
 13. **Children’s Health Insurance Program, CHIP, or ARKids B:** A program established under Title XXI of the Social Security Act to provide health coverage for children whose family incomes are above Medicaid eligibility limits.
 14. **Claim:** An itemized statement requesting payment for services rendered by Providers and billed electronically, billed through a web-based portal, or on the American Dental Association Dental claim form.
 15. **Clean Claim:** A Claim submitted by a Provider for Dental Services rendered to a Beneficiary, with documentation required under the Provider Agreement or otherwise reasonably necessary for the Contractor to adjudicate and pay the Claim.
 16. **Contract:** The Contract awarded to the successful bidding Vendor(s) pursuant to this RFP, which includes but **shall not** be limited to this RFP and all documents referenced to this RFP, the Vendor proposal, and all other documented negotiations or agreements between DHS and the successful Vendors.
 17. **Contract Commencement:** The date the Contract is approved/released by OSP after both the Arkansas State Legislature and CMS approvals.
 18. **Contract Monitor:** The State representative for this Contract who is primarily responsible for Contract administration functions, including issuing written direction, invoice approval, monitoring this Contract to ensure compliance with the terms and conditions of the Contract, and achieving completion of the Contract on budget, on time, and within scope. The Contract Monitor **shall** be a DHS staff member.
 19. **Contract Term:** The initial Contract period plus any renewal terms.

20. **Contractor:** The successful bidding Vendors selected by the State to be awarded the Contract. For the purposes of this RFP, the term “Contractor” **shall** be construed to mean all Vendors selected by the State.
21. **Covered Services:** Dental Services the Contractor **must** arrange to provide to Beneficiaries and the Spend Down Population, including all services required by the Contract and State and federal law, and all Value-Added Services negotiated by DHS and the successful Vendors.
22. **CMS:** The Centers for Medicare and Medicaid Services, an agency within the United States Department of Health and Human Services responsible for overseeing, among other things, the Medicaid and Children’s Health Insurance Program.
23. **Dental Providers:** Licensed facilities or professionals providing Dental Services.
24. **Dental Services:** All emergency, diagnostic, preventive, restorative, or therapeutic services for oral diseases, as listed on Attachment B.
25. **Dentist:** A person licensed by the Arkansas State Board of Dental Examiners as a dentist.
26. **DHS:** The Arkansas Department of Human Services.
27. **DMO:** Dental maintenance organization.
28. **Emergency Care:** Dental services that are medically necessary to treat acute disorder of oral health that requires dental and/or medical attention, including broken, loose, or avulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.
29. **Encounter:** A Beneficiary interaction with a Provider that involves the provision of Medically Necessary Covered Services or Value-Added Services.
30. **Encounter Data:** Data elements from Claims or capitated services proxy claims that are submitted to DHS by the Contractor in accordance with DHS’s required format.
31. **EPSDT:** The Early and Periodic Screening, Diagnosis, and Treatment program mandated by 42 U.S.C. § 1396d(e) and amended by the Omnibus Budget Reconciliation Act (OBRA) of 1989.
32. **FQHC:** Federally Qualified Health Center, as defined in 42 § CFR 405.2401(b), as amended.
33. **Go-Live Date:** The date when the Contractor **must** begin providing all services required by this bid Contract. The Go-Live Date is anticipated to be January 1, 2018.
34. **Grievance:** An expression of dissatisfaction, from or on behalf of a Beneficiary or Provider, about any action taken by the Contractor or Provider, other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Beneficiary’s rights regardless of whether remedial action is requested. The meaning of “Grievance” includes a Beneficiary’s right to dispute an extension of time proposed by the Contractor to make an authorization decision.
35. **Grievance and Appeal System:** The processes the Contractor implements to handle Appeals and Grievances, as well as the processes to collect and track information about them.
36. **HIPAA or The Health Insurance Portability and Accountability Act:** A federal statute (passed in 1996 and amended in 2009) requiring standardization of electronic patient health, administrative, and financial data; unique health identifiers for individuals, employers, health plans, and health care providers; and security standards to protect the confidentiality and integrity of individually identifiable health information.
37. **HRSA:** The Health Resources and Services Administration.

38. **Insure Kids Now:** The Insure Kids Now website is a State locator tool that offers profile information for each oral health care provider participating in Medicaid and Children's Health Insurance Program (CHIP).
39. **Medicaid:** The medical assistance entitlement program authorized and funded pursuant to Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) and administered by DHS.
40. **Medicaid Management Information System (MMIS):** The enrollment and payment information system for Arkansas Medicaid.
41. **Medically Necessary:** A service or benefit is considered "medically necessary" when it satisfies all the following criteria:
 - a. It directly relates to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
 - b. It is consistent with currently accepted standards of good medical practice;
 - c. It is the most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and
 - d. It is not primarily for the convenience of the patient, family, or Provider.
42. **Network:** All Dental Providers that have a contract with the Contractor (or a Subcontractor) for the delivery of Covered Services to Beneficiaries under the Contract.
43. **Non-Compliant Beneficiary:** A Beneficiary who refuses or fails to seek Dental Services, habitually misses scheduled dental appointments, or has no history of dental Encounters in MMIS.
44. **Notice to Proceed (NTP):** A written notice from the Contract Monitor, after the Readiness Review described in this RFP that, subject to the conditions of the Contract, work under the Contract is to begin as of a specified date. The start date listed in the NTP is the Go-Live Date, and is the official start date for the actual delivery of services as described in the Contract. After Contract Commencement, additional NTPs may be issued by either the Procurement Officer or the Department Contract Monitor regarding the start date for any service included within this solicitation with a delayed or non-specified implementation date.
45. **Pay for Performance:** A payment model that offers financial incentives to the Contractor upon achievement of specified quality benchmarks.
46. **Performance Standards:** Criteria that Contractor **must** meet to comply with the terms of the Contract. Failure to meet Performance Standards will result in damages (see Attachment C).
47. **Preauthorization:** An approval required from the Contractor before the provision of a particular Covered Service.
48. **Premium Payment:** The aggregate amount paid by DHS to the Contractor on a monthly basis for the provision of Medically Necessary Covered Services to enrolled Beneficiaries (including associated Administrative Services) in accordance with the Premium Rates in the Contract.
49. **Premium Rate:** A fixed predetermined fee paid by DHS to the Contractor each month in accordance with the Contract, for each enrolled Beneficiary in a defined Rate Cell, in exchange for the Contractor arranging for or providing a defined set of Medically Necessary Covered Services to such a Beneficiary, regardless of the amount of Medically Necessary Covered Services actually used by the enrolled Beneficiary that are within the defined limits as stated in the Medically Necessary Covered Services attachment to the Contract.
50. **Primary Care Dentist (PCD):** A primary care dentist is the principal Dental Services provider for a Beneficiary, responsible for coordinating and integrating the Beneficiary's Dental Services.
51. **Primary Dental Services:** Preventive Dental Services as performed by a dentist.
52. **Protected Health Information (PHI):** Individually identifiable information, including demographics, which relates to a person's health, health care, or payment for health care, as further defined under HIPAA.

53. **Provider or Network Provider:** An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a contract with the Contractor for the delivery of Medically Necessary Covered Services to the Beneficiaries enrolled with the Contractor.
54. **Provider Agreement:** An agreement between the Contractor and a Provider that describes the conditions under which the Provider agrees to furnish Covered Services to Beneficiaries.
55. **Quality Measures:** The metrics on which the Contractor will be evaluated for the purposes of evaluating whether any portion of the shared savings incentive will be paid to Contractor (see Attachment D). Shared savings incentive payments are payments made to a Contractor for delivery of economic, efficient and quality care.
56. **Readiness Review:** Submission of documentation at least 120 days before Go-Live, as required by CMS, to DHS by the Contractor to allow the State to assess the ability and capacity of the Contractor to perform in key operational areas prior to enrollment.
57. **Rural:** Geographic area represented by a postal zip code where at least 50% of the total area included in the zip code is outside any Metropolitan Service Area (MSA).
58. **Scope of Work:** The set of services, deliverables, and performance standards specified in RFP Section 3, and any agreed modifications thereto.
59. **Service Location:** Any location at which a Beneficiary obtains any oral health care service covered by the Contractor pursuant to the terms of this RFP.
60. **Specialty Services:** Dental services that are generally considered outside standard Dental Services because of the specialized knowledge required for service delivery and management, including, but not limited to, pediatric dentistry, oral surgery, endodontics, periodontics, and orthodontics.
61. **Spend Down Population:** The group of individuals who are eligible for Medicaid coverage only after incurring medical expenses that reduce their incomes to Medicaid eligibility levels.
62. **Start-Up Period:** The period of time between Contract Commencement and the Go-Live Date. During the Start-Up Period the Contractor **shall** perform start-up activities such as are necessary to enable the Contractor to begin the successful performance of Contract activities as of the Go-Live Date. No compensation will be paid to the Contractor for any activities it performs during the Start-Up Period.
63. **State:** The State of Arkansas.
64. **Subcontract:** An agreement entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to DHS under the terms of this RFP (e.g., claims processing, outreach and education, provider relations) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this RFP. Agreements to provide covered services **shall** be considered Provider Agreements and not subcontracts.
65. **Subcontractor:** Any State-approved organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the DHS under the terms of this RFP. For the purposes of this Contract, the Subcontractor's providers **shall** also be considered providers of the Contractor.
66. **Third Party Liability (TPL):** When any individual, entity, or program is or may be responsible for paying all or a part of the expenditures for Covered Services.
67. **Urban:** A Metropolitan Service Area (MSA), as determined by the US Department of Commerce, which has more than 50,000 residents in the population nucleus and adjacent integrated communities.
68. **Urgent Care:** Dental Services that do not constitute Emergency Care but that is needed to treat pain.

- 69. **Value-Added Services (VAS):** Actual Dental Services, Benefits, or positive incentives determined by DHS to promote healthy lifestyles and improve dental outcomes among Beneficiaries. “Best practice” approaches to delivering Medically Necessary Covered Services are not considered VAS.
- 70. **Vendor:** An entity or its corporate affiliate that submits a proposal in response to this RFP.
- 71. **Vendors’ Library:** A collection of rules, forms and documents which are included with this RFP for reference purposes. These documents are relevant to the Vendor's preparation of a proposal and/or the Contractor's duties under the Contract. They are specifically referenced in this RFP where applicable.

1.7 RFP OUTLINE

The following outlines the contents of this RFP.

Section/Document	Description
Section 1	General Information and Instructions
Section 2	General Requirements and Qualifications
Section 3	Scope of Work
Section 4	Criteria for Selection
Section 5	General Contractual Requirements
Section 6	Standard Terms and Conditions
Attachment A1	Capitation Rates
Attachment A2.1	Data Book Supplemental Information
Attachment A2.2	Data Book
Attachment A2.3	Rating Region Membership
Attachment A3	Risk Corridor Examples
Attachment B	Schedule of Covered Dental Services
Attachment C	Performance Standards
Attachment D	Quality Measures
Attachment E	Cost Sharing (Copayments)
Attachment F	American Academy and Pediatric Dentistry Standards
Attachment G	Provider Agreement Requirements
Attachment H	HIPAA Business Associate Agreement
Attachment I	Readiness Review
Posted as separate document	Technical Proposal Packet
Posted as separate document	Official Bid Price Sheet
Posted as separate document	Contract & Grant Disclosure Form
Posted as separate document	Vendors’ Library

1.8 RESPONSE DOCUMENTS

A. Original Technical Proposal Packet

- 1. The original *Technical Proposal Packet* **must** be submitted on or before the bid opening date and time.
- 2. The Proposal Packet should be clearly marked “Original” and **must** include the following:
 - a. Original signed *Proposal Signature Page*. (See *Proposal Signature Page*.)
 - b. Original signed *Agreement and Compliance Pages*. (See *Agreement and Compliance Pages*.)
 - c. Original signed *Proposed Subcontractors Form*. (See *Subcontractors*.)
 - d. Response to the *Submission Requirements* section included in the Technical Proposal Packet.
 - e. *Technical Proposal* response to the *Information for Evaluation* section included in the *Technical Proposal Packet*.
 - f. Other documents and/or information as may be expressly required in this *Bid Solicitation*.

3. The following items should be submitted in the original *Technical Proposal Packet*.
 - a. EO 98-04 Disclosure Form. (See *Standard Terms and Conditions, #27. Disclosure.*)
 - b. Copy of Vendor's *Equal Opportunity Policy*. (See *Equal Opportunity Policy.*)
 - c. *Voluntary Product Accessibility Template (VPAT)*. (See *Technology Access.*)
4. **DO NOT** include any other documents or ancillary information, such as a cover letter or promotional/marketing information.

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

1. Vendor's original *Official Bid Price Sheet* **must** be submitted in hard copy format.
2. Vendor should also submit one (1) electronic copy of the *Official Bid Price Sheet*, preferably on a flash drive. A CD will also be acceptable.
3. The *Official Bid Price Sheet*, including the hard copy and electronic copy, **must** be separately sealed from the *Technical Proposal Packet* and should be clearly marked as "Pricing". Vendor **must not** include any pricing in the hard copies or electronic copies of their *Technical Proposal Packet*.

C. *Additional Copies and Redacted Copy of the Technical Proposal Packet*

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

1. Additional Copies of the *Technical Proposal Packet*
 - a. Five (5) complete hard copies (marked "COPY") of the *Technical Proposal Packet*.
 - b. Six (6) electronic copies of the *Technical Proposal Packet*, preferably on flash drives. CDs will also be acceptable.
 - c. All additional hard copies and electronic copies **must** be identical to the original hard copy. In case of a discrepancy, the original hard copy **shall** govern.
 - d. If OSP requests additional copies of the proposal, the copies **must** be delivered within twenty-four (24) hours of request.
2. One (1) redacted (marked "REDACTED") copy the original *Technical Proposal Packet*, preferably on a flash drive. A CD will also be acceptable. (See *Proprietary Information.*)

1.9 ORGANIZATION OF RESPONSE DOCUMENTS

- A. It is strongly recommended that Vendors adhere to the following format and suggestions when preparing their Technical Proposal response.
- B. The original *Technical Proposal Packet* and all copies should be arranged in the following order.
 - *Proposal Signature Page.*
 - *All Agreement and Compliance Pages.*
 - *Proposed Subcontractors Form.*
 - Signed Addenda, if applicable.
 - E.O. 98-04 – *Contract Grant and Disclosure Form.*
 - *Equal Opportunity Policy.*
 - *Voluntary Product Accessibility Template (VPAT).*
 - Other documents and/or information responsive to the *Submission Requirements* of the Technical Proposal Packet.
 - Technical Proposal response to the *Information for Evaluation* section of the *Technical Proposal Packet*.

1.10 CLARIFICATION OF BID SOLICITATION

- A. The initial deadline for vendors to submit written questions requesting clarification of information for this solicitation was September 28, 2016; however, because of the update in this final RFP in section 3.4.F. *Deferred Compensation Plan*, OSP will accept questions *relevant to this section only*.
- B. The deadline to submit questions for section 3.4.F is 4:00 Central Time on October 12, 2016. Submit written questions by email to the OSP buyer as shown on page one (1) of this *Bid Solicitation*.
 - 1. Vendors' written questions will be consolidated and responded to by the State. The State's consolidated written response is anticipated to be posted to the OSP website by the close of business on October 14, 2016.
 - 2. Official responses to Vendors' written questions will only be provided in writing by the State. Verbal answers should not be interpreted as a binding response.
- C. Vendors may contact the OSP buyer with procurement-related questions at any time prior to the bid opening.
- D. Answers to verbal questions may be given as a matter of courtesy and **must** be received and evaluated at the Vendor's risk.

1.11 PROPOSAL SIGNATURE PAGE

- A. An official authorized to bind the Vendor(s) to a resultant contract **must** sign the *Proposal Signature Page* included in the *Technical Proposal Packet*.
- B. Vendor's signature on this page **shall** signify Vendor's agreement that either of the following **shall** cause the Vendor's proposal to be disqualified:
 - 1. Additional terms or conditions submitted intentionally or inadvertently.
 - 2. Any exception that conflicts with a Requirement of this *Bid Solicitation*.

1.12 AGREEMENT AND COMPLIANCE PAGES

- A. Vendor **must** sign all *Agreement and Compliance Pages* relevant to each section of the *Bid Solicitation Document*. The *Agreement and Compliance Pages* are included in the *Technical Proposal Packet*.
- B. Vendor's signature on these pages **shall** signify agreement to and compliance with all Requirements within the designated section.

1.13 SUBMISSION REQUIREMENTS PAGE

- A. Vendor must respond to items specified on the Submission Requirements Page. The page is included in the Technical Proposal Packet.

1.14 SUBCONTRACTORS

- A. Vendor **must** complete, sign and submit the *Proposed Subcontractors Form* included in the *Technical Proposal Packet*.
- B. Additional Subcontractor information may be required or requested in following sections of this *Bid Solicitation* or in the *Information for Evaluation* section provided in the *Technical Proposal Packet*. **Do not** attach any additional information to the *Proposed Subcontractors Form*.
- C. DHS **shall** have the right to approve or disapprove of all subcontractors.

1.15 PRICING

- A. Vendor(s) **must** include all pricing on the *Official Price Bid Sheet(s)* only. Any cost not identified by the successful Vendor but subsequently incurred in order to achieve successful operation **shall** be borne by the Vendor. The *Official Bid Price Sheet* is provided as a separate file posted with this *Bid Solicitation*.
- B. All pricing **must** fall within the rate ranges specified in Attachment A1 – Capitation Rates.

- C. The *Official Bid Price Sheet*, including the hard copy and electronic copy, **must** be separately sealed from the *Technical Proposal Packet* and should be clearly marked as "Pricing". DO NOT submit any ancillary information not related to actual pricing in the sealed pricing package.
- D. Vendor **must not** include any pricing in the hard copies or electronic copies of their *Technical Proposal Packet*. Should hard copies or electronic copies of their *Response Packet* contain any pricing, the response **shall** be disqualified.
- E. Failure to complete and submit the *Official Bid Price Sheet* **shall** result in disqualification.
- F. All proposal pricing **must** be in United States dollars and cents.
- G. The *Official Bid Price Sheet* may be reproduced as needed.

1.16 **PRIME CONTRACTOR RESPONSIBILITY**

- A. A joint proposal submitted by two or more Vendors is acceptable. However, in the event, as in the event of the use of subcontractors, a single Vendor **must** be identified as the prime Contractor.
- B. The prime Contractor **shall** be held responsible for the contract and **shall** be the sole point of contact.

1.17 **INDEPENDENT PRICE DETERMINATION**

- A. By submission of this proposal, the Vendor certifies, and in the case of a joint proposal, each party thereto certifies as to its own organization, that in connection with this proposal:
 - The prices in the proposal have been arrived at independently, without collusion.
 - No prior information concerning these prices has been received from, or given to, a competitive company.
- B. Evidence of collusion **shall** warrant consideration of this proposal by the Office of the Attorney General. All Vendors **shall** understand that this paragraph may be used as a basis for litigation.

1.18 **PROPRIETARY INFORMATION**

- A. Submission documents pertaining to this *Bid Solicitation* become the property of the State and are subject to the Arkansas Freedom of Information Act (FOIA).
- B. One (1) complete copy of the submission documents from which any proprietary information has been redacted should be submitted on a flash drive in the *Technical Proposal Packet*. A CD is also acceptable.
- C. Except for the redacted information, the redacted copy **must** be identical to the original hard copy, reflecting the same pagination as the original and showing the space from which information was redacted.
- D. The Vendor **shall** be responsible for identifying all proprietary information and for ensuring the electronic copy is protected against restoration of redacted data.
- E. The redacted copy **shall** be open to public inspection under the Freedom of Information Act (FOIA) without further notice to the Vendor.
- F. If a redacted copy of the submission documents is not provided with Vendor's response packet, a copy of the non-redacted documents, with the exception of financial data (other than pricing), **shall** be released in response to any request made under the Arkansas Freedom of Information Act (FOIA).
- G. If the State deems redacted information to be subject to FOIA, the Vendor will be contacted prior to release of the documents.

1.19 **CAUTION TO VENDORS**

- A. Prior to any contract award, all communication concerning this *Bid Solicitation* **must** be addressed through OSP.
- B. Vendor **must not** alter any language in any solicitation document provided by the State.

- C. Vendor **must not** alter the *Official Bid Price Sheet*.
- D. All official documents and correspondence related to this solicitation **shall** be included as part of the resultant contract.
- E. Proposals **must** be submitted only the English language.
- F. The State **shall** have the right to award or not award a contract, if it is in the best interest of the State to do so.
- G. Vendor **must** provide clarification of any information in their response documents as requested by OSP.
- H. Qualifications and proposed services **must** meet or exceed the required specifications as set forth in this *Bid Solicitation*.

1.20 **REQUIREMENT OF ADDENDUM**

- A. This *Bid Solicitation* **shall** be modified only by an addendum written and authorized by OSP.
- B. An addendum posted within three (3) calendar days prior to the bid opening **shall** extend the bid opening and may or may not include changes to the Bid Solicitation.
- C. The Vendor **shall** be responsible for checking the OSP website, <http://www.arkansas.gov/dfa/procurement/bids/index.php>, for any and all addenda up to bid opening.

1.21 **AWARD PROCESS**

A. Successful Vendor Selection

The Grand Total Score for each Vendor, which **shall** be a sum of the Technical Score and Cost Score, **shall** be used to determine the ranking of proposals. The State may move forward to negotiations with those responsible offerors determined, based on the ranking of the proposals, to be reasonably susceptible of being selected for award.

B. Negotiations

1. If the State so chooses, it **shall** have the right to conduct negotiations with the highest ranking Vendors. All negotiations **shall** be conducted at the sole discretion of the State. The State **shall** solely determine the items to be negotiated.
2. If negotiations fail to result in a contract, the State may begin the negotiation process with the next highest ranking Vendor. The negotiation process may be repeated until anticipated successful Vendors have been determined, or until such time the State decides not to move forward with an award.

C. Anticipation to Award

1. Once the anticipated successful Vendors have been determined, the anticipated awards will be posted on the OSP website at http://www.arkansas.gov/dfa/procurement/pro_intent.php.
2. The anticipated awards will be posted for a period of fourteen (14) days prior to the issuance of contracts. Vendors and agencies are cautioned that these are preliminary results only, and a contract will not be issued prior to the end of the fourteen day posting period.
3. OSP **shall** have the right to waive the policy of Anticipation to Award when it is in the best interest of the State.
4. It is the Vendor's responsibility to check the OSP website for the posting of an anticipated award.

D. Issuance of Contract

1. Any resultant contract of this *Bid Solicitation* **shall** be subject to State approval processes which may include Legislative review and approval.

2. A State Procurement Official will be responsible for award and administration of any resulting contract.

1.22 **MINORITY BUSINESS POLICY**

A. Minority is defined by Arkansas Code Annotated § 15-4-303 as a lawful permanent resident of this State who is:

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

B. The Arkansas Economic Development Commission conducts a certification process for minority businesses and disabled veterans. The Vendor's Certification Number should be included on the Vendor's *Proposal Signature Page*.

1.23 **EQUAL OPPORTUNITY POLICY**

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

B. *EO Policies* may be submitted in electronic format to the following email address: eeopolicy.osp@dfa.arkansas.gov, but should also be included as a hardcopy accompanying the solicitation response.

C. The submission of an *EO Policy* to OSP is a one-time Requirement. Vendors are responsible for providing updates or changes to their respective policies, and for supplying *EO Policies* upon request to other State agencies that **must** also comply with this statute.

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

1.24 **PROHIBITION OF EMPLOYMENT OF ILLEGAL IMMIGRANTS**

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

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

1.25 **PAST PERFORMANCE**

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

1.26 **TECHNOLOGY ACCESS**

A. When procuring a technology product or when soliciting the development of such a product, the State of Arkansas is required to comply with the provisions of Arkansas Code Annotated § 25-26-201 et seq., as amended by Act 308 of 2013, which expresses the policy of the State to provide individuals who are blind or visually impaired with access to information technology purchased in whole or in part with state funds. The Vendor expressly acknowledges and agrees that state funds may not be expended in connection with the purchase of information technology unless that technology meets the statutory Requirements found in 36 C.F.R. § 1194.21, as it existed on January 1, 2013 (software applications and operating ICSs) and 36 C.F.R. § 1194.22, as it existed on January 1, 2013 (web-based intranet and internet information and applications), in accordance with the State of Arkansas technology policy standards relating to accessibility by persons with visual impairments.

B. ACCORDINGLY, THE VENDOR EXPRESSLY REPRESENTS AND WARRANTS to the State of Arkansas through the procurement process by submission of a Voluntary Product Accessibility Template (VPAT) for 36 C.F.R. § 1194.21, as it existed on January 1, 2013 (software applications and operating ICSs) and 36 C.F.R. § 1194.22, that the technology provided to the State for purchase is capable, either by virtue of features included within the technology, or because it is readily adaptable by use with other technology, of:

1. Providing, to the extent required by Arkansas Code Annotated § 25-26-201 et seq., as amended by Act 308 of 2013, equivalent access for effective use by both visual and non-visual means

2. Presenting information, including prompts used for interactive communications, in formats intended for non-visual use
 3. After being made accessible, integrating into networks for obtaining, retrieving, and disseminating information used by individuals who are not blind or visually impaired
 4. Providing effective, interactive control and use of the technology, including without limitation the operating system, software applications, and format of the data presented is readily achievable by nonvisual means;
 5. Being compatible with information technology used by other individuals with whom the blind or visually impaired individuals interact
 6. Integrating into networks used to share communications among employees, program members, and the public
 7. Providing the capability of equivalent access by nonvisual means to telecommunications or other interconnected network services used by persons who are not blind or visually impaired
- C. State agencies cannot claim a product as a whole is not reasonably available because no product in the marketplace meets all the standards. Agencies **must** evaluate products to determine which product best meets the standards. If an agency purchases a product that does not best meet the standards, the agency **must** provide written documentation supporting the selection of a different product, including any required reasonable accommodations.
- D. For purposes of this section, the phrase “equivalent access” means a substantially similar ability to communicate with, or make use of, the technology, either directly, by features incorporated within the technology, or by other reasonable means such as assistive devices or services which would constitute reasonable accommodations under the Americans with Disabilities Act or similar State and federal laws. Examples of methods by which equivalent access may be provided include, but are not limited to, keyboard alternatives to mouse commands or other means of navigating graphical displays, and customizable display appearance. As provided in Arkansas Code Annotated § 25-26-201 et seq., as amended by Act 308 of 2013, if equivalent access is not reasonably available, then individuals who are blind or visually impaired **shall** be provided a reasonable accommodation as defined in 42 U.S.C. § 12111(9), as it existed on January 1, 2013.
- E. If the information manipulated or presented by the product is inherently visual in nature, so that its meaning cannot be conveyed non-visually, these specifications do not prohibit the purchase or use of an information technology product that does not meet these standards.

1.27 COMPLIANCE WITH THE STATE SHARED TECHNICAL ARCHITECTURE PROGRAM

The respondent’s solution **must** comply with the State’s shared Technical Architecture Program which is a set of policies and standards that can be viewed at: <http://www.dis.arkansas.gov/policiesStandards/Pages/default.aspx>. Only those standards which are fully promulgated or have been approved by the Governor’s Office apply to this solution.

1.28 VISA ACCEPTANCE

- A. Awarded Vendor should have the capability of accepting the State’s authorized VISA Procurement Card (p-card) or a different Procurement Card if the State changes the P-card during the Contract, as a method of payment.
- B. Price changes or additional fee(s) **shall not** be levied against the State when accepting the p-card as a form of payment.
- C. VISA is not the exclusive method of payment.

1.29 PUBLICITY

- A. Vendors **shall not** issue a news release pertaining to this *Bid Solicitation* or any portion of the project without OSP’s prior written approval.
- B. Failure to comply with this Requirement **shall** be cause for a Vendor’s proposal to be disqualified.

1.30 RESERVATION

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

SECTION 2 – GENERAL REQUIREMENTS AND QUALIFICATIONS

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

2.1 SERVICE REQUIREMENT OVERVIEW

- A. The Contractor **shall** arrange for and pay for all Covered Services rendered to Beneficiaries. The Contractor **must** be capable of performing the following functions:
1. Credentialing and contracting with a Network of Providers meeting the access requirements specified in this RFP.
 2. Enrolling all Providers in the Arkansas Medicaid program.
 3. Performing Provider relations functions, including developing Provider manuals and addressing Provider Grievances and Appeals through the Grievance and Appeal System.
 4. Educating and engaging Beneficiaries.
 5. Assisting Beneficiaries in accessing Covered Services and coordinating care across Providers.
 6. Implementing a Grievance and Appeal System to address and track all Beneficiary Grievances and Appeals.
 7. Maintaining a call center and website.
 8. Authorizing the provision of Covered Services.
 9. Monitoring utilization of Covered Services.
 10. Processing and paying Claims.
 11. Maintaining quality assurance and quality improvement programs.
 12. Maintaining appropriate staff and systems.
 13. Coordination of Benefits, third-party liability, and post-payment recovery.
 14. Maintaining program integrity, including fraud, waste, and abuse investigation and recoveries.
- B. The Contractor **shall** arrange for and process Claims for all Covered Services rendered to the Spend Down Population. The Spend Down Population becomes eligible for services on a monthly basis after spending a pre-determined amount towards medical expense, as determined by their eligibility. The Contractor will not be at financial risk for the Spend Down Population. All Claims paid for Spend-Down Claims do not count towards a Beneficiary's policy maximum.
- C. The Contractor **shall** monitor and comply with any and all CMS Managed Care regulations that apply to the Contractor.
- D. The Contractor **shall** cooperate with all other DHS contractors (e.g. MMIS contractor) involved in implementing and operating the program proposed in this RFP.
- E. Payment to Contractor will begin when services are provided after Go-Live. No compensation will be paid to the Contractor for any activities it performs during the Start-Up Period.
- F. **DHS will be responsible for all enrollment and eligibility determination processing for all beneficiaries and for conducting beneficiary-initiated appeals and hearings.**

G. The AR Department of Health will be responsible for conducting provider-initiated appeals & hearings.

2.2 **VENDOR QUALIFICATIONS**

A. Vendor Experience and Licensure

1. The Vendor or a corporate affiliate of the Vendor **must** have a minimum of five (5) years of experience administering a comprehensive dental managed care program for Medicaid Beneficiaries to similar sized population as the population described in this RFP or have commensurate experience. Vendors **shall** discuss previous experience at the designated place in the Technical Proposal.
2. The Vendor **must** have the experience and ability to establish and maintain a Network in order to be one of the Plans to effectively accommodate approximately 650,000-700,000 Beneficiaries (with the option to add certain Beneficiaries under Arkansas Works). The associated actuarial information is included in the Data Book (included in Attachment A).
3. At the designated place in the Technical Proposal, the Vendor **must** disclose all information required which is related to the following items in regard to any other states' Medicaid managed care programs within the past five (5) years:
 - a. Any on-going litigation, and any litigation resolved (including by settlement).
 - b. Any states' departments of insurance market conduct examinations and findings.
4. The Vendor **must** meet one of the following two criteria and **must** provide a response to this requirement in the designated place in the Response Packet.
 - a. The Vendor currently possesses a certificate of authority issued by the Arkansas Insurance Department (AID), is fully authorized to conduct business in the State, and plans to maintain such certificate.
 - b. The Vendor **shall** obtain a certificate of authority from AID and all other qualifications necessary to conduct business in the State no later than 120 days after Contract Commencement.
5. The Vendor **must** meet all criteria required to enroll as a Medicaid provider, as found at 42 C.F.R. Part 455.

B. Financial Capability

The Vendor **must** maintain a fiscally solvent operation in accordance with federal requirements and Arkansas Insurance Department (AID) requirements for minimum net worth. In accordance with the instructions in the Technical Proposal Response Packet, the Vendor **must** prove it is financially solvent by:

1. Guaranteeing that the Vendor will provide financial resources sufficient to maintain a 300% or higher Risk Based Capital ratio as defined by the National Association of Insurance Commissioners; and
2. Guaranteeing that it will comply with federal solvency standards for MCOs/PAHPs/PIHPs set forth in 42 CFR 438.116.

In support of these guarantees, the Vendor **must** submit its most recent statutory annual financial statement and actuarial opinion, most recent quarterly statutory financial statement, independent audit report, and most recent statutory financial examination report.

The ultimate controlling parent of the Vendor, if any, **must** also guarantee it will provide financial resources to the Vendor sufficient to maintain a 300% or higher Risk Based Capital ratio as defined by the National Association of Insurance Commissioners (NAIC). The State reserves the right to request additional information to validate the guarantees.

The Contractor **must** provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Beneficiaries, and the State, will not be liable for the Vendor's debts if the entity becomes insolvent. These guarantees **must** be signed by an officer of the Vendor (and parent if applicable), must run for the length of the Contract, and may be contingent on the Vendor being awarded the Contract. Vendors who do not meet the qualifications listed in this section will be disqualified.

SECTION 3 – SCOPE OF WORK

The Contractor **shall** perform all services described in this RFP and **shall** comply with all applicable State and federal statutes, State and federal regulations, and State and federal policies transmitted through published notices, letters, manual provisions, or transmittals.

The Contractor **shall** immediately notify the Contract Monitor, by a method to be determined by DHS, of any liabilities that threaten its financial ability 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 Contractor. The Contract Monitor is the person identified by DHS at the time of Contract Commencement who will be the primary point for contact at the State for the Contractor. Should the Contract Monitor change during the contract period, DHS will notify the Contractor.

3.1 PERFORMANCE STANDARDS

- A. State law requires that all contracts for services include Performance Standards for measuring the overall quality of services provided. The Performance Standards are summarized in Attachment C, including expected deliverables, performance measures, or outcomes, as well as damages for failure to meet minimum standards.
- B. Performance Standards **shall** continue throughout the term of the contract.
- C. The State may be open to negotiations of Performance Standards prior to contract award, prior to the commencement of services, or at times throughout the Contract Term. The State **shall** have the right to modify, add, or delete Performance Standards throughout the Contract Term, 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 Vendor so as to establish standards that are reasonably achievable. All changes made to the Performance Standards **shall** become an official part of the contract.
- D. In the event a Performance Standard is not met, the Contractor will have the opportunity to respond to the insufficiency.
- E. The State **shall** have the right to waive damages if it determines there were extenuating factors beyond the control of the Vendor that hindered the performance of services. In these instances, the State **shall** have final determination of the performance acceptability.
- F. Should any compensation be owed to the DHS due to the assessment of damages, Vendor **shall** follow the direction of the DHS regarding the required compensation process.

3.2 MEDICALLY NECESSARY COVERED SERVICES AND VALUE-ADDED SERVICES

- A. Medically Necessary Covered Services
 1. 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 B. The types and definitions of Medically Necessary Covered Services **shall** be subject to change by the State.
 - a. The Contractor will not bear financial risk for the first two (2) years of any new Covered Service.
 - b. During the first two (2) years after a new Covered Service is added, the Contractor **shall** pay Claims for such new Covered Services at a rate specified by DHS.
 - c. The Contractor **shall** include the total amount paid for such new Covered Services on each invoice provided to DHS. DHS **shall** reimburse Contractor for the cost of Claims for such new Covered Services.
 - d. After two (2) years, pending contract renewal, the costs for the new Covered Services will be included into the capitation rate.
 2. 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.

3. 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.
4. 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.
5. 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 E, unless they have exhausted applicable maximum Benefit limits.

Note: The transition from benefit limits based on a fiscal year time period to benefit limits based on a calendar year time period does not impact rate development or risk corridor calculations. The rates were developed using two years of data, and each year captured an entire twelve month benefit limit cycle. This allows for the impact of an annual benefit limit to be fully inherent in the rate development. When benefit limits are transitioned to a calendar year basis, rates are not impacted, because it is still the twelve month benefit limit cycle, which exactly matches the base data. Since the rate development is consistent with this policy, no adjustments are needed in the risk corridor to compensate for the change in the benefit limit accumulation period.

The benefit limit will be administered on a calendar year basis beginning January 1, 2018. All members will have their accumulation towards the limit returned to \$0 as of this date, and will begin accumulating to a new twelve month benefit limit. Rate development is consistent with this policy.

B. Value-Added Services

1. The Vendor may propose to offer Value-Added Services (VAS), defined as additional Covered Services beyond those required under this RFP. While VAS are optional, the Vendor will be evaluated based on the VAS it proposes.
2. All VAS **must** be offered at no cost to DHS, Beneficiaries, or Providers.
 - a. The Contractor **shall not** receive additional compensation for any VAS offered, and **shall not** 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 Beneficiaries that receive the VAS, the types of Providers responsible for proving the VAS including any limitation, and outreach efforts to Beneficiaries 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 by the State. 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. After an amended Contract has been renewed, the Contractor **shall** update Beneficiary and Provider materials as necessary to reflect the VAS changes.

C. Coordination of Non-Capitated Services

1. Except as specified in Section 3.15 for the Spend Down Population, in the event that 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 Beneficiaries.

3.3 **ACCESS TO CARE**

A. **General Requirements**

1. During the Contract Term, the Contractor's Provider Network **must** ensure that all Medically Necessary Covered Services **shall** be available to Beneficiaries on a timely basis (as defined in this RFP), 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:
 - 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 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 Monitor 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.
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 90% of Beneficiaries **must** have access to two or more Primary Care Dentists who are accepting new patients within 30 miles of the Beneficiary's residence in Urban counties and 60 miles of the Beneficiary's residence in Rural counties.
 - b. At least 85% of all Beneficiaries **must** have access to at least one specialty provider within 60 miles of the Beneficiary's residence.
 - c. At least 90% of pediatric Beneficiaries **must** have access to Pediatric Dental Services through two or more Primary Care Dentists who are accepting new patients within 30 miles of the Beneficiary's residence in Urban counties and 60 miles of the Beneficiary's 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 Beneficiary's dental condition, but no later than 30 days.
- h. Non-urgent specialty care **must** be provided within 60 days of authorization.

B. Assigning a Primary Care Dentist

1. The Contractor **shall** maintain a sufficient Network for each Beneficiary to have a Primary Care Dentist (PCD).
2. By the Readiness Review, the Contractor **shall** submit to the Contract Monitor the Contractor's plan for pairing newly enrolled Beneficiaries with a PCD. This plan **must** conform to the following requirements:
 - a. When Beneficiaries enroll, the Contractor **shall** offer them a choice of PCDs in their geographic area.
 - b. If a Beneficiary 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 Beneficiary resides. If there is a Medicaid Claims history for the Beneficiary, the Contractor **shall** link auto-assigned Beneficiaries to their historic Provider. The Contractor **shall** assign a PCD within 60 days after a Beneficiary's failure to select a PCD and notify the Beneficiary of this assignment.
 - c. Beneficiaries **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 a Beneficiary 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 the Provider Manual, to:
 - a. Provide children enrolled in Medicaid or CHIP with diagnostic and preventive services in accordance with American Academy of Pediatric Dentistry (AAPD) recommendations (see Attachment F). 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. Assess the dental needs of Beneficiaries for referral to specialty care Providers and provide referrals as needed. The Contractor **must**, at a minimum, engage in Provider education and review of Provider referral patterns.

C. Out-of-Network Referrals

1. If a Medically Necessary Covered Service is not available through a Network Provider based on the standards in Section 3.3(A)(3), 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 Beneficiary.
2. The Contractor **must** review and act upon the request within a reasonable time in light of the circumstances, not to exceed five (5) Business Days after receipt of reasonably requested documentation.
3. When a Beneficiary 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 in accordance with the process for reimbursing out-of-network providers used by the State's Medicaid program.
 - a. The Contractor **must** ensure that out-of-network providers do not balance bill Beneficiaries.

- b. Out-of-network providers **must** submit Claims to the Contractor, and may only charge Beneficiaries for allowable point-of-service Cost Sharing.
- c. The prohibition on balance billing does not apply if a Beneficiary seeks services from an out-of-network provider without following the required referral procedures described in this Subsection C.
 - i. The Contractor **shall** be responsible for reimbursing the out-of-network provider up to the allowable amount.
- d. Contractor **shall** be responsible for the full amount charged by an out-of-network provider, including any amount over the maximum Benefit amount remaining in the Beneficiary's policy.
- e. The Contractor **shall** ensure no greater than 20% percent of the total dollars billed to the Contractor for outpatient services **shall** be billed by out-of-network providers.

D. Monitoring Access

- 1. The Contractor **must** regularly and systematically verify that Medically Necessary Covered Services furnished by Network Providers are available and accessible to Beneficiaries in compliance with the standards described in Section 3.3(A)(3), above.
- 2. The Contractor **must** enforce access and other Network standards required by the Contract and take appropriate action with Providers whose performance is determined by the Contractor to be out of compliance.
- 3. By the time of Readiness Review and in a method and format as determined or approved by the Contract Monitor, the Contractor **shall** submit for the Contract Monitor's review and approval a plan for how the Contractor will monitor access and take appropriate action.
- 4. The Vendor **must** make modifications to any part of the plan not approved by the Contract Monitor, and a modified plan **must** be re-submitted to the Contract Monitor for approval in a timeframe agreed upon by the Contractor and Contract Monitor.

3.4 PROVIDER NETWORK PROVISIONS

A. 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 3.18. 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, as describe in Section 3.4(B) below.
- 2. During the Start-up Period, the Contractor **shall**:
 - a. Develop a process to accept an initial file load of Provider Network data from DHS with the file format to be determined by DHS. This process will also be used to reconcile the Contractor's Network with DHS's Dental Provider Network during the Readiness Review and prior to the Go-Live Date.
 - b. Enroll into the Contractor's Network Dental Providers who are currently credentialed by Arkansas Medicaid to offer Dental Services, **at least in year one (1)**, pursuant to the process described in Section 3.4.
 - i. If the Contractor has already received approval for its enrollment process, described in Section 3.4, the Contractor may also enroll Dental Providers who are not currently credentialed by Arkansas Medicaid.

- ii. If previously credentialed providers want to participate in the program, they will have to contract with at least one of the two selected vendors and they will have to negotiate any terms regarding the provider contract with the vendor directly.
 - c. Using the Arkansas Provider Portal, submit monthly updates of Provider Network information beginning thirty (30) days after Contract Commencement.
 - d. Submit to the Contract Monitor proof of Network adequacy, consistent with the standards specified in Section 3.3 by the Readiness Review.
 - e. Submit corrective action plans for areas that do not meet Network adequacy standards as referenced in this RFP.
- 3. During the Contract Term, the Contractor **shall**:
 - a. Submit to the Contract Monitor, in a method and format, and by a deadline determined by the Contract Monitor:
 - i. A monthly report on Provider recruitment activities, including the type of Provider, location, date, and type of recruitment activity.
 - ii. A quarterly 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. Use the Arkansas Provider Portal to maintain Provider Network data in the DHS MMIS.
 - c. Develop and submit corrective action plans to the Contract Monitor in the timeframe specified by the Contract Monitor to address Network adequacy issues, whether geographic or specialty driven, that arise during the Contract Term per the standards defined in Section 3.3.
 - d. Relating to PCD assignment and capacity:
 - i. Submit, in a method and format determined by the Contract Monitor, written procedures for assigning the Beneficiaries to a PCD for the Contract Monitor'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 Monitor, report of PCD capacity to the Contract Monitor at the end of the 2nd and 4th quarter of each calendar year within ten (10) Business Days of the end of those respective 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.
- 4. At least 90 days prior to the first anniversary of the Go-Live Date by a deadline determined by the Contractor Monitor, the Contractor **shall** submit to the Contract Monitor, in a method and format determined by the Contract Monitor, its proposed Provider credentialing and enrollment process for review and approval. The Contractor **must** make modifications to the process as deemed necessary by the Contract Monitor. The Contractor's Provider credentialing and enrollment process **shall**:
 - a. Comply with all applicable Program Integrity Requirements outlined in Section 3.18 below as well as all applicable State and Federal laws, rules and regulations.
 - b. Require that all individuals and entities applying to become Providers complete an application, approved by the Contract Monitor, which contains at least all of the information included on any provider enrollment application used by DHS.

- c. Require that all individuals and entities who have applied to become Providers complete the Enrollment Disclosure Form included in the Vendors' Library.
 - d. Ensure that all Providers possess the licenses and credentials necessary to render services under State law.
 - e. Ensure that the Network does not include Providers who have been suspended or excluded from federal healthcare programs, including Medicare and Medicaid.
 - f. Verify that the Provider has current professional liability insurance.
 - g. Review sanction history verified through the National Practitioner Data Bank or other appropriate entity and act accordingly.
 - h. Maintain an electronic database of all persons who apply to become Providers, which includes, at a minimum:
 - i. The date the application was received.
 - ii. The application.
 - iii. Attachments to the application and all subsequent information submitted as part of the application.
 - iv. The dates and nature of the actions taken and the date a decision was rendered.
 - i. Allow the Contract Monitor and designees access to the Provider database.
 - j. Require that all Providers enroll to participate in the Arkansas Medicaid program.
 - k. Assist Providers in completing required forms to participate in the Arkansas Medicaid program.
 - l. Provide, in a method and format and by a deadline determined by the Contract Monitor, a weekly update file to MMIS containing all additions and deletions from the Network.
 - m. Ensure that the Contractor only pays Claims for Providers appropriately enrolled in MMIS.
 - n. Enter Provider changes/updates to contact information in the Arkansas Provider Portal so that the Contractor and MMIS files are consistent.
5. Special Network provisions
- a. The Contractor **shall** include in its Network any willing provider who meets the Contractor's quality standards and agrees to accept the Contractor's rates.
 - b. The Contractor **shall** accept into the Network through the first anniversary of the Go-Live Date any providers currently credentialed by Arkansas Medicaid to offer Dental Services, including all community health centers.
 - i. When re-credentialing Providers after the first anniversary of the Go-Live Date, the Contractor may apply its own credentialing standards but these **shall** be, pursuant to the procedure developed under Section 3.4.

B. Provider Re-Credentialing and Re-Validation

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. Additionally, at least once every five (5) years, the Contractor **must** revalidate all Network Providers' enrollment in Arkansas Medicaid, meaning that the Contractor **shall** confirm that each Network Provider meets all criteria required for Medicaid enrollment.

C. Provider Agreements

1. The Contractor **must** enter into written contracts with properly credentialed Providers who participate in the Network. These Provider Agreements **must** be in writing, **must** comply with applicable federal and State laws and regulations, and **must** include the minimum requirements specified in this RFP at Attachment G.
 - a. The Contractor **must** submit model Network Provider agreements to the Contract Monitor for review during the Start-Up Period, and any substantive revisions thereafter. DHS, through the Contract Monitor, **shall** have the right to reject or require changes to any Network Provider agreement that do not comply with the Contract.
2. The Contractor **shall** be prohibited from the following:
 - a. Requiring a Provider or Provider group to enter into an exclusive contracting arrangement with the Contractor as a condition for Network participation.
 - b. Requiring Providers to participate in the Contractor's other lines of business as a condition of joining the Contractor's Network for Arkansas Medicaid.
 - c. Reimbursing Providers at rates lower than prevailing rates in the Arkansas Medicaid fee-for-service system.
 - i. If the Contractor enters into a capitated, **bundled or non-fee for service** arrangement with a Provider, the Contractor **must** submit to the Contract Monitor a certification from an actuary to demonstrate that the capitated, **bundled or non-fee for service** rate paid is sufficient at expected levels of utilization to cover the prevailing rates in the Arkansas Medicaid fee-for-service system.
 - ii. Such certification **must** be submitted to the Contract Monitor at least thirty (30) days before the Contractor begins making capitated payments to the Provider.
 - iii. The Contractor **must** adjust the amount of capitated, **bundled or non-fee for service** payments in the event that the Contract Monitor determines that the capitated, **bundled or non-fee for service** payments are not sufficient.
 - iv. Any such adjustments **must** be retroactive to the date on which the Contractor began making the capitated, **bundled or non-fee for service** payments outlined in the actuary's certification.
 - v. **The Contractor may enforce a withhold on Providers within the Contractors network as long as the payment amount, net of the withhold amount, is no lower than prevailing rates in the Arkansas Medicaid fee-for-service program. Any withholding must be preapproved DMS.**
3. The Contractor will not be responsible for cost settlements with FQHCs in accordance with federal requirements. DHS will retain responsibility for ensuring that FQHCs receive the rate required under the prospective payment system.

D. Provider Relations and Education

1. The Contractor **shall** have a specific provider relations representative assigned to each dentist within the Network.
 - a. These representatives should be contactable by phone, email, and mail via the United States Postal Service, and they should be able to visit Provider offices when necessary, but visits **shall not** be 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 Providers. For example, if requested, these staff **shall** inform Providers of the Contractor's availability to assist with:
 - i. Helping Beneficiaries 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 Beneficiaries or on their own behalf.
 - vi. Providing any other relevant information needed or requested by a Provider.
 2. 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.
 - a. The Contractor **shall** work with DHS and other DHS contractors as necessary to develop dental education materials tailored for children, including specifically describing the EPSDT program requirements.
 - b. Practice guidelines for pediatric dental utilization **shall** include timely provision of exams, cleaning, fluoride treatment, sealants, and any medically necessary referral for treatment of children of all ages.
 - c. The Contractor **shall** provide training and education to Providers on dental practice guidelines for young children, pregnant women and special needs populations.
 3. The Contractor **shall** be responsible for educating Providers on its utilization management system and the program requirements of Medicaid.
 4. The Contractor **shall** encourage Providers to call the provider call center if they need immediate assistance and are unable to reach their Provider relations representative.
- E. Provider Manual
1. The Contractor **shall** develop, produce, and distribute a Provider Manual 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 Beneficiaries.
 - d. Detailed description of the Grievance and Appeal System processes available to Providers, including the reconsideration process for denied or down-coded prior authorization decisions.
 - e. A detailed description of billing requirements and a copy of the Contractor's HIPAA-compliant paper billing forms and electronic billing format.
 - f. Instructions for all electronic Claim submissions and information on its no-cost direct data entry method for entering Claims through a web portal.

2. During the Start-Up Period, the Contractor **shall**:
 - a. Submit, in a method and format determined by the Contract Monitor, drafts of the Manual for Contract Monitor 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 Monitor.
 - b. Mail the approved 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 Monitor for inclusion on the DHS website.
 - d. Offer Provider trainings to orient Providers and their staff to the information contained in the Provider Manual.
 - i. At least fifteen (15) days prior to the Go-Live Date, the Contractor **shall** provide to the Contract Monitor, in a method and format determined by the Contract Monitor, 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.
 - c. Offer Provider trainings to update Providers and their staff on the information contained in the Provider Manual.
 - i. The Contractor **must** provide documentation of all formal training activities to the Contract Monitor by the 15th day after the end of each quarter of the Contract Year.
 - d. 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 Monitor for approval at least thirty (30) days prior to distribution.
 - ii. After completing all modifications required by the Contract Monitor, 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.

F. Deferred Compensation Plan

1. The Contractor shall provide a method by which providers with a Medicaid Provider Agreement with the Division of Medical Services enrolled in the Contractor's network may elect to participate in a Deferred Compensation Plan under Section 457 of the Internal Revenue Code of 1986, as amended.
 - a. The Contractor shall notify the Providers in the Contractor's network of the availability of the Deferred Compensation Plan and how to enroll.
 - b. The Contractor shall develop and implement a process by which Providers can notify the Contractor regarding the amount the Provider will defer to the Deferred Compensation Plan, up to the annual maximum amount.

- c. The Contractor shall develop and implement a process by which the provider's individual deferral amounts can be transmitted to the Deferred Compensation Plan administrator, up to the annual maximum amount. Where applicable, the Contractor must also notify the provider when the annual maximum amount has been reached, following which claim payments shall be made to the Provider instead.
 - d. The Contractor shall track and report on a quarterly basis to DMS, by provider, the amounts transmitted to the Deferred Compensation Plan.
2. Following the expiration of the initial two-year contract term, DMS may, at its sole discretion, require the Contractor to continue to offer the Deferred Compensation Plan to eligible providers.

Note: Vendor questions for this section (3.4.F. Deferred Compensation Plan) will be accepted by OSP and posted as a formal Q&A document on the OSP website. See section 1.10 for further information.

3.5 BENEFICIARY MATERIALS, EDUCATION, AND OUTREACH

A. General Requirements.

1. The Contractor **shall** design, produce, and distribute to Beneficiaries outreach and education materials that are appropriate for Beneficiaries' age, language, culture, and reading level, as defined by the Federal Plain Language requirements referenced in this RFP.
2. Educational materials to be produced **shall** include those specified in this RFP, as well as other materials necessary to provide information to Beneficiaries as required by this RFP, however, the Vendor may propose in its *Technical Proposal* additional materials and information beyond those described in this RFP.
3. The Contractor **shall** take a proactive role in reaching out to Beneficiaries to ensure that each Beneficiary has the information necessary to receive Medically Necessary Covered Services.
4. The Contractor **shall** conduct regularly scheduled and targeted outreach and education activities for all covered Beneficiaries.
 - a. 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 in Section 3.5(F).
 - b. 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.
 - c. The Contractor **shall** develop creative means to achieve effective outreach and communications including collaborating with groups in the community who interact with Beneficiaries, such as local health department eligibility staff, local departments of social services case workers, 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.
 - d. If a review of the scheduling and targeted Beneficiaries is requested, the Contract Monitor **shall** have the right to require modifications to these factors of the outreach plan.
5. The Contractor **shall** submit all materials to the Contract Monitor for 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 materials, including final copies of approved materials, **shall** be submitted by the Contractor in an electronic format approved by the Contract Monitor, unless the type of material prohibits it from being produced or copied in an electronic format.
 - b. The Contract Monitor reserves the right to withdraw or modify its approval of any material at any time.
 - c. Initial materials **must** be submitted to the Contract Monitor by the time of Readiness Review.

6. The Contractor **shall** submit to the Contract Monitor any marketing and advertising materials referencing the services it is providing on behalf of DHS for 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 the Contract Monitor of all marketing materials **shall** be required.

B. Orientation Materials and Beneficiary Handbook

1. The Contractor **shall** produce a Beneficiary orientation packet, including a letter introducing the Contractor and the Beneficiary's identification card.
2. The introductory letter and identification card **shall** be mailed to all Beneficiaries at least fifteen (15) days prior to the Go-Live Date and to all Beneficiaries becoming eligible for Covered Services after the Go-Live Date within ten (10) days of enrollment.
3. The Contractor **shall** also produce a Beneficiary Handbook and a Provider Directory, which **shall** be made available online.
 - a. The introductory letter **shall** direct the Beneficiary to those online resources and **shall** state that the Beneficiary may request hardcopies of the Beneficiary Handbook and Provider Directory, which the Contractor **shall** mail free of charge.
4. The identification card **shall** include:
 - a. The Contractor's name.
 - b. The Beneficiary's unique identification number (as established by the Contractor).
 - c. The Contractor's Call Center 800 number.
 - d. The Contractor's website address.
 - e. The Beneficiary's PCD's name and telephone number.
 - f. The State's customer service number.
5. The Handbook and other orientation materials **must**:
 - a. Explain the nature of the Beneficiary's relationship with the Contractor.
 - b. List the toll-free telephone number for the Contractor's Call Center with a statement that the Beneficiary may contact the Contractor to locate a dentist, to 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 Dental Services are available at no cost and without point-of-service Cost Sharing responsibilities for Beneficiaries and Covered Services described in this RFP, except that Beneficiaries covered by ARKids B **shall** be subject to point-of-service Cost Sharing obligations for some services.

- h. Explain Beneficiaries' Rights and Responsibilities.
 - i. Explain the Grievance and Appeal System.
 - j. Inform Beneficiaries of the availability of the State's customer service line.
 - k. Explain the relationship between the Beneficiary and the PCD and encourage Beneficiaries to maintain PCD relationships.
6. The Contractor **must** submit the Beneficiary Handbook and identification card template, along with the Provider Directory discussed below, to the Contract Monitor for the Department's 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 are made.
7. During the Contract Term, the Contractor **shall** submit a monthly report to the Contract Monitor by the 15th day of the following month, and by a method and format as approved by the Contract Monitor, showing the date each new enrollment record was received and the date that the orientation packet was mailed.

C. Provider Directory

1. The Contractor **shall** provide all Beneficiaries with access to a Provider Directory, which **shall** be sorted by County and Specialty and list all office locations. The Provider Directory **shall** include:
- a. Provider name
 - b. Address
 - c. Telephone numbers
 - d. Office hours
 - e. Languages spoken, aside from English;
 - f. Specialty
 - g. Whether or not the Provider is accepting new patients
 - h. Practice limitations including whether the Provider is willing to serve children and adults with special health care needs and whether the Provider's practice has age restrictions.
2. The Contract Monitor **must** approve the Provider Directory, which the Contractor **shall** submit along with the Beneficiary Handbook for approval by the time of Readiness Review.
3. The Contractor **shall** update this Directory on a website maintained by the Contractor as Provider information changes, and **shall** make it available to Beneficiaries and stakeholders (e.g. advocate and community organizations and local health departments) at all times electronically and in written format.
4. The on-line version of the Provider Directory **must** be updated whenever there is a change in the Network (including additions and deletions of Providers and changes to the Provider listing as described above). The on-line version **must** be updated based on the timeliness standards listed in Section 3.6(E)(6) of this RFP.
5. The hardcopy version, which **shall** be sent to Beneficiaries at their request, **must** be updated at least quarterly, i.e., every three months of the Contract Year.
6. The Contractor **shall** submit Provider directory information monthly to HRSA on the Insure Kids Now web portal.

D. Content of Education Materials

1. The Contractor **must** educate Beneficiaries (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, 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.

E. Standards for Development of Written Outreach and Education Materials

1. During the Start-Up Period and the Contract period, the Contractor **shall** produce oral health outreach and educational materials including, but not limited to:
 - a. Beneficiary Handbook that meets the requirements listed above.
 - 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 Beneficiaries.
 - c. Materials needed for other forms of public contact, such as health fairs and telemarketing scripts.
2. All materials **shall** meet the following standards:
 - a. Be worded in plain language in accordance with the Federal Plain Language Guidelines, unless otherwise approved by the Contract Monitor.
 - b. Be clearly legible with a minimum font size of 12 pt., unless otherwise approved by the Contract Monitor.
 - 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 Beneficiaries with special needs or appropriate interpretation services **shall** be provided by the Contractor at no charge to the Beneficiary.
3. All materials **must** be pre-approved by the Contract Monitor 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 Beneficiaries of any changes in policies or procedures described in written materials previously sent to Beneficiaries at least thirty (30) days before the effective date of the change.
6. The cost of design, printing, and distribution (including postage) of all Beneficiaries materials **shall** constitute Allowable Expenses.
 - a. The Contractor **shall** comply with all Federal postal regulations and requirements for mailing of all materials.

F. Outreach to Target Groups

1. The Contractor **shall** submit an outreach plan to the Contract Monitor which outlines objectives and strategies that will increase awareness of the importance of dental care, the availability of Dental Services, and increase utilization to meet DHS goals for all Beneficiaries.
2. The Contractor **shall** target specific efforts to children and adults with special health care needs, pregnant women, and those Beneficiaries who have not seen the dentist in a 12-month period of time.

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 Beneficiaries about the availability of Dental Services and to meet or exceed DHS-established utilization goals.
 5. For pregnant women, the Contractor **shall** make at least three (3) attempts to provide outreach and education services to each Beneficiary identified on the eligibility file or otherwise known to be pregnant.
 - a. The first two (2) attempted contacts with each Beneficiary 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 Monitor 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 Beneficiaries on the initial eligibility file on the "go live" date.
 6. For Non-Compliant Beneficiaries, the Contractor **shall** make at least three (3) attempts to provide outreach within ten (10) days of enrollment or within ten (10) days of the Contractor's determination that a Beneficiary is a Non-Compliant Beneficiary if a Beneficiary becomes non-compliant after enrollment.
 - a. The first two (2) attempted contacts with each Non-Compliant Beneficiary should be telephone calls, at least one (1) day apart, within ten (10) days of enrollment with the Contractor or within ten (10) days of determination that the Beneficiary is a Non-Compliant Beneficiary if a Beneficiary becomes non-compliant after enrollment.
 - b. If this contact is unsuccessful, a written notice should be sent within eight (8) days of the second phone attempt. The Contractor **shall** document attempts to schedule follow-up appointments or bring the Non-Compliant Beneficiary into care.
 - c. The Contractor **shall** have 60 days to meet this requirement for those Beneficiaries on the initial eligibility file on the "go live" date.
 7. 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.
 8. This report **shall** describe activities conducted, measures of activity effectiveness, and other entities involved in the activity.
- G. Coordination with Public Health and Other Entities.
1. The Contractor will work closely and cooperatively with DHS, local health departments, and 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 a Beneficiary requires transportation services;
 - c. Work closely and cooperatively with entities who are working on behalf of a Beneficiary to secure needed Dental Services for the Beneficiary.

- i. Such entities may include case management Providers in local communities, community services organizations, dental Provider associations, advocacy groups, dental Providers, schools, 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 Beneficiary or the Beneficiary's responsible party in regard to the issue/need communicated by the interested party.

3.6 **BENEFICIARY AND PROVIDER ASSISTANCE**

A. The Contractor **shall** operate a toll-free Call Center to provide accurate and timely assistance to Beneficiaries and Providers, including appointment setting and handling Grievances and Appeals.

B. Call Center Requirements

1. The Contactor **shall** install, operate, monitor and support an Automated Distribution Call (ADC) system. 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 Beneficiaries by:
 - i. Locating a Network Provider and contacting the office for an appointment, either while the Beneficiary is on the line or via call back, or
 - ii. Locating a non-network Provider to treat the Beneficiary when no participating 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 Beneficiary Grievances and Appeals
 - d. Handling Provider Grievances and Appeals.
 - e. Transferring the Beneficiary to the State's 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 Beneficiaries 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. Beneficiaries **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 Monitor, for handling calls received after normal Business hours and during State-approved holidays.
 - d. Meeting Performance Standards, including:
 - i. 95% of all calls **must** be answered within 3 rings or 15 seconds for any month.
 - ii. Number of busy signals **shall not** exceed 5% of total incoming calls for any month.

- iii. The wait time in queue should not be longer than 2 minutes for 95% of the incoming calls for any month.
 - iv. All calls requiring a call back to the Beneficiary or Provider should be returned within one (1) Business Day of receipt.
 - v. The abandoned call rate **shall not** exceed 3% for any month.
 - vi. For calls received during non-Business hours, return calls to Beneficiaries and Providers **must be** made on the next Business Day.
- e. Having a list of referral sources, which includes “safety net” Providers, teaching institutions and facilities necessary to ensure that Beneficiaries are able to access services that are not covered by Arkansas Medicaid.
 - f. 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.
 - g. 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.
 - h. Having a 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.
 - i. Relinquishing ownership of the toll-free numbers upon Contract termination, at which time DHS **shall** take title to these telephone numbers.
3. During the Start-Up Period, the Contractor **shall** demonstrate for DHS approval that all hardware, software, and staff necessary to administer the Call Center are available and operational.
- a. The Contract Monitor will approve or require corrective action as necessary.
4. During the Contract Term, the Contractor **shall**:
- a. Track and report monthly to the Contract Monitor, by a method, format, and deadline approved by the Contract Monitor, the number of requests for assistance to obtain an appointment, including the county in which the Beneficiary required assistance.
 - b. After the Go-Live Date, report the following information to the Contract Monitor weekly for months 1–3; monthly for months 4–12; and 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 Monitor, 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 made available to the Contract Monitor upon request and **must** include the following at a minimum:
- i. Name of customer service representative.
 - ii. Date of Grievance.
 - iii. Name of complainant.
 - iv. Name of Beneficiary (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 (if different from customer service representative who took the initial 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.

C. Grievance and Appeal System

1. The Contractor will utilize DHS-approved policies and procedures for recording, investigating, resolving, and analyzing all Grievances and Appeals, received telephonically or written, within State-established time frames.
2. Grievances and Appeals **shall** include reconsiderations of denials and down-coding of prior authorization requests.
3. The Department 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, and the Contractor **shall** be bound by any decision made during the State's Administrative Hearing. The Administrative Hearings are held via telephone unless otherwise requested.
4. The Contractor **shall**:
 - a. Maintain a knowledgeable staff capable of distinguishing between Grievances and Appeals and routing them accordingly.

- b. Maintain sufficient staff trained to investigate and resolve all Grievances within the following time frames:
 - i. Emergency, clinical issues: within twenty-four (24) hours of receipt or by the close of the next Business Day.
 - ii. Non-Emergency clinical issues: within five (5) business days of receipt.
 - iii. Non-clinical issues: within thirty (30) business days of receipt.
- c. Handle all Grievances and Appeals in compliance with 42 CFR §§ 438.400–410 and the Arkansas Medicaid Fairness Act (a copy of which is included in the Vendors' Library).
- d. Have an electronic documentation system that includes, at a minimum, a complete description of the issue, investigation, resolution, and Beneficiary notification. All written Beneficiary notifications **shall** utilize a Department-approved template and a copy of all Beneficiary notifications should be sent to the Provider who requested the service, if applicable.
- e. Aggregate and analyze Grievance and Appeal data as described in Section 3.6(C)(4), and as requested by the Contract Monitor on an ad-hoc basis.
- f. Provide a clinician (a Dentist) 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. Beneficiary name
 - ii. Medicaid ID number (if the aggrieved party is a Beneficiary)
 - iii. Subject of Grievance
 - iv. Provider name
 - v. Date received
 - vi. Date resolved
 - vii. Classification of Grievance:
 - Emergency clinical
 - Non-Emergency clinical
 - Non-clinical
- i. Submit a monthly report of all Appeals received. The report **must** contain at least the following information for each Appeal:
 - i. Beneficiary name
 - ii. Medicaid ID number (if the Appeal relates to a Beneficiary)
 - iii. Initial Claim determination (denied, down-coded, etc.)
 - iv. Provider name
 - v. Date received
 - vi. Outcome of Contractor Review

vii. Classification of Appeal:

- Emergency clinical
- Non-Emergency clinical
- Non-clinical

D. 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 Beneficiaries and Providers.

E. Website Requirements

1. The website **shall** contain separate pages of information for Beneficiaries 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, including the Provider Directory described in this RFP.
4. At a minimum, the site **shall** contain the following:
 - a. A link to the Contractor's current Provider Directory (see Section 3.5.), and with the capability to search for Providers by geographic locations, type of practice, and panel restrictions (i.e., accepting or not accepting new patients).
 - b. An outline of Covered Services.
 - c. The Beneficiary Handbook (as described in Section 3.5).
 - 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 Grievances and Appeals to the Contractor.
 - g. A link to the Contractor's secure electronic Beneficiary portal where a Beneficiary can view 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. Provider Directory (as described in Section 3.5)
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. Website, including the Beneficiary portal and the Provider portal, **must** have uptime of 99% each month, excluding maintenance time which **shall** be allowable only from 1:00 a.m. to 5:00 a.m. Central Time each Saturday.

3.7 **PREAUTHORIZATION AND UTILIZATION MANAGEMENT**

A. Authorization of Covered Services in General

1. In arranging for the provision of Medically Necessary Covered Services to Beneficiaries, the Contractor **shall**:
 - a. 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.
 - i. Services for children **shall** be approved in accordance with the periodicity standards of the AAPD in order to meet the EPSDT standard. See Attachment F for AAPD's Periodicity of Examination, Preventive Dental Services and Oral Treatment for Children.
 - b. Authorize the provision of orthodontics to Beneficiaries under the age of 21 when the orthodontic treatment plan meets all of the criteria set by Arkansas Medicaid.
2. 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 approval that will describe how the Contractor will meet the requirements set forth in this section.
3. These policies and procedures **shall** include all Covered Services, EPSDT and AAPD standards, preauthorization, and the Grievance and Appeal System.

B. Preauthorization

1. 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 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, and 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 tentative 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 a Beneficiary's individual needs.
 - d. Cover orthodontic care cases for children that 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 Beneficiary'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 Beneficiary 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.
 - 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 beneficiary moves or the original dental provider is otherwise unable to complete the approved treatment plan.
 - The Beneficiary PMPM payments to the Contractor will stop as soon as a Beneficiary loses eligibility.
 - The Beneficiaries that lost eligibility is not specifically captured in the present system. Additionally, under the current claims payment process, providers receive full payment at the time the orthodontics are installed and agree to perform all follow up treatments according to the treatment plan.
- e. Not require prior authorization for:
 - i. Any Medically Necessary pediatric preventive services.
 - ii. Diagnostic Dental Services.
 - iii. Patients who present a specific symptomatic problem such as dental pain.
 - iv. Dental emergencies such as trauma or acute infection.
- f. Determine Medical Necessity for Dental Services rendered in a non-dental office setting.
- g. Serve as the point of contact for the dental Provider, the Arkansas Medicaid, and any other required medical Provider.
- h. Provide multiple easy-to-use, no-cost methods for Providers to submit pre-authorization requests; such methods can include, but are not limited to, a toll-free phone number, toll-free fax machine, web portal, and email; and all such methods **must** comply with the following requirements:
 - i. All methods **must** direct Providers immediately to the unit performing the pre-authorizations, with the exception of the toll free number, which can direct the call to the appropriate unit using simple prompts;
 - ii. Providers **must** be permitted to submit electronic attachments, regardless of the method the Provider uses to submit preauthorization requests; and
 - iii. All transmissions **must** be HIPAA-compliant.
- i. Render a decision (approve or deny) in a timely manner so as not to adversely affect the Beneficiary'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 request;
- j. Include all of 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 approved by the Contractor Dental Director (see Section 3.8.).
 - iv. All Adverse Benefit Determinations **must** be issued by a Dentist licensed to practice in the State of Arkansas.
 - v. 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.
 - vi. 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.
 - vii. 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.
 - viii. 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.
- k. Maintain an electronic log of all Adverse Benefit Determinations including:
- i. Date of request
 - ii. Name of Beneficiary
 - iii. Medicaid ID number
 - iv. Name of Provider making the request
 - v. Date of Adverse Benefit Determination
 - vi. Reason for the Adverse Benefit Determination
 - vii. Name of Contractor employee who made the Adverse Benefit Determination
 - viii. Date of notification of Adverse Benefit Determination to Provider and Beneficiary.
- l. Submit a quarterly report to the Contract Monitor, including, at a minimum:
- i. Beneficiary name
 - ii. Medicaid ID number
 - iii. Date of request
 - iv. Date of Adverse Benefit Determination
 - v. Reviewer's name
 - vi. Service denied.
- m. Submit a quarterly report no later than fifteen (15) days after the end of the quarter showing:
- i. All preauthorization requests received during the previous quarter.
 - The report **must** list, for each type of requested procedure, the number of denials for the procedure by reason and by age of the Beneficiaries for whom the services were requested.
 - ii. Services that were preauthorized but not received as determined through Claims data for dates of service up to six (6) months after the issuance of the authorization.

C. 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-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 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.

D. Utilization Management

1. The Contractor **shall** establish a system, by the time of Readiness Review, to monitor access to care to ensure that utilization goals established by DHS are met.
2. All utilization management processes **must** meet Utilization Review Accreditation Commission standards.
3. The Contractor **shall**:
 - a. Develop and implement tools to enable it to routinely assess its progress toward achieving DHS's goal of improving annual utilization of preventive and restorative services.
 - b. Maintain a tracking system with the capability to identify and report each Beneficiary's dental utilization; preventive treatment due dates; referrals for corrective treatment; whether treatment was received; and, if so, the date of service.
 - c. 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. Produce and submit utilization reports 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.

3.8 CONTRACTOR OFFICE, STAFFING, AND SUBCONTRACTING

A. Office Location

- a. The Contractor **must** maintain a physical office in Pulaski County, Arkansas.

- b. At minimum, the following staff **shall** be located in the Arkansas office: Project Director, Dental Director, Provider relations staff, and outreach staff.

B. Staffing Plan

- a. 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.
- b. The Contractor **shall not** have an employment, consulting, or any other agreement with a person that has been debarred or suspended by any federal or State agency for the provision of items or services related to the entity's contractual obligation with the State.
- c. The Contractor **shall** implement its staffing plan as proposed in its *Technical Proposal*.
- d. If the Contract necessitates lower staffing levels, the Contractor may request the Contract Monitor to approve a modified staffing plan.
- e. The Contractor **shall** at all times maintain staffing levels at 90 percent of its proposed staffing plan set forth in its *Technical Proposal* or its modified staffing plan as approved by the Contract Monitor.
- f. The staffing for the plan covered by this RFP **must** be capable of fulfilling the requirements of this RFP.
- g. A single individual **shall not** hold more than one position unless otherwise specified.
- h. For the purpose of reporting staffing rates, the Contractor **shall** submit to the Contract Monitor by the 15th of each month a list of all Contractor Personnel with associated full time equivalencies (40 hours equals one (1) full time equivalent position) and the number of days of any vacancies for those Personnel for the previous month.
- i. The Contract Monitor will compare this monthly staffing report to the Contractor's Staffing Plan for the purposes of calculating damages.

C. The minimum staff requirements shall be as follows:

1. A full-time administrator (Project Director) dedicated 100% to this Contract, **shall** be specifically responsible for the coordination and operation of all aspects of the Contract. This person **shall** be at the Contractor's officer level and **must** be approved by the Contract Monitor, including upon replacement.
2. Sufficient numbers of trained and experienced staff who shall conduct daily business in an orderly manner, including such functions as administration, accounting and finance, prior authorizations, Grievance and Appeal System, and Claims adjudication and reporting.
3. Provider Relations Director, and Provider relations staff, whose primary duties shall include development and implementation of the Contractor's ongoing strategies to increase Provider participation and to perform other necessary Provider relation activities.
4. A full-time Outreach and Education Coordinator dedicated 100% to this Contract and regionally located outreach staff, whose primary duties **shall** include development and implementation of the Contractor's ongoing strategies to increase utilization of Dental Services, lead the Contractor's program for dealing with Non-Compliant Beneficiaries as described and perform all other necessary outreach and education activities described in Section 3.5.
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 Beneficiaries.
6. A dentist who **shall** represent DHS and the Contractor at all dental Administrative Hearings.
7. A staff of qualified, clinically trained personnel whose primary duties **shall** be to assist in evaluating Medical Necessity for dental specialty services.

8. A Quality Assurance Coordinator who **shall** coordinate requirements and monitor quality of care, as described in Section 3.9 of this RFP.
 9. An appropriately experienced Information Technology Director who **shall** manage all necessary data functions including eligibility, Claims, and reporting.
 10. Sufficiently trained and experienced full-time staff who **shall** maintain Beneficiary and Provider Call Center functions and **shall** be responsible for explaining the program, assisting Beneficiaries in the selection of dental Providers, assisting Beneficiaries to make appointments and obtain services, and maintaining the Grievance and Appeal System.
 11. A Chief Financial Officer who **shall** have direct supervisory responsibility for all personnel performing financial functions required for the fulfillment of the Contract.
 12. 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 in compliance with the terms of the Contract and the law.
 13. Special Investigation Unit staff to review and investigate Contractor's Providers and enrolled Beneficiaries that are suspected of engaging in wasteful, abusive, or fraudulent billing or service utilization.
- D. Staff members described above with titles of "Director," "Coordinator," or "Officer" **shall** be considered Key Personnel under this Contract.
- a. The Contractor **shall** submit to the Contract Monitor names, qualifications, and resumes of all proposed Key Personnel by the Readiness Review. The State **shall** reserve the right to approve Key Personnel or request alternate candidates.
 - b. **Key positions may be filled after award of the contract, but the Dental Director position shall be filled within thirty (30) days of contract start date.**

E. 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. Key personnel **shall not** be removed by the Contractor from working under this Contract without the prior written approval of the Contract Monitor.
4. For the purposes of this section, the following definitions **shall** apply:
 - a. **Extraordinary Personal Circumstance:** Any circumstance in an individual's personal life that reasonably requires immediate and continuous attention for more than fifteen (15) days and that precludes the individual from performing his/her job duties under this Contract. Examples of such circumstances may include, but are not limited to:
 - i. A sudden leave of absence to care for a family member who is injured, sick, or incapacitated.
 - ii. The death of a family member, including the need to attend to the estate or other affairs of the deceased or his/her dependents.
 - iii. Substantial damage to, or destruction of, the individual's home that causes a major disruption in the individual's normal living circumstances.

- iv. Criminal or civil proceedings against the individual or a family member.
 - v. Jury duty.
 - vi. Military service call-up.
 - b. **Incapacitating:** Any health circumstance that substantially impairs the ability of an individual to perform the job duties described for that individual's position in the RFP or the Contractor's Technical Proposal.
 - c. **Sudden:** When the Contractor has less than thirty (30) days' prior notice of a circumstance beyond its control that will require the replacement of any key personnel working under the Contract.
5. The following provisions **shall** apply to all of 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 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 or 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. Except for replacements due to vacancy, 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 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 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 requiring the immediate removal of the key personnel at issue.
 - If at all 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 the State's 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.

F. Approval of Staffing and Facilities

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

- a. Provide an organizational chart/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.
- 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:
 - i. Positions:
 - Project Director
 - Dental Director
 - Provider Relations Director
 - Quality Assurance Director
 - Clinician for Dental Administrative Hearings
 - Outreach Coordinator
 - ii. Departments:
 - Accounting and Finance
 - Prior Authorizations
 - Claims Processing
 - Information Systems
 - The Call Center
 - Provider Relations.

G. 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.

H. Approval of Subcontractors

1. During the Start-Up Period and the Contract Term, the Contractor **shall** submit to the Contract Monitor any proposed arrangements with a Subcontractor at least 90 days prior to implementation.
2. The State will approve or deny Subcontractor requests within 90 days of receipt.
3. While the Contractor may choose to subcontract claims processing functions, or portions of those functions, with a State-approved subcontractor, the Contractor **shall** demonstrate that the use of such subcontractors is invisible to Providers, including out-of-network and self-referral Providers, and will not result in confusion to the Provider community about where to submit claims for payments. For example, the Contractor may elect to establish one post office box address for submission of all out-of-network Provider claims. If different subcontracting organizations are responsible for processing those claims, the Contractor **shall** ensure that the subcontracting organizations forward claims to the appropriate processing entity.

3.9 QUALITY ASSURANCE AND IMPROVEMENT

- A. 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.
- B. At least 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** describe all aspects of its quality assurance and improvement program, which **shall**, at a minimum,
 - 1. Include measurable goals and objectives.
 - 2. Address both clinical and non-clinical aspects of care.
 - 3. Include all demographic and special needs groups, care settings, and types of services.
- C. 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.
- D. The Contractor **shall** implement and maintain all necessary processes and procedures, including timeliness, to support its quality assurance and improvement plan.
- E. On an ongoing basis, the Contractor **shall** look for opportunities for quality improvement and implement timely corrective action.
- F. The Contractor **shall** be required to meet a set of performance measures outlined in Attachment C.
- G. The Contractor **must** report periodically to the Contract Monitor, in a method and format approved by the Contract Manager, on the quality of the dental program.
- H. These reports, as specified in the deliverables section below, will be monthly for the first year of the Contract but, if requested by the Contract Monitor, **must** move to quarterly submissions.
- I. The Contractor **shall** cooperate with the State's External Quality Review Organization.
- J. 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.
- K. In order 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.
 - 1. One group **shall** be composed of Beneficiaries and the other group **shall** be composed of Providers.
 - 2. Each group **shall** meet at least quarterly, and **must** have at least ten (10) members that represent all geographic areas throughout the State.
 - 3. Meetings should be scheduled in locations and at times that encourage maximum attendance.
 - 4. 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.
 - 5. The Contract Monitor **must** approve all appointments to the groups.
- L. 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.

1. The Contractor **shall** submit for the Contract Monitor's approval a reporting template by the Readiness Review.
2. 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:
 - a. All quality assurance improvement activities that took place during the month, including:
 - i. A summary of the Beneficiary and Provider advisory group meetings.
 - ii. An up-to-date list of representatives in each advisory group.
 - b. The status of the Contractor's goals and objectives;
 - c. All quality improvements that were implemented during the month; and
 - d. All corrective actions that were implemented during the month.

3.10 **ELIGIBILITY & ENROLLMENT**

- A. The Contractor **shall** maintain and utilize an enrollment system which **shall** accept and process daily eligibility files and full replacement data files provided by DHS in order to verify active enrollment in Arkansas Medicaid prior to authorizing or paying for any Dental Services.
 1. Each Beneficiary's eligibility file **shall** include the Beneficiary's Medicaid ID number.
 2. The full replacement file **shall** occur at the discretion of DHS.
 3. The Contractor **must** use the data contained in the Department 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 level of access the contractor may have to the DHS Medicaid eligibility system will be finalized as part of contract negotiations with the awarded vendor(s).
- B. DHS is responsible for providing updated enrollment information to the Contractor for eligible Medicaid Beneficiaries Tuesday through Saturday of each week, subject to change based on holiday scheduling.
- C. The Contractor **shall**:
 1. Operate a system that electronically accepts and processes Arkansas Medicaid eligibility files from the Arkansas MMIS on a daily basis, as well as a full replacement file when deemed necessary by DHS.
 2. Determine whether a person requesting assistance, or for whom preauthorization is requested, is eligible for a specific service, pursuant to Arkansas Medicaid policies.
 3. Refer individuals that have lost eligibility to their local Division of County Operations for assistance.
 4. Verify during Claims adjudication that the Beneficiary was eligible for Dental Services on the date of service.
 5. Add additional Beneficiaries at the request of the Contract Monitor.
 6. Submit a daily report of Beneficiary eligibility daily update statistics to DHS in a method and format as approved by DHS.

- D. DHS is responsible for developing and administering a process through which Beneficiaries and members of the Spend Down Population will select the Contractor through which they will access Covered Services.
1. DHS **shall** offer a choice of a Contractor for all Beneficiaries and members of the Spend Down Population.
 2. If a Beneficiary or member of the Spend Down Population does not choose a Contractor within 60 days after enrollment, DHS **shall** assign to a Contractor.
 3. In assigning Beneficiaries and members of the Spend Down Population to a Contractor, DHS will endeavor to select the same Contractor for individuals residing in the same location.
 4. DHS will allocate Beneficiaries and members of the Spend Down Population evenly across Contractors, to the extent possible.
 5. DHS will notify Beneficiaries and members of the Spend Down Population of the Contractor selected for them by DHS, and DHS will inform them that they may switch Contractors for any reason for the ninety (90) days from the date on the notice.
 6. Enrollment for new enrollees will not be limited to an open enrollment period. Plans must accept new enrollees at any point during the year. Reassignment opportunities for enrollees will occur on an annual basis.

3.11 **CLAIMS PROCESSING**

A. General Requirements

1. The Contractor **shall** develop and maintain an accurate and efficient system to receive and adjudicate Claims for Medically Necessary Dental Services.
2. The Contractor **shall** operate its Claims processing system in accordance with all applicable State and Federal requirements, including the Arkansas Medicaid Fairness Act (a copy of which is included in the Vendors' Library).
3. 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.
4. The Contractor **shall** retain Claims payment history for the duration of Contract and ten (10) years thereafter.
5. All Claims data **must** be easily sorted and produced in formats as requested by DHS.

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. During 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 of Claims, allowing Providers to:
 - a. Verify client eligibility.
 - b. Submit and view preauthorization 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 Beneficiary eligibility on all Claim transactions submitted.
 - b. Verify Provider eligibility on all Claim transactions submitted. The Contract **must** withhold all or part of payment for any Claim submitted by a Provider:
 - i. Excluded or suspended from a federal healthcare program for fraud, abuse, or waste;
 - ii. On payment hold under DHS authority, or
 - iii. With debts, settlements, or pending payments due to the State or the federal government.
 - c. Ensure that Provider information submitted on claims transactions matches the Provider information in Contractor’s database of Providers.
 - d. Maintain clear billing instructions for Providers.
 - e. Verify third-party insurance billing information.
 - f. Verify preauthorization 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 a Beneficiary’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 Beneficiaries 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.
 - 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 option for Providers to elect 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, in order to pay claims from medical Providers that offer Dental Services.
 - s. Have a program to detect and promptly report suspected fraud and abuse to the Contract Monitor 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.

D. Encounter Data

- 1. The Contractor **must** provide complete and accurate Encounter Data for all Medically Necessary Covered Services including Value-Added Services.

2. Encounter Data **must** follow the format and include the data elements described in the most current version of HIPAA- compliant 837D Companion Guides and Encounters Submission Guidelines.
3. DHS **shall** specify the method of transmission, the submission schedule, and any other requirements.
4. The Contractor **must** submit Encounter Data transmissions at least monthly and include all Encounter Data and Encounter Data adjustments processed by the Contractor.
5. Encounter Data quality validation **must** incorporate assessment standards developed jointly by the Contractor and DHS.
6. The Dental Contractor **must** make original records available for inspection by DHS for validation purposes.
7. Encounter Data that does not meet quality standards **must** be corrected and returned within a time period specified by DHS.
8. 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.
9. Any exceptions will be considered on a code-by-code basis after DHS receives written notice from the Contractor requesting an exception.
10. The Contractor **shall** ensure at least 99% of all Encounter Data **must** be accurate.

3.12 **COORDINATION OF BENEFITS & THIRD PARTY LIABILITY**

A. Identification of Third Party Liability

1. Pursuant to federal law, the Medicaid program **shall** be the payer of last resort, unless there is an express statutory exception.
2. All other available Third Party Liability (TPL) resources **must** meet their legal obligation to pay Claims before the Medicaid program pays for the care of an individual eligible for Medicaid.
3. DHS will provide Contractor with a monthly TPL file including the names of all Beneficiaries and members of the Spend Down Population who are known or believed to have other insurance.
4. 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 Beneficiary or member of the Spend Down Population).

B. Payment of Claims

1. For individuals 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.
 - c. The Contractor **shall** instruct the Provider to bill the TPL resource.
 - d. If a balance remains after the TPL resource has paid the provider or denied the Claim, the Provider can submit a claim to the Contractor for payment of the balance, up to the Contractor's maximum allowable amount.
 - e. 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 a Beneficiary 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 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 individuals without an identified TPL resource listed in the TPL file, the Contractor **must** pay Claims consistent with the requirements set forth in Section 3.11.
 - 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.
- 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 recovered.

3.13 SYSTEMS AND SECURITY

A. General Requirements

1. The Contractor **shall** maintain its own management information system throughout the duration of the Contract in order 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 Start-Up 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 and Transition Plan that addresses:
 - i. Communication Plan for normal and contingency communication between the Contractor and 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 with a start-up date no later than fifteen (15) 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. 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.
3. The Disaster Recovery 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.

C. Other Security Measures

1. The Contractor **shall** at all times 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 the Contract Monitor.
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 conduct and provision to the State of State and Federal criminal background checks, including fingerprinting, for each individual 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 to allow any individual employee to work on State premises, based upon information provided in a background check. At all times, at any facility, the Contractor's personnel **shall** ensure cooperation with State site requirements.
 - e. Per 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.
 - g. 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 for default.
6. 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 when a deficiency exists within the Contractor's system.
 - c. Should the Contractor feel that changes, corrections, or enhancements are needed to the system, the Contract Monitor **must** be advised of the changes, corrections, or enhancements and **must** approve before implementation.
7. The Department **shall** advise the Contractor of changes to MMIS throughout the Contract Term.
8. The Contractor **shall** adapt to any and all changes in order to fulfill all the tasks outlined in this RFP.

3.14 **READINESS REVIEW**

- A. As required by CMS, the Contractor **must** participate in the Readiness Review process prior to the enrollment of any members in a plan.
- B. Attachment I details the operational documents the vendor **must** submit to DHS as part of the Readiness Review to allow DHS to assess the ability and capacity of the Contractor to perform in key operational areas.
- C. The listed documents **must** be submitted to the Contract Monitor at least three (3) months prior to planned enrollment, or at a date set by the Contract Monitor.
- D. DHS **shall** have the right to perform the review itself, or to procure an outside counsel to lead the review.

- E. DHS and the Contractors will finalize the requirements of the Readiness Review soon after Contract Commencement at a time which **shall** be determined by DHS.

3.15 **ADMINISTRATION OF CLAIMS FOR SPEND DOWN POPULATION**

- A. The Contractor **shall** administer the Covered Services for the Spend Down Population in accordance with requirements outlined in this Section 3. **The Contractor is to perform all necessary administrative functions, including prior authorization reviews, and process and pay claims for this population on a fee for service basis.**
- B. Notwithstanding the foregoing, the Contractor **shall not** bear financial risk for the cost of Covered Services delivered to the Spend Down Population.
- C. The Contractor **shall** process all Claims for the Spend Down population consistent with the requirements established in Section 3.11, except that instead of submitting Encounter Data, the Contractor **shall** submit, along with its monthly invoice (as further described in Section 3.16), a list of all Claims paid to Providers for Covered Services delivered to the Spend Down Population.
- D. The State will reimburse Contractor for all such Claims **and will pay the Contractor an administrative fee to provide this service. The administrative fee is to be established during contract negotiations. The average monthly total eligible for this category is 65.** Any amount paid for these spend down Claims **shall not** count towards the Beneficiary's maximum amounts under their respective policies.

3.16 **PAYMENT TO CONTRACTOR**

- A. The Contractor **shall** generate an invoice on a monthly basis. The invoice **shall** specify:
 - 1. The number of Beneficiaries in each rate cell;
 - 2. The total capitation payment owed by rate cell;
 - 3. The total value of Claims paid for the Spend Down Population and for services added to the list of Covered Services in the prior two (2) years;
 - 4. The administrative fee, **to be established during contract negotiations** for the Spend Down Population; and
 - 5. The total payment owed.
- B. The State will verify the information listed on the invoice and will pay the Contractor within the time period specified in the Contract.
- C. All disputes regarding the amount owed **shall** be addressed in accordance with the process determined in contract negotiations.
- D. In the event that a Beneficiary 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. In the event that a Beneficiary is retroactively disenrolled from coverage for any reason, including but not limited to by death or incarceration, the State **shall** recoup premiums paid for such Beneficiary.
- F. At the end of each year, the Contractor **shall** submit reports on its medical loss ratio calculated in accordance with the requirements established under federal regulations.
- G. The Contractor **shall** track and report to DHS actual medical expenditures against a minimum loss ratio of 85%. During the initial term of this contract, the Contractor will not be required to pay a rebate to the State in an amount equal to the difference between the medical expenditures required to attain a medical loss ratio of 85% and the actual medical expenditures. DHS **shall** reserve the right to re-negotiate the above at any-time.
- H. Attachment **A3** illustrates the **Risk Corridor parameters** relevant to this contract. In the event that 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 two (2) years of service provision after Go-Live. However, DHS **shall** retain the right to re-negotiate the methodology prior to renewal of the contract for the third year of services or at any-time during the remaining life of the Contract.
- I. The Risk Corridor and Medical Loss Ratio are two separate calculations. The first year of the dental managed care program will include a risk corridor limiting vendor gains and losses to 3%. The MLR will be monitored per CMS rules and regulations, but in the initial term of the dental managed care program DMS will not enforce any MLR rebate. Due to this, while plan profits and losses are capped at 3% there is no corresponding cap on Medical Loss Ratios and calculations will not solve to an 85% MLR.
- J. 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.

3.17 **QUALITY MEASURES**

- A. The State will develop performance withhold standards that **shall** withhold a portion of capitation rates that the Contractor can earn in accordance with the achievement of the Quality Measures set forth in Attachment D. Actual performance withhold measures and the corresponding amounts of the withholds will be finalized as part of contract negotiations.
- B. 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.

3.18 **PROGRAM INTEGRITY**

The Arkansas Office of the Attorney General, Medicaid Fraud Control Unit (MFCU) and the Office of the Medicaid Inspector General (OMIG) are the State entities responsible for the investigation of provider fraud in the Arkansas Medicaid program. The Contractor **shall** work collaboratively with these agencies and units as described below.

A. Required 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 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).

B. Screening for Excluded and/or Disbarred Entities

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. 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 Vendors' Library).

3. Any services provided by excluded individuals **shall** be refunded to and/or obtained by the State and/or the Contractor as prescribed in Section 3.18.J - Program Integrity Overpayment Recovery.
4. 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.
5. Any Provider listed on any of these excluded or disbarred entity databases **shall not** be included in the Contractor's Network.

C. Program Integrity Staffing Adequacy

1. The Contractor **shall** have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.
2. The Contractor **shall** comply with all federal and State requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act. The Contractor **shall** also provide all documentation and information requested by DHS or OMIG or required under this section and its subsections in the form and manner mandated by DHS or OMIG.

D. Program Integrity Plan

1. Pursuant to 42 CFR § 438.608, which sets program integrity requirements, the Contractor **must** have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse.
2. The first iteration of the Program Integrity Plan (PI Plan) **shall** be submitted for review and approval by DHS and OMIG 90 days prior to the Go-Live Date. Thereafter, the Program Integrity Plan **shall** be submitted annually and upon request by DHS or OMIG, and updated quarterly, or more frequently if required by DHS or OMIG.
3. The PI Plan 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 Contractor 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 Contractor'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 Contractor **shall** inform DHS and OMIG of such actions in its audit plan.
 - The assessment **shall** also include a listing of the Contractor's top three (3) vulnerable areas and **shall** outline action plans mitigating such risks.

- e. Provision for internal monitoring and auditing.
- f. Procedures designed to prevent and detect abuse and fraud in the administration and delivery Dental Services under the Contract.
- g. 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. A list of automated pre-payment claims edits.
 - ii. A list of automated post-payment claims edits.
 - iii. A list of types of desk audits on post-processing review of claims.
 - iv. A list of reports for Provider profiling and credentialing used to aid program and payment integrity reviews.
 - v. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services.
 - vi. A list of provisions in the subcontractor and Provider agreements that ensure the integrity of Provider credentials.
 - vii. A list of references in Provider and Beneficiary material regarding fraud and abuse referrals.
 - viii. A list of provisions for the confidential reporting of PI Plan violations to the designated person.
 - ix. 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.
- h. Provisions ensuring that the identities of individuals reporting violations of the Contractor are protected and that there is no retaliation against such persons.
- i. Specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance PI Plan violations.
- j. Requirements regarding the reporting of any confirmed or suspected provider fraud and abuse under State or federal law to the DHS.
- k. Assurances that no individual who reports Contractor's potential violations or suspected fraud and abuse is retaliated against.
- l. Policies and procedures for conducting both announced and unannounced site visits and field audits of Providers to ensure services are rendered and billed correctly.
- m. Provisions for prompt response to detected offenses, and for development of corrective action initiatives.
- n. Program integrity-related goals, objectives and planned activities for the upcoming year.

E. Program Integrity Operations

1. The Contractor **shall** have surveillance and utilization control programs and procedures (42 CFR §§ 456.3, 456.4, 456.23) to safeguard Medicaid funds against improper payments and unnecessary or inappropriate use.
2. The Contractor **shall** have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected waste, fraud and abuse activities.
3. Contractor **shall** have operations sufficient to enable the efficient identification, investigation, and resolution of waste, fraud and abuse issues of Contractor's Providers.
4. Contractor **shall** conduct all operations and deploy all capabilities described below on a routine basis and as necessary for the effective reduction of Medicaid waste, fraud and abuse.

5. The Contractor **shall** have the ability to make referrals of suspected malfeasance to DHS and OMIG, and accept referrals from a variety of sources including: directly from Providers (either provider self-referrals or from other providers), Beneficiaries, law enforcement, government agencies, etc.
6. The Contractor **shall** also have effective procedures for timely reviewing, investigating, and processing such referrals.
7. Contractor **shall** conduct and maintain at a minimum the following operations and capabilities:
 - a. Data mining, analytics, and predictive modeling for the identification of potential overpayments and aberrant payments/providers warranting further review/investigation.
 - b. Provider profiling and peer comparisons of all of Contractor's Provider types and specialties – at a minimum annually - to identify aberrant service and billing patterns warranting further review/audit.
 - c. Onsite audit capability and protocols identifying how and when the Contractor or State **shall** conduct such onsite audits of providers.
 - d. Medical claim audit capabilities sufficient to enable the Contractor to audit any payment issued to any provider, including the ability to audit payments before they are made for newly enrolled providers, providers suspected of improper practices, or providers with a history of payment issues.
 - e. Member service utilization analytics to identify members that may be abusing services.

F. Preliminary Investigation of Suspected Waste, Fraud or Abuse

1. The Contractor **shall** promptly perform a preliminary investigation of all incidents of suspected and/or confirmed waste, fraud or abuse. If the preliminary investigation determines that further investigation is warranted, the Contractor **shall** report the suspected incident to DHS and OMIG.
2. Unless prior written approval is obtained from DHS, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the Contractor **shall not**:
 - a. Contact the subject of the investigation about any matters related to the investigation;
 - b. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
 - c. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
3. The Contractor **shall** cooperate with all appropriate State and federal agencies, including the Arkansas MFCU, OMIG and DHS, in investigating fraud and abuse. The Contractor **shall** have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §§ 455.13, 455.14, 455.21).

G. Reporting Suspected or Confirmed Incidences of Waste, Fraud or Abuse

1. After a preliminary investigation, the Contractor **shall** immediately report all suspected or confirmed instances of waste, fraud and abuse to the State and DHS.
2. The Contractor **shall** be subject to non-compliance remedies under the Contract for willful failure to report fraud and abuse by Providers, Beneficiaries, or applicants to DHS as appropriate.

H. Quarterly Audit Activity Report

1. On a quarterly basis, or as otherwise directed by DHS or OMIG, and in a method and format approved by DHS or OMIG, the Contractor **shall** submit a detailed Audit Report to DHS and OMIG 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.

2. The Audit Report should also specify individual Provider recoupment, repayment schedules, and actions taken for each audit or investigation.
 - a. The quarterly progress report **must** identify recoupment totals for the reporting period.
 - b. The Audit Report **shall** identify projected upcoming activity, including the top five (5) Providers on Contractor's list for audit, and the type(s) of audit(s) envisioned.
 3. DHS **shall** review and approve, approve with modifications, or reject the Audit Report and specify the grounds for rejection.
 4. Recoupment totals and summaries for each reporting period (quarterly unless otherwise specified by DHS) **must** be submitted in the Audit Report.
- I. Cooperation with Further Investigation and/or Prosecution
1. The Contractor **shall** cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal.
 2. Such cooperation **shall** include providing, upon request, information, access to records, and access to interview Contractor employees and consultants, including but not limited to those with expertise in the administration of the program and/or any matter related to an investigation.
- J. Program Integrity Overpayment Recovery
1. The Contractor **shall** have primary responsibility for the identification of all potential waste, fraud and abuse associated with Dental Services and billings generated as a result of the Contract.
 2. In cases involving wasteful or abusive provider billing or service practices (including overpayments) identified by DHS or OMIG, DHS **shall** have the right to recover any identified overpayment directly from the Provider or to require Contractor to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by DHS. DHS **shall** have the right to take disciplinary action against any Provider identified by Contractor or DHS as engaging in inappropriate or abusive billing or service provision practices.
 3. If a fraud referral from Contractor generates an investigation and/or corresponding legal action results in a monetary recovery to DHS, the reporting Contractor will be entitled to share in such recovery following final resolution of the matter (settlement agreement/final court judgment) and following payment of recovered funds to the State of Arkansas. The Contractor's share in the recovery **shall** be as follows:
 - a. From the recovery, the State (including the MFCU) **shall** retain its costs of pursuing the action, including any costs associated with DHS or OMIG operations associated with the investigation, and its actual documented loss (if any). The State will pay to the Contractor the remainder of the recovery, not to exceed the Contractor's actual documented loss. Actual documented loss of the parties **shall** be determined by paid false or fraudulent claims, canceled checks or other similar documentation which objectively verifies the dollar amount of loss.
 - b. If the State determines it is in its best interest to resolve the matter under a settlement agreement, the State **shall** have final authority concerning the offer, or acceptance, and terms of a settlement. The State will exercise its best efforts to consult with the Contractor about potential settlement. The State may consider the Contractor's preferences or opinions about acceptance, rejection or the terms of a settlement, but they **shall** not be binding on the State.
 - c. If final resolution of a matter does not occur until after the Contract has expired, the preceding terms concerning disposition of any recovery and consultation with the Contractor **shall** survive expiration of the Contract and remain in effect until final resolution of a matter referred to the MFCU by the Contractor under this section.
 - d. If the State makes a recovery from a fraud investigation and/or corresponding legal action where the Contractor has sustained a documented loss but the case did not result from a referral made by the Contractor, the State **shall not** be obligated to repay any monies recovered to Contractor, but may do so at its discretion. Funds recovered as a result of a multi-state fraud

investigation/litigation, however, will be shared with Contractor as prescribed for funds recovered as a result of Contractor's fraud referral absent extenuating circumstances.

4. The Contractor **shall** be prohibited from the repayment of State-, federally-, or Contractor-recovered funds to any provider (including Providers) when the issues, services or claims upon which the repayment is based meets one or more of the following:
 - a. The funds from the issues, services or claims have been obtained by the State or Federal governments, either by the State directly or as part of a resolution of a State or federal audit, investigation and/or lawsuit, including but not limited to false claims act cases;
 - b. When the issue, services or claims that are the basis of the repayment have been or are currently being investigated by DHS, OMIG, the Federal Medicaid Integrity Contractor (MIC), Contractor, Arkansas MFCU, or Assistant United State Attorney (AUSA), are the subject of pending Federal or State litigation, or have been/are being audited by the State's Recovery Audit Contractor (RAC).
5. This prohibition described above **shall** be limited to a specific Provider(s), for specific dates, and for specific issues, services or claims. The Contractor **shall** check with DHS before initiating any repayment of any program integrity related funds to ensure that the repayment is permissible.
6. If required, Contractor **shall** correct Federal Financial Participation (FFP) from MMIS in accordance with any overpayment recovery.

K. Auditing Program Integrity Operations

1. DHS or OMIG **shall** have the right to conduct audits of Contractor's program integrity activities to determine the effectiveness of Contractor's operations. Such audit activities may include conducting interviews of relevant staff, reviewing all documentation and systems used for Special Investigation Unit activities, and reviewing the SI Unit's performance metrics.
2. DHS or OMIG **shall** have the right to issue a corrective action or performance improvement plan and outline timelines for improvement measures. The failure to adhere to operational improvement measures may result in the State's imposing damages up to the amount of overpayments recovered from Contractor's providers by DHS or OMIG audits for the preceding calendar year, or imposing other non-compliance remedies including damages.

3.19 TRANSITION AT END OF CONTRACT

- A. At the end of this Contract, the Contractor **shall** work cooperatively with DHS and if applicable, any new contractor, to ensure an efficient and timely transition of Contract responsibilities with minimal disruption of service to Beneficiaries and Providers.
- B. At least six (6) months prior to the scheduled expiration of the Contract Term, including any option period, the Contractor **shall** develop and provide to the Contract Monitor a detailed Full Operations Resources report describing which resources (systems, software, equipment, materials, staffing, etc.) **shall** be required by DHS or another contractor to take over the requirements specified in the RFP/Contract.
- C. An Exit Transition Period **shall** begin at least 60 days, but no more than 90 days, prior to the last day the Contractor is responsible for the requirements of the Contract resulting from this RFP.
- D. During the Exit Transition Period, the Contractor **shall** work cooperatively with DHS and the new contractor and **shall** provide program information and details specified by DHS.
- E. Both the program information and the working relationship between the Contractor and the new contractor **shall** be defined by DHS.
- F. Within the Exit Transition Period, the Contractor **shall** prepare and submit an Exit Transition Plan and Schedule of Activities to facilitate the transfer of responsibilities, information, computer systems, software and documentation, materials, etc., to a new contractor and/or DHS.

- G. The Exit Transition Plan **shall** be submitted by the Contractor within ten (10) days of the date of notification by DHS. The Exit Transition Plan **shall** include, at a minimum:
1. The Contractor's proposed approach to the transition;
 2. The Contractor's tasks, subtasks, and schedule for all transition activities;
 3. An organizational chart and staffing matrix of the Contractor's staff (titles, phone, fax) responsible for transition activities;
 4. A detailed explanation of how the Contractor will begin work with a new Contractor and/or DHS within ten (10) days of receipt of notice from DHS that another contractor has been selected to provide comprehensive Dental Services.
- H. The Contract Monitor **must** approve the Exit Transition Plan before it can be implemented.
- I. The Contract Monitor and the new Contractor will define the information required during this transition period and time frames for submission.
- J. The Contract Monitor **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.

3.20 **INSURANCE REQUIREMENTS**

A. General Coverage

1. The Contractor **shall** maintain, at Contractor's own expense, during the Contract Term and until final acceptance of all services and deliverables, the following insurance coverage:
 - a. Business Automobile Liability Insurance for all owned, non-owned, and hired vehicles, for bodily injury and property damage;
 - b. Comprehensive General Liability insurance of at least \$1,000,000.00 per occurrence and \$5,000,000.00 in the aggregate (including Bodily injury coverage of \$100,000.00 per each occurrence and Property Damage Coverage of \$25,000.00 per occurrence.
 - c. If the contractor's current Comprehensive General Liability insurance coverage does not meet the above stated requirements, the Contractor will obtain Umbrella Liability insurance to compensate for the difference in the coverage amounts.
 - d. If Umbrella Liability insurance is provided it **must** follow the form of the primary coverage.

B. Professional Liability Coverage

1. The Contractor **must** maintain, at its own expense, or cause its Network Providers to maintain, during the Term of the Contract and until final acceptance of all services and deliverables, the following insurance coverage:
 - a. Professional Liability Insurance for each Network Provider of \$100,000.00 per occurrence and \$300,000.00 in the aggregate. The Contractor **must** provide proof of such coverage upon request to DHS.
 - b. An Excess Professional Liability (Errors and Omissions) Insurance Policy for the greater of \$3,000,000.00 or an amount (rounded to the nearest \$100,000.00) that represents the number of Beneficiaries enrolled with the Contractor in the first month of the applicable Contract Year multiplied by \$150.00, not to exceed \$10,000,000.00.

C. General Requirements for All Insurance Coverage

1. All exceptions to the Contract's insurance requirements **must** be approved in writing by DHS.
2. The Contractor or Provider **shall** be responsible for any and all deductibles stated in the policies.
3. Insurance coverage **must** be issued by insurance companies authorized by applicable law to conduct business in the State of Arkansas.
4. Insurance coverage kept by the Contractor **must** be maintained in full force at all times during the Contract Term and until DHS's final acceptance of all services and deliverables. Failure to maintain such insurance coverage **shall** constitute a material breach of the Contract.
5. The Contractor **shall** require that any subcontractors providing services under this Contract obtain and maintain similar levels of insurance and **shall** provide the Contract Monitor with the same documentation as is required of the Contractor.
6. With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section **must** have an extended reporting period of two (2) years. When policies are renewed or replaced, the policy retroactive date **must** coincide with, or precede, the Contract Commencement.
7. Any insurance coverages and limits furnished by the Contractor **shall** not in any way expand or limit the Contractor's liabilities and responsibilities specified within the Contract documents or by applicable law.
8. Any insurance maintained by DHS will apply in excess of and **shall not** contribute to insurance provided by the Contractor under the Contract.
9. If the Contractor or its Network Providers desire additional coverage, higher limits of liability, or other modifications for its own protection, the Contractor or its Network Providers **shall** be responsible for the acquisition and cost of such additional protection. Such additional protection **shall not** be an Allowable Expense under this Contract.
10. Insurance coverage **must** name DHS as an additional insured, with the exception of Professional Liability insurance maintained by Network Providers. Insurance coverage **must** name DHS as a loss payee, with the exception of Professional Liability insurance maintained by Network Providers and Business Automobile Liability insurance.
11. With the exception of 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 HHSC to ensure no break in coverage.
12. The Contractor **must** require all insurers to waive their rights of subrogation against DHS.

D. Proof of Insurance Coverage

1. The Contractor **must** furnish DHS with original Certificates of Insurance evidencing the required insurance coverage on or before the Contract Commencement. Such Certificates **must** be submitted prior to Contract award. The failure of DHS or OSP to obtain such evidence from Contractor before permitting the Contractor to commence work **shall not** be deemed to be a waiver by DHS or OSP, and the Contractor **shall** remain under continuing obligation to maintain and provide proof of the insurance coverage.
2. If insurance coverage is renewed during the Contract Term, the Contractor **must** furnish DHS renewal certificates of insurance, or such similar evidence within five (5) Business Days of renewal.
3. The insurance specified above **must** be carried until all required services and deliverables are satisfactorily completed. Failure to carry or keep such insurance in force **shall** constitute a violation of the Contract.

3.21 PROBLEM ESCALATION PROCEDURE

- A. The Contractor **must** provide and maintain a Problem Escalation Procedure (PEP) for both routine and emergency situations.
- B. The PEP **must** state how the Contractor will address problem situations as they occur during the performance of the Contract, especially problems that are not resolved to the satisfaction of the State within appropriate timeframes.
- C. The Contractor **shall** provide contact information to the Contract Monitor, as well as to other State personnel, as directed should the Contract Monitor not be available.
- D. The Contractor **must** provide the PEP to the Contract Monitor no later than ten (10) Business Days after Contract Commencement.
- E. The PEP, including any revisions thereto, **must** also be provided within ten (10) Business Days after the start of each Contract year and within ten (10) Business Days after any change in circumstance which changes the PEP.
- F. The PEP **shall** detail how problems with work under the Contract will be escalated in order to resolve any issues in a timely manner. The PEP **shall** include:
 1. The process for establishing the existence of a problem;
 2. The maximum duration that a problem may remain unresolved at each level in the Contractor's organization before automatically escalating the problem to a higher level for resolution;
 3. Circumstances in which the escalation will occur in less than the normal timeframe;
 4. The nature of feedback on resolution progress, including the frequency of feedback to be provided to the State;
 5. Identification of, and contact information for, progressively higher levels of personnel in the Contractor's organization who would become involved in resolving a problem;
 6. Contact information for persons responsible for resolving issues after normal business hours (e.g., evenings, weekends, holidays, etc.) and on an emergency basis; and
 7. A process for updating and notifying the Contract Monitor of any changes to the PEP.
- G. Nothing in this section **shall** be construed to limit any rights of the Contract Monitor or the State which may be allowed by the Contract or applicable law.

3.22 AUDITS AND ACCESS TO RECORDS

A. Audits

1. The Contractor **shall** have an annual audit performed by an independent audit firm of its handling of DHS's critical functions and/or sensitive information, which is identified as Claims processing (collectively referred to as the "Information Functions and/or Processes").
2. Such audits **shall** be performed in accordance with audit guidance: *Reporting on Controls at a Service Organization Relevant to Security, Availability, Processing Integrity, Confidentiality, or Privacy* (SOC 2) as published by the American Institute of Certified Public Accountants (AICPA) and as updated from time to time, or according to the most current audit guidance promulgated by the AICPA or similarly-recognized professional organization, as agreed to by the Department, to assess the security of outsourced client functions or data (collectively, the "Guidance") as provided in this section.
3. The type of audit to be performed in accordance with the Guidance **shall** be a SOC 2 Type II Report.
4. The SOC 2 Report **shall** be completed annually, submitted by July 31 for the previous State fiscal year.
5. The SOC 2 Report **shall** report on a description of the Contractor's system and the suitability of the design and operating effectiveness of controls of the Information Functions and/or Processes relevant to the following trust principles: Processing Integrity, as defined in the Guidance.
6. The SOC 2 Report **shall** include work performed by subcontractors that provide essential support to the Contractor for the Information Functions and/or Processes for the services provided to DHS under the Contract. The Contractor **shall** ensure the performance of the SOC 2 Audits includes its Subcontractor(s).
7. All SOC 2 Audits, including the SOC 2 Audits of Contractor's subcontractors, **shall** be considered Allowable Expenses.
8. The Contractor **shall** promptly provide a complete copy of the final SOC 2 Report to the Contract Monitor upon completion of each SOC 2 Audit engagement.
9. The Contractor **shall** provide to the Contract Monitor, within thirty (30) calendar days of the issuance of the final SOC 2 Report, a documented corrective action plan which addresses each audit finding or exception contained in the SOC 2 Report.
10. The corrective action plan **shall** identify in detail the remedial action to be taken by the Contractor along with the date(s) when each remedial action is to be implemented.
11. If the Contractor currently has an annual information security assessment performed that includes the operations, systems, and repositories of the Information Functions and/or Processes services being provided by the Contractor to DHS under the Contract, and if that assessment generally conforms to the content and objective of the Guidance, the Department **shall** have the determination in consultation with appropriate State government technology and audit authorities, whether the Contractor's current audits are acceptable in lieu of the SOC 2 Report(s).
12. If the Contractor fails during the Contract Term to obtain an annual SOC 2 Report by July 31 for the preceding fiscal year, the Department **shall** have the right to retain an independent audit firm to perform an audit engagement to issue a SOC 2 Report of the Information Functions and/or Processes being hosted by the Contractor.
13. The Contractor **shall** allow the independent audit firm to access its facilities for purposes of conducting this audit engagement(s), and provide reasonable support to the independent audit firm in the performance of the engagement. DHS will invoice the Contractor for the expense of the SOC 2 Audit(s), or deduct the cost from future payments to the Contractor.
14. The audit **shall** be completed at the Contractor's expense.

B. Record Retention and Access

1. Contractor **shall** retain, and **shall** require its Subcontractors to retain, all records related to the Contract for a period of the later 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. 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.
3. 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.
4. Any costs of such access **shall** be borne by the Contractor, and **shall not** constitute Allowable Expenses under the Contract.

SECTION 4 – CRITERIA FOR SELECTION

- Do not provide responses to items in this section.

4.1 TECHNICAL PROPOSAL SCORE

- A. OSP will review each *Technical Proposal Packet* to verify submission Requirements have been met. *Technical Proposals Packets* that do not meet submission Requirements **shall** be disqualified and **shall not** be evaluated.
- B. A DHS-appointed Evaluation Committee will evaluate and score qualifying Technical Proposals. Evaluation will be based on Vendor’s response to the *Information for Evaluation* section included in the *Technical Proposal Packet*. Other agencies, consultants, and experts may also examine documents at the discretion of the Agency.
- C. The *Information for Evaluation* section has been divided into sub-sections.
- In each sub-section, items/questions have each been assigned a maximum point value of ten (10) points. The total point value for each sub-section is reflected in the table below as the Maximum Raw Score Possible.
 - The agency has assigned Weighted Percentages to each sub-section according to its significance.

Information for Evaluation Sub-Sections		Maximum Raw Points Possible	Sub-Section Weighted Percentage of Total Score	* Maximum Weighted Score Possible
E.1	VENDOR QUALIFICATIONS	30	15%	105
E.2	PERFORMANCE STANDARDS, CONTRACT SERVICES, & COORDINATION OF NON-CAPITATED SERVICES	90	9%	63
E.3	ACCESS TO CARE & PROVIDER NETWORK PROVISIONS	140	15%	105
E.4	BENEFICIARY MATERIALS, OUTREACH, & EDUCATION	100	5%	35
E.5	BENEFICIARY & PROVIDER CALL CENTER & WEBSITE	100	5%	35
E.6	GRIEVANCE & APPEAL SYSTEM & QUALITY ASSURANCE & IMPROVEMENT	60	8%	56
E.7	AUTHORIZATION & PREAUTHORIZATION OF COVERED SERVICES & UTILIZATION MANAGEMENT	90	10%	70
E.8	CONTRACTOR OFFICE, STAFFING, & SUBCONTRACTING & PROBLEM ESCALATION PROCEDURE	70	5%	35
E.9	ELIGIBILITY AND ENROLLMENT	30	9%	63
E.10	CLAIMS PROCESSING & COORDINATION OF BENEFITS & THIRD PARTY LIABILITY	70	10%	70
E.11	SYSTEMS & SECURITY & PROGRAM INTEGRITY	110	4%	28
E.12	READINESS REVIEW, TRANSITION AT END OF CONTRACT AND ACCESS TO RECORDS	50	5%	35
Totals		940	100.00%	700

*Sub-Section’s Percentage Weight x Total Weighted Score = Maximum Weighted Score Possible for the sub-section.

D. The Vendor’s weighted score for each sub-section will be determined using the following formula:

$$(A/B)*C =D$$

A = Averaged Raw Points received for sub-section in evaluation
 B = Maximum Raw Points possible for sub-section
 C = Maximum Weighted Score possible for sub-section
 D = Weighted Score received for sub-section

E. Vendor’s weighted scores for sub-sections will be added to determine the Total Technical Score for the Proposal.

F. Technical Proposals that do not receive a minimum weighted score of 300 may not move forward in the solicitation process and pricing **shall** remain sealed and **shall not** be scored.

4.2 COST SCORE

A. When pricing is opened for scoring, the maximum amount of cost points will be given to the Vendor with the lowest total as shown in Table A on the *Official Bid Price Sheet*. (See *Grand Total Score* for maximum points possible for cost score.)

B. The amount of cost points given to the remaining Vendors will be allocated by using the following formula:

$$(A/B)*(C) =D$$

A = Lowest Total Cost
 B = Second (third, fourth, etc.) Lowest Total Cost
 C = Maximum Points for Lowest Total Cost
 D = Total Cost Points Received

4.3 GRAND TOTAL SCORE

The Technical Score and Cost Score will be added together to determine the Grand Total Score for the Vendor. The two (2) Vendors with the highest Grand Total Score will be selected as the apparent successful Vendors. (See *Award Process*.)

	Maximum Points Possible
Technical Proposal	700
Cost	300
Maximum Possible Grand Total Score	1000

4.4 VENDOR ACCEPTANCE OF EVALUATION TECHNIQUE

A. Vendor **must** agree to all evaluation processes and procedures as defined in this solicitation.

B. The submission of a *Technical Proposal Packet* **shall** signify the Vendor’s understanding and agreement that subjective judgments **shall** be made during the evaluation and scoring of the Technical Proposals.

SECTION 5 – GENERAL CONTRACTUAL REQUIREMENTS

- **Do not provide responses to items in this section.**

5.1 PAYMENT AND INVOICE PROVISIONS

- A. All invoices **shall** be forwarded to:

Division of Medical Services
Financial Activities
PO Box 1437 Slot S416
Little Rock, AR 72203

- B. Payment will be made in accordance with applicable State of Arkansas accounting procedures upon acceptance goods and services by the agency.
- C. The State **shall not** be invoiced in advance of delivery and acceptance of any goods or services.
- D. Payment will be made only after the Vendor has successfully satisfied the agency as to the reliability and effectiveness of the goods or services purchased as a whole.
- E. The Vendor should invoice the agency by an itemized list of charges. The agency's Purchase Order Number and/or the Contract Number should be referenced on each invoice.
- F. Other sections of this *Bid Solicitation* may contain additional Requirements for invoicing.
- G. Selected Vendor **must** be registered to receive payment and future *Bid Solicitation* notifications. Vendors may register on-line at <https://www.ark.org/vendor/index.html>.

5.2 GENERAL INFORMATION

- A. The State **shall not** lease any equipment or software for a period of time which continues past the end of a fiscal year unless the contract allows for cancellation by the State Procurement Official upon a 30 day written notice to the Vendor/lessor in the event funds are not appropriated.
- B. The State **shall not** contract with another party to indemnify and defend that party for any liability and damages.
- C. The State **shall not** pay damages, legal expenses or other costs and expenses of any other party.
- D. The State **shall not** continue a contract once any equipment has been repossessed.
- E. Any litigation involving the State **must** take place in Pulaski County, Arkansas.
- F. The State **shall not** agree to any provision of a contract which violates the laws or constitution of the State of Arkansas.
- G. The State **shall not** enter a contract which grants to another party any remedies other than the following:
- The right to possession.
 - The right to accrued payments.
 - The right to expenses of deinstallation.
 - The right to expenses of repair to return the equipment to normal working order, normal wear and tear excluded.
 - The right to recover only amounts due at the time of repossession and any unamortized nonrecurring cost as allowed by Arkansas Law.
- H. The laws of the State of Arkansas **shall** govern this contract.

- I. A contract **shall not** be effective prior to award being made by a State Procurement Official.
- J. In a contract with another party, the State will accept the risk of loss of the equipment or software and pay for any destruction, loss or damage of the equipment or software while the State has such risk, when:
 - The extent of liability for such risk is based upon the purchase price of the equipment or software at the time of any loss, and
 - The contract has required the State to carry insurance for such risk.

5.3 **CONDITIONS OF CONTRACT**

- A. The Vendor **shall** at all times observe and comply with federal and State of Arkansas laws, local laws, ordinances, orders, and regulations existing at the time of, or enacted subsequent to the execution of a resulting contract which in any manner affect the completion of the work.
- B. The Vendor **shall** indemnify and save harmless the agency and all its officers, representatives, agents, and employees against any claim or liability arising from or based upon the violation of any such law, ordinance, regulation, order or decree by an employee, representative, or Subcontractor of the Vendor.

5.4 **STATEMENT OF LIABILITY**

- A. The State will demonstrate reasonable care but will not be liable in the event of loss, destruction or theft of Vendor-owned equipment or software and technical and business or operations literature to be delivered or to be used in the installation of deliverables and services. The Vendor **shall** retain total liability for equipment, software and technical and business or operations literature. The State **shall** not at any time be responsible for or accept liability for any Vendor-owned items.
- B. The Vendor's liability for damages to the State **shall** be limited to the value of the Contract or \$5,000,000, whichever is higher. The foregoing limitation of liability **shall not** apply to claims for infringement of United States patent, copyright, trademarks or trade secrets; to claims for personal injury or damage to property caused by the gross negligence or willful misconduct of the Vendor; to claims covered by other specific provisions of the Contract calling for damages; or to court costs or attorney's fees awarded by a court in addition to damages after litigation based on the Contract. The Vendor and the State **shall not** be liable to each other, regardless of the form of action, for consequential, incidental, indirect, or special damages. This limitation of liability **shall not** apply to claims for infringement of United States patent, copyright, trademark or trade secrets; to claims for personal injury or damage to property caused by the gross negligence or willful misconduct of the Vendor; to claims covered by other specific provisions of the Contract calling for damages; or to court costs or attorney's fees awarded by a court in addition to damages after litigation based on the Contract.
- C. Language in these terms and conditions **shall not** be construed or deemed as the State's waiver of its right of sovereign immunity. The Vendor agrees that any claims against the State, whether sounding in tort or in contract, **shall** be brought before the Arkansas Claims Commission as provided by Arkansas law, and **shall** be governed accordingly.

5.5 **RECORD RETENTION**

- A. The Vendor **shall** maintain all pertinent financial and accounting records and evidence pertaining to the contract in accordance with generally accepted principles of accounting and as specified by the State of Arkansas Law. Upon request, access **shall** be granted to State or Federal Government entities or any of their duly authorized representatives.
- B. Financial and accounting records **shall** be made available, upon request, to the State of Arkansas's designee(s) at any time during the contract period and any extension thereof, and for five (5) years from expiration date and final payment on the contract or extension thereof.
- C. Other sections of this *Bid Solicitation* may contain additional Requirements regarding record retention.

5.6 **CONFIDENTIALITY**

- A. The Vendor, Vendor's subsidiaries, and Vendor's employees **shall** be bound to all laws and to all Requirements set forth in this *Bid Solicitation* concerning the confidentiality and secure handling of information of which they may become aware of during the course of providing services under a resulting contract.

- B. Consistent and/or uncorrected breaches of confidentiality may constitute grounds for cancellation of a resulting contract, and the State **shall** have the right to cancel the contract on these grounds.
- C. Previous sections of this *Bid Solicitation* may contain additional confidentiality Requirements.

5.7 **CONTRACT INTERPRETATION**

Should the State and Vendor interpret specifications or contract terms differently, either party may request clarification. However if an agreement cannot be reached, the determination of the State **shall** be final and controlling.

5.8 **CANCELLATION**

- A. In the event the State no longer needs the service or commodity specified in the contract or purchase order due to program changes, changes in laws, rules, or regulations, relocation of offices, or lack of appropriated funding. The State **shall** give the Vendor written notice of cancellation, specifying the terms and the effective date of contract termination. The effective date of termination **shall** be 30 days from the date of notification, unless a longer timeframe is specified in the notification.
- B. Upon default of a Vendor, the State **shall** agree to pay only sums due for goods and services received and accepted up to cancellation of the contract.

5.9 **SEVERABILITY**

If any provision of the contract, including items incorporated by reference, is declared or found to be illegal, unenforceable, or void, then both the agency and the Vendor **shall** be relieved of all obligations arising under such provision. If the remainder of the contract is capable of performance, it **shall not** be affected by such declaration or finding and **shall** be fully performed.

SECTION 6 – STANDARD TERMS AND CONDITIONS

- **Do not provide responses to items in this section.**
- 1. **GENERAL:** Any special terms and conditions included in this solicitation **shall** override these Standard Terms and Conditions. The Standard Terms and Conditions and any special terms and conditions **shall** become part of any contract entered into if any or all parts of the bid are accepted by the State of Arkansas.
- 2. **ACCEPTANCE AND REJECTION:** The State **shall** have the right to accept or reject all or any part of a bid or any and all bids, to waive minor technicalities, and to award the bid to best serve the interest of the State.
- 3. **BID SUBMISSION:** Original Proposal Packets **must** be submitted to the Office of State Procurement on or before the date and time specified for bid opening. The Proposal Packet **must** contain all documents, information, and attachments as specifically and expressly required in the *Bid Solicitation*. The bid **must** be typed or printed in ink. The signature **must** be in ink. Unsigned bids **shall** be disqualified. The person signing the bid should show title or authority to bind his firm in a contract. Multiple proposals **must** be placed in separate packages and should be completely and properly identified. Late bids **shall not** be considered under any circumstances.
- 4. **PRICES:** Bid unit price F.O.B. destination. In case of errors in extension, unit prices **shall** govern. Prices **shall** be firm and **shall not** be subject to escalation unless otherwise specified in the *Bid Solicitation*. Unless otherwise specified, the bid **must** be firm for acceptance for thirty days from the bid opening date. "Discount from list" bids are not acceptable unless requested in the *Bid Solicitation*.
- 5. **QUANTITIES:** Quantities stated in a *Bid Solicitation* for term contracts are estimates only, and are not guaranteed. Vendor **must** bid unit price on the estimated quantity and unit of measure specified. The State may order more or less than the estimated quantity on term contracts. Quantities stated on firm contracts are actual Requirements of the ordering agency.
- 6. **BRAND NAME REFERENCES:** Unless otherwise specified in the *Bid Solicitation*, any catalog brand name or manufacturer reference used in the *Bid Solicitation* is descriptive only, not restrictive, and used to indicate the type and quality desired. Bids on brands of like nature and quality will be considered. If bidding on other than referenced specifications, the bid **must** show the manufacturer, brand or trade name, and other descriptions, and should include the manufacturer's illustrations and complete descriptions of the product offered. The State **shall** have the right to determine whether a substitute offered is equivalent to and meets the standards of the item specified, and the State may require the Vendor to supply additional descriptive material. The Vendor **shall** guarantee that the product offered will meet or exceed specifications identified in this *Bid Solicitation*. Vendors not bidding an alternate to the referenced brand name or manufacturer **shall** be required to furnish the product according to brand names, numbers, etc., as specified in the solicitation.
- 7. **GUARANTY:** All items bid **shall** be newly manufactured, in first-class condition, latest model and design, including, where applicable, containers suitable for shipment and storage, unless otherwise indicated in the *Bid Solicitation*. The Vendor hereby guarantees that everything furnished hereunder **shall** be free from defects in design, workmanship and material, that if sold by drawing, sample or specification, it **shall** conform thereto and **shall** serve the function for which it was furnished. The Vendor **shall** further guarantee that if the items furnished hereunder are to be installed by the Vendor, such items **shall** function properly when installed. The Vendor **shall** guarantee that all applicable laws have been complied with relating to construction, packaging, labeling and registration. The Vendor's obligations under this paragraph **shall** survive for a period of one year from the date of delivery, unless otherwise specified herein.
- 8. **SAMPLES:** Samples or demonstrators, when requested, **must** be furnished free of expense to the State. Each sample should be marked with the Vendor's name and address, bid or contract number and item number. If requested, samples that are not destroyed during reasonable examination will be returned at Vendor's expense. After reasonable examination, all demonstrators will be returned at Vendor's expense.
- 9. **TESTING PROCEDURES FOR SPECIFICATIONS COMPLIANCE:** Tests may be performed on samples or demonstrators submitted with the bid or on samples taken from the regular shipment. In the event products tested fail to meet or exceed all conditions and Requirements of the specifications, the cost of the sample used and the reasonable cost of the testing **shall** be borne by the Vendor.
- 10. **AMENDMENTS:** Vendor's proposals cannot be altered or amended after the bid opening except as permitted by regulation.
- 11. **TAXES AND TRADE DISCOUNTS:** Do not include State or local sales taxes in the bid price. Trade discounts should be deducted from the unit price and the net price should be shown in the bid.
- 12. **AWARD:** Term Contract: A contract award will be issued to the successful Vendor. It results in a binding obligation without further action by either party. This award does not authorize shipment. Shipment is authorized by the receipt of a purchase order from the ordering agency. Firm Contract: A written State purchase order authorizing shipment will be furnished to the successful Vendor.
- 13. **DELIVERY ON FIRM CONTRACTS:** This solicitation shows the number of days to place a commodity in the ordering agency's designated location under normal conditions. If the Vendor cannot meet the stated delivery, alternate delivery schedules may become a factor in an award. The Office of State Procurement **shall** have the right to extend delivery if reasons appear valid. If the date is not acceptable, the agency may buy elsewhere and any additional cost **shall** be borne by the Vendor.

- 14. DELIVERY REQUIREMENTS:** No substitutions or cancellations are permitted without written approval of the Office of State Procurement. Delivery **shall** be made during agency work hours only 8:00 a.m. to 4:30 p.m. Central Time, unless prior approval for other delivery has been obtained from the agency. Packing memoranda **shall** be enclosed with each shipment.
- 15. STORAGE:** The ordering agency is responsible for storage if the contractor delivers within the time required and the agency cannot accept delivery.
- 16. DEFAULT:** All commodities furnished **shall** be subject to inspection and acceptance of the ordering agency after delivery. Back orders, default in promised delivery, or failure to meet specifications **shall** authorize the Office of State Procurement to cancel this contract or any portion of it and reasonably purchase commodities elsewhere and charge full increase, if any, in cost and handling to the defaulting contractor. The contractor **must** give written notice to the Office of State Procurement and ordering agency of the reason and the expected delivery date. Consistent failure to meet delivery without a valid reason may cause removal from the Vendors list or suspension of eligibility for award.
- 17. VARIATION IN QUANTITY:** The State assumes no liability for commodities produced, processed or shipped in excess of the amount specified on the agency's purchase order.
- 18. INVOICING:** The contractor **shall** be paid upon the completion of all of the following: (1) submission of an original and the specified number of copies of a properly itemized invoice showing the bid and purchase order numbers, where itemized in the *Bid Solicitation*, (2) delivery and acceptance of the commodities and (3) proper and legal processing of the invoice by all necessary State agencies. Invoices **must** be sent to the "Invoice To" point shown on the purchase order.
- 19. STATE PROPERTY:** Any specifications, drawings, technical information, dies, cuts, negatives, positives, data or any other commodity furnished to the contractor hereunder or in contemplation hereof or developed by the contractor for use hereunder **shall** remain property of the State, **shall** be kept confidential, **shall** be used only as expressly authorized, and **shall** be returned at the contractor's expense to the F.O.B. point provided by the agency or by OSP. Vendor **shall** properly identify items being returned.
- 20. PATENTS OR COPYRIGHTS:** The contractor **must** agree to indemnify and hold the State harmless from all claims, damages and costs including attorneys' fees, arising from infringement of patents or copyrights.
- 21. ASSIGNMENT:** Any contract entered into pursuant to this solicitation **shall not** be assignable nor the duties thereunder delegable by either party without the written consent of the other party of the contract.
- 22. CLAIMS:** Any claims the Contractor may assert under this Agreement shall be brought before the Arkansas State Claims Commission ("Commission"), which shall have exclusive jurisdiction over any and all claims that the Contractor may have arising from or in connection with this Agreement. Unless the Contractor's obligations to perform are terminated by the State, the Contractor shall continue to provide the Services under this Agreement even in the event that the Contractor has a claim pending before the Commission.
- 23. CANCELLATION:** In the event, the State no longer needs the commodities or services specified for any reason, (e.g., program changes; changes in laws, rules or regulations; relocation of offices; lack of appropriated funding, etc.), the State **shall** have the right to cancel the contract or purchase order by giving the Vendor written notice of such cancellation thirty (30) days prior to the date of cancellation.
- Any delivered but unpaid for goods will be returned in normal condition to the contractor by the State. If the State is unable to return the commodities in normal condition and there are no funds legally available to pay for the goods, the contractor may file a claim with the Arkansas Claims Commission under the laws and regulations governing the filing of such claims. If upon cancellation the contractor has provided services which the State has accepted, the contractor may file a claim. **NOTHING IN THIS CONTRACT SHALL BE DEEMED A WAIVER OF THE STATE'S RIGHT TO SOVEREIGN IMMUNITY.**
- 24. DISCRIMINATION:** In order to comply with the provision of Act 954 of 1977, relating to unfair employment practices, the Vendor agrees that: (a) the Vendor **shall not** discriminate against any employee or applicant for employment because of race, sex, color, age, religion, handicap, or national origin; (b) in all solicitations or advertisements for employees, the Vendor **shall** state that all qualified applicants **shall** receive consideration without regard to race, color, sex, age, religion, handicap, or national origin; (c) the Vendor will furnish such relevant information and reports as requested by the Human Resources Commission for the purpose of determining compliance with the statute; (d) failure of the Vendor to comply with the statute, the rules and regulations promulgated thereunder and this nondiscrimination clause **shall** be deemed a breach of contract and it may be cancelled, terminated or suspended in whole or in part; (e) the Vendor **shall** include the provisions of above items (a) through (d) in every Subcontract so that such provisions **shall** be binding upon such Subcontractor or Vendor.
- 25. CONTINGENT FEE:** The Vendor guarantees that he has not retained a person to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee, except for retention of bona fide employees or bona fide established commercial selling agencies maintained by the Vendor for the purpose of securing business.
- 26. ANTITRUST ASSIGNMENT:** As part of the consideration for entering into any contract pursuant to this solicitation, the Vendor named on the *Proposal Signature Page* for this solicitation, acting herein by the authorized individual or its duly authorized agent, hereby assigns, sells and transfers to the State of Arkansas all rights, title and interest in and to all causes of action it may have under the antitrust laws of the United States or this State for price fixing, which causes of action have accrued prior to the date of this assignment and which relate solely to the particular goods or services purchased or produced by this State pursuant to this contract.
- 27. DISCLOSURE:** Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that order, **shall** be a material breach of the terms of this contract. Any contractor,

whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy **shall** be subject to all legal remedies available to the agency.