

FIRST AMENDMENT

This Amendment (“Amendment”) is made to the written agreement between _____ (“DMO”) and the Arkansas Department of Human Services (“DHS”), comprising of Request for Proposal No. SP-17-0011 and all attachments, exhibits, and appendices thereto (collectively the “Agreement”), and is effective as of January 1, 2020.

WHEREAS the DMO and DHS have previously entered into the Agreement for the provision of managed care Dental Services under Arkansas Medicaid;

WHEREAS the DMO and DHS wish to now add certain new terms and/or conditions to the Agreement and amend certain existing terms and/or conditions of the Agreement as required by the federal regulations governing managed care (42 CFR, Part 438), as outlined herein;

WHEREAS in the event that any terms and/or conditions in this Amendment conflict with the terms and/or conditions in the Agreement, the terms and/or conditions of this Amendment will govern; and

WHEREAS unless otherwise specified in this Amendment, the terms and/or conditions in the Agreement shall remain in full force and effect.

Section 1: Definitions and Acronyms

Definitions contained in the Agreement apply, unless otherwise defined herein.

Agreement

The written agreement between the DMO and DHS, comprising Request for Proposal No. SP-17-0011 and all attachments, exhibits, and appendices thereto.

Appellant

An individual or entity who challenges an Adverse Benefit Determination of the DMO.

Auto Assignment

The process by which DHS assigns a newly eligible Enrolled Member among the active DMOs.

Capitated Payment

The aggregate amount paid monthly by DHS to the DMO for the provision of Medically Necessary Covered Services to Enrolled Members, including value-added services, in accordance with the Capitated Rates.

Capitated Rate

A fixed predetermined fee paid by DHS to the DMO each month in accordance with the Agreement, for each Enrolled Member in a defined rate cell, in exchange for the DMO arranging for or providing a defined set of Covered Services to such an Enrolled Member, regardless of the amount of Medically Necessary Covered Services actually used by the Enrolled Member that are within the defined limits as stated in the Agreement.

Client

Has the same meaning as “beneficiary” in the Agreement, and can be used interchangeably.

Co-Payment

A fixed amount that an Enrolled Member must pay for a Covered Service after having satisfied any applicable deductible.

Enrolled Member

A Medicaid beneficiary who is eligible to be enrolled in the Healthy Smiles program and is either subject to Auto Assignment or chooses to enroll in the DMO during the open enrollment period.

Fair 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 Medicaid fair hearings in Arkansas: a) Provider initiated - conducted by administrative law judges from ADH and governed, in part, by provisions of the Arkansas Medicaid Fairness Act in addition to CMS and Arkansas State Plan policies and regulations, and b) Beneficiary initiated – conducted by administrative law judges from DHS and governed by CMS and Arkansas State Plan policies and regulations.

FFS

Fee for Service

Healthy Smiles

The Arkansas Dental Managed Care Program, as approved by CMS in AR.0008.

MFCU

Medicaid Fraud Control Unit, the division of the Arkansas Attorney General’s Office that investigates and prosecutes cases of Medicaid Fraud.

MLR

Medical Loss Ratio, the calculation of the MLR is defined at 42 CFR § 438.8.

Network Provider

Providers who contract with the DMO to provide services to the DMO's Enrolled Members.

OMIG

Office of Medicaid Inspector General, which performs the Program Integrity functions for Arkansas Medicaid.

Open Enrollment Period

A time period established by DHS that will last at least forty-five (45) days. Open enrollment will occur on a yearly basis.

PAHP

Prepaid Ambulatory Health Plan, an entity that provides services to beneficiaries under contract with a state, and on the basis of capitation payments, or other payment arrangements that do not use state plan payment rates. A PAHP does not provide or arrange for and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its beneficiaries; and a PAHP does not have a comprehensive risk contract. The Dental Managed Care Organizations (DMOs) are PAHPs.

Potential Member

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.

Prior Authorization

An approval required from the DMO before the provision of a Covered Service.

Provider Incentive Plan

A compensation arrangement with Network Providers that is designed to increase quality of services provided and decrease waste and overuse of services. Examples of Provider Incentive Plans include, but are not limited to, value-based payments, capitation arrangements, bonus payments, or payment withholds.

Provider Preventable Condition

A healthcare acquired infection or other preventable condition, as defined by the state, that Medicaid is prohibited from paying for under 42 CFR S 447.26.

Section 2: Eligibility, Enrollment, and Disenrollment

2.1 Eligibility

- 2.1.1 All Arkansas Medicaid beneficiaries who are eligible for dental benefits will be enrolled in a DMO except for:
- a. The Spend Down Population.
 - b. Medicaid beneficiaries who are fully admitted to a Human Development Center (HDC).
 - c. Medicaid beneficiaries who are only enrolled in the ARChoices in Homecare or Independent Choices programs or a successor waiver for the elderly or physically disabled.
 - d. Medicaid beneficiaries who are enrolled in the Program for All Inclusive Care for the Elderly (PACE) (42 CFR § 460 et seq.).
 - e. Adults made eligible for Medicaid under the Patient Protection and Affordable Care Act (42 U.S.C. §§ 18001 et seq.), unless the individual is designated as American Indian or Alaskan Native and elects to remain in the FFS Medicaid program.
 - f. Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

2.2 Auto Assignment

- 2.2.1 A newly identified Enrolled Member that meets the criteria for mandatory enrollment will be assigned into the DMO based upon the following rules:
- a. Enrolled Members will be auto assigned to the DMO based upon proportional assignment. Under proportional assignment, the first Enrolled Member is assigned to DMO A, the next to DMO B, the next to DMO A, the next to DMO B, etc.
 - b. The proportional assignment methodology will be utilized to assign Enrolled Members to the DMO, unless at least one of the following conditions exists:
 1. The DMO fails to meet specified quality metrics as defined in Attachment A and DHS notifies the DMO that it will no longer receive Auto Assignments; or
 2. The DMO is subject to a sanction, including a moratorium on having members assigned.
- 2.2.2 An Enrolled Member may voluntarily transition from their assigned DMO and choose another DMO within ninety (90) calendar days of Auto Assignment. An Enrolled Member will not be permitted to change his/her DMO more than once within a twelve-month period, unless:
- a. The change occurs during the open enrollment period; or
 - b. There is cause for transition, as described in 42 CFR § 438.56, and Section 2.4.1 of this Amendment (“for cause” transition).

2.3 Enrollment

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

- 2.3.2 The execution of enrollments will occur daily, and the results of the enrollment will be sent to the DMO nightly in the daily 834-file.
- 2.3.3 DHS reserves the right, upon advanced written notice to the DMO, to cap enrollment of additional members to the DMO for any of the following reasons, as determined by DHS, in its sole discretion:
 - a. Consistently poor-quality performance;
 - b. Inadequate Network capacity;
 - c. High number of Enrolled Member complaints about the DMO's services or access to care;
 - d. Financial solvency concerns; or
 - e. Failure to meet quality metrics outlined in Attachment A or the Performance Indicators outlined in Attachment B.
- 2.3.4 Anti-Discrimination Policy:
 - a. The DMO must accept new enrollment from Potential Members in the order in which they apply without restriction, unless enrollment is capped by DHS, up to the limits set under the Agreement.
 - b. The DMO is prohibited from discriminating against Potential Members eligible to enroll on the basis of health status or need for health care services.
 - c. The DMO is prohibited from discriminating against Potential Members eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability.

2.4 Transition

- 2.4.1 DHS shall complete transition of an Enrolled Member from the DMO, as follows:
 - a. For cause, at any time, and in accordance with 42 CFR § 438.56. For cause reasons for transition include:
 - 1. The DMO is sanctioned pursuant to the Agreement, this Amendment, the Healthy Smiles Waiver, or any applicable state or federal law.
 - 2. The Enrolled Member loses Medicaid eligibility.
 - 3. The Enrolled Member needs related services to be performed at the same time, and not all related services are available within the Network of the DMO. The Enrolled Member's PCD or other provider must determine that receiving the related services separately would subject the enrollee to unnecessary risk.
 - 4. The DMO does not, because of moral or religious objections, cover the services the Enrolled Member seeks; or
 - 5. Any other reason that rises to the level of good cause, including poor quality of care, lack of access to services covered under the Agreement, or lack of access to providers experienced in dealing with the Enrolled Member's care needs. Other just cause reasons will be determined by DHS, in its sole discretion.

- b. Without cause, the member may transition to a different DMO for any reason at one of the following times:
 - 1. Within the first ninety (90) calendar days after initial enrollment or re-enrollment (or within the first ninety (90) days after notification of initial enrollment, whichever is later), or
 - 2. During the annual Open Enrollment Period.
 - c. If no action is taken by the Enrolled Member during one of the times set out in paragraph (b) above, he/she will remain in the DMO and will not be permitted to transition to a new DMO, unless for cause, during the next year.
- 2.4.2 The Enrolled Member (or his or her representative) must request transition by submitting an oral or written request to DHS's enrollment vendor.
- 2.4.3 The DMO is not authorized to process transition requests. If the DMO receives a transition request from an Enrolled Member, the DMO shall forward the request to DHS's enrollment vendor.
- 2.4.4 DHS shall process transitions with an effective date that is no later than the first day of the second month following the month in which the Enrolled Member requested a transition.
- a. A transition is effective at midnight on the date provided in the enrollment or disenrollment file.
 - b. If DHS fails to make a transition determination within a specified time, the transition is considered approved for the effective date that would have been established had DHS made a determination in the specified timeframe.
- 2.4.5 The DMO must implement transition policies and procedures that, at a minimum:
- a. Ensure that it does not restrict the Enrolled Member's right to voluntarily transition to a different DMO, in accordance with this Amendment, in any way; and
 - b. Are consistent with the federal requirements outlined in 42 CFR § 438.62.
- 2.4.6 The DMO and its subcontractors, providers and vendors must assist in the transition of an Enrolled Member from its DMO to another, and vice versa.
- 2.4.7 The DMO may not request that an Enrolled Member be transitioned to a different DMO unless it completes the following process:
- a. Submits a request for transition to DHS's designated reviewer for approval. The request must be made in writing and must specify the reason for transition.
 - b. The DMO cannot request transition of an Enrolled Member for the following reasons:
 - 1. An adverse change in the Enrolled Member's health status;
 - 2. Due to the Enrolled Member's utilization of services;
 - 3. Due to the Enrolled Member's diminished mental capacity; or
 - 4. Due to the Enrolled Member's uncooperative or disruptive behavior resulting from his or her special needs (except when failure to transition seriously impairs the ability of the DMO to furnish services to this Enrolled

- Member or other Enrolled Members).
- c. If DHS approves the request, the DMO must continue to provide services to the Enrolled Member until DHS sends notice to the Enrolled Member of the transition, the reason for the transition, the new DMO and the effective date of the transition.
 - d. Once transition is approved, the current DMO must assist in the transition of the member.

2.5 Disenrollment

- 2.5.1 Disenrollment shall be based solely upon a determination by DHS that an Enrolled Member is no longer eligible to receive DMO services.
- 2.5.2 Disenrollment will occur only because of the following:
 - a. The Enrolled Member loses Medicaid eligibility.
 - b. The Enrolled Member is placed in a setting or begins receiving services excluding them from enrollment in Healthy Smiles (see Section 2.1.1).
 - c. The Enrolled Member voluntarily disenrolls from the Healthy Smiles or Medicaid program.
- 2.5.3 The DMO cannot request disenrollment of an Enrolled Member. However, the DMO must alert DHS if it becomes aware that an Enrolled Member may meet one of the criteria listed in 2.5.2.
- 2.5.4 Capitated Payments made by DHS to a DMO on behalf of a disenrolled Enrolled Member will be reconciled to the date of disenrollment.

2.6 Re-Enrollment

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

2.7 Reinstatement

- 2.7.1 An Enrolled Member who was disenrolled from the DMO may be reinstated for the following month with no lapse in coverage if the Enrolled Member re-establishes his/her eligibility and such eligibility is entered into MMIS by the last day of the month of disenrollment, which would generate notification to the DMO that they will continue to be responsible for the Enrolled Member.
- 2.7.2 A lapse in eligibility that is not resolved in the timeframe set out in Section 2.7.1 would

lead to the Enrolled Member not being reinstated for the following month. That Enrolled Member would be disenrolled from the DMO.

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

Section 3: Enrolled Member Information and Services

3.1 General Information Requirements

- 3.1.1 The DMO must provide information to Enrolled Members in accordance with 42 CFR § 438.10. Additionally, and in accordance with the CFR, the DMO must notify Enrolled Members, on at least an annual basis, of their right to request and obtain information.
- 3.1.2 The DMO must notify all Enrolled Members when it adopts a policy to discontinue coverage of a service due to moral or religious objections. The notice must be provided at least thirty (30) calendar days prior to the effective date of the policy and must be sent in accordance with the terms of the Agreement and this Amendment.
- 3.1.3 The DMO must make all information provided to Potential and Enrolled Members, whether required by the Agreement or otherwise, accessible, as defined in Section 3.1.4. Additionally, the DMO must notify all Potential or Enrolled Members of their right to accessible information at no additional cost and how to access information in an accessible format.
- 3.1.4 At a minimum, "accessible" means that:
- a. All member communications, including written materials, spoken scripts, and websites must be at or below the sixth (6th) grade comprehension level.
 - b. All written materials must be provided in a font size no smaller than 12-point.
 - c. All written materials critical to obtaining services must be made available in English, Spanish, and Marshallese.
 - d. For all individuals whose primary language is not English, an interpreter must be provided, free of charge, in accordance with the Federal Limited English Proficiency (LEP) regulations.
 - e. Interpretation, either oral or written, of any provided information must be made available in any language spoken by the Enrolled Member or Potential Member.
 - f. All written and oral information must be provided in alternative formats, when appropriate, and in a manner that takes into consideration an Enrolled Member's special needs, including any visual impairment, hearing impairment, limited reading proficiency, or limited English proficiency.
 - g. Auxiliary aids and services must be made available upon request for Enrolled Members and Potential Members with disabilities.
 - h. A Teletypewriter Telephone/Text Telephone (TTY/TDY) number must be provided for Enrolled Members and Potential Members.
 - i. All written materials must be available in large print. Large print means printed in a font size no smaller than 18-point.
- 3.1.5 All information provided to Potential Enrollees must be provided in accordance with 42 CFR 438.10(e).

3.2 Member Handbook

- 3.2.1 In addition to the requirements set out in the Agreement, as of the Effective Date the member handbook must meet the requirements set forth in 42 CFR § 438.10(g), including, at a minimum:

- a. The terms, conditions, and procedures for enrollment and disenrollment, including reinstatement;
- b. The Enrolled Member's rights and responsibilities, as described in Section 3.7 of this Amendment;
- c. How to access information in accessible formats, as described in Sections 3.1.3 and 3.1.4.
- e. A description of services provided by the DMO in sufficient detail to ensure that Enrolled Members understand the services that may be available to them, including the availability of Emergency Care from the DMO, including (i) how Emergency Care is provided; (ii) definitions of what warrants and what constitutes Emergency Care; (iii) that prior authorizations are not required for Emergency Care; and (iv) that an Enrolled Member may use *any* hospital or other setting for Emergency Care, regardless of whether it is a Network Provider for the DMO.
- f. Any limitations and general restrictions on provider access, exclusions from use of out-of-network providers, including how to access those providers.
- g. Procedures for obtaining required services, including second opinions, at no cost to the Enrolled Member (in accordance with 42 CFR § 438.206(b)(3) and authorization requirements, including service authorization documentation requirements, any services available without prior authorization, and information about the extent to which, and how, after-hours care is provided.
- h. Describe services not covered by the Agreement or this Amendment, as well as how and where to access any benefits that are available under the Arkansas Medicaid State Plan but are not covered under the Agreement or this Amendment.
- i. Procedures for reporting Medicaid fraud, waste, abuse and overpayment.
- j. Information on the right to file a Grievance or appeal an Adverse Benefit Determination, and the procedure by which a Grievance or Appeal may be filed, including the address, toll-free telephone number, and hours of the DMO's Appeals and Grievance staff and the availability of assistance with filing a Grievance or Appeal.
- k. Information on the right to a Fair Hearing through DHS and the procedures for filing a request for a Fair Hearing, including the DHS-approved timeframes, the address for filing a request for Fair Hearing, and the availability of assistance with requesting a Fair Hearing.
- l. Notice that an Enrolled Member has the right to continue services upon appeal of a denial of services, but that the Enrolled Member may have to pay for the denied services if there is an Adverse Benefit Determination.
- m. Notice of Privacy Practices for Protected Health Information, as required by the HIPAA Privacy Rule, 45 CFR § 164.520.
- n. Procedures for reporting abuse, neglect or exploitation of the Enrolled Member by the DMO, its subcontractor, or a provider providing services on behalf of the DMO.
- o. Notice of the right to file a complaint against the DMO, any of its subcontractors, or Network Providers; and information on the procedure for filing a complaint;
- p. Directions for how to obtain the following information about the DMO, upon request:
 1. The DMO's non-discrimination policies and the individual responsible for overseeing those policies, as well as responding to accessibility and

- 2. discrimination claims made against the DMO (*see* Section 2.3.4); and
 - 2. A list of any services not provided by the DMO due to moral or religious objections, and how the Enrolled Member may obtain information on those services and how to access them through DHS.
 - 3. Currently effective practice guidelines.
 - q. Explain how to access transportation services, such as those currently offered by Arkansas Medicaid.
 - r. Explain that Covered Services provided by the DMO are available at no cost to the Enrolled Member and without point-of-service cost sharing responsibilities, except that Enrolled Members covered by ARKids B shall be subject to point-of-service cost sharing obligations for some services.
- 3.2.2 The DMO must make the member handbook available to Enrolled Members in accordance with Section 3.1.5, within at least ten (10) business days of enrollment.
- 3.2.3 The DMO is required to provide each Enrolled Member notice of any significant changes of the information specified in the Member Handbook, at least thirty (30) calendar days before the effective date of the change. A significant change is one that materially affects the Enrolled Members' rights, access, or list of available services.

3.3 Provider Directory

- 3.3.1 In addition to the requirements set out in the Agreement, as of the Effective Date the DMO must maintain a provider directory that meets the requirements set out in 42 CFR 438.10(h), including, at a minimum, the following:
- a. Information on each Network Provider, including:
 - 1. Name, street address, and telephone number(s);
 - 2. Group affiliations, if any;
 - 4. Website URLs, if any;
 - 5. Specialties, as appropriate;
 - 6. If the provider is accepting new Medicaid Clients;
 - 7. The cultural and linguistic capabilities, including the languages offered by the Network Provider or skilled medical interpreter at the Network Provider's office; and
 - 8. Practice limitations, including whether the Network Provider is willing to serve children and adults with special health care needs and whether the Network Provider's practice has age limitations.
 - b. Clearly explains the difference between a Network Provider and an out-of-network provider.
 - c. States that some Network Providers may choose not to perform certain services based on religious or moral beliefs, as required by the Social Security Act (the "Act").
- 3.3.2 Updating the Provider Directory:
- a. The DMO must ensure the paper format provider directory is updated at least monthly and made available to Enrolled Members in accordance with 42 CFR § 438.10.

- b. The DMO must ensure the electronic provider directory is updated no later than thirty (30) calendar days after the DMO receives updated provider information.
- 3.3.3 The DMO must make its provider directory available online, and in print form, upon request. The online version must be in a machine-readable file and format.

3.4 Distribution of Member Information

- 3.4.1 The DMO must mail new informational materials to an Enrolled Member who was disenrolled and subsequently re-enrolled, if:
- a. It has been more than one hundred eighty (180) calendar days since the disenrollment; or
 - b. It has been less than one hundred eighty (180) calendar days since disenrollment and there was a significant change in the member materials during the time he/she was disenrolled.
- 3.4.2 When the DMO provides required information electronically to Potential or Enrolled Members, the DMO must:
- a. Comply with the electronic and information technology accessibility requirements under the federal civil rights laws, including Section 504 and Section 508 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA);
 - c. Provide the material in a format that is accessible as defined in Section 3.1.3 and 3.1.4;
 - d. Place the information on the DMO's website in a location that is prominent and easy to access;
 - e. Provide the information in an electronic format which can be electronically retained and printed;
 - f. Follow the content and language requirements set forth in this Section of the Amendment;
 - g. Notify the Enrolled Member that the information is available in paper form without charge upon request; and
 - h. Provide the information in paper form within five (5) business days of a request.

3.5 DMO Website

In addition to the requirements set out in the Agreement, the DMO's website must be accessible and subject to the marketing material limitations described in Section 3.6 of this Amendment.

3.6 Marketing

Marketing is only allowed in accordance with the criterion set out in the Marketing Guidelines issued by DHS and attached to this Amendment as Attachment C.

3.7 Member Rights Policy

- 3.7.1 The DMO must develop and implement a written policy, in clear and understandable language, to protect Enrolled Member's rights.
- 3.7.2 The DMO must take reasonable action to inform Enrolled Members of their rights and responsibilities by dissemination of the DMO's member handbook.

- 3.7.3 The DMO must ensure the following Enrolled Member rights, at a minimum:
- a. The right to receive information on the DMO in accordance with 42 CFR § 438.10;
 - b. The right to be treated with respect and with due consideration for his or her dignity and privacy;
 - d. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrolled Member's ability to understand;
 - e. The right to participate in decisions regarding his or her care, including the right to refuse treatment;
 - f. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
 - g. The right to choose a Network Provider for any service the Enrolled Member is eligible and authorized to receive;
 - h. As applicable, the right to request and receive a copy of his or her medical records and request that they be amended or corrected under HIPAA; and
 - i. The right to obtain needed, available and accessible health care services covered by the DMO.
- 3.7.4 The DMO, its subcontractors, and Network Providers are prohibited from treating an Enrolled Member adversely for exercising his or her rights, as outlined above.

3.8 Cultural Competency Plan

In accordance with 42 CFR § 438.206, the DMO must assist DHS in its efforts to promote the delivery of health care services in a culturally competent manner to all Enrolled Members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

Section 4: Grievances and Appeals

4.1 General Requirements

- 4.1.1 To the extent not covered below, the DMO's Grievance and Appeal System must comply the requirements set forth in § 160.000 and § 190.000 of the Medicaid Provider Manual, and with all applicable federal and state laws, including 42 CFR Part 431, Subpart E (Fair Hearings for Applicants and Beneficiaries) and 42 CFR Part 438, Subpart F (Grievance and Appeal System), the Medicaid Fairness Act, Ark. Code Ann. § 20-77-1701 et seq., and the Arkansas Administrative Procedures Act, Ark. Code Ann. § 25-15-201 et seq.
- 4.1.2 Section 3.7(B)(1)(j)(iii) of the Agreement is hereby deleted. The DMO must ensure that all Adverse Benefit Determinations, Grievance decisions, or Appeal resolutions are made by an Arkansas licensed dentist with the appropriate clinical expertise in treating the Enrolled Member's condition or disease when the following applies:
 - a. The decision involves a denial of services based on lack of medical necessity;
 - b. The decisions involves a denial of an expedited resolution of appeal; or
 - c. The decision involves a clinical issue.
- 4.1.3 The DMO must ensure that the decision makers for Appeals and Grievances do not have a conflict of interest. At a minimum, this means that the decision makers must not be:
 - a. Involved in any previous level of review or decision-making; and
 - b. The subordinate of any individual who was involved in a previous level of review or decision-making.
- 4.1.4 Upon request, the DMO shall give Enrolled Members reasonable assistance in completing all Grievance and Appeal forms and other procedural steps related to Grievances and Appeals, including but not limited to auxiliary aids and services, such as interpreter services and toll-free numbers with TTY/TDD and interpreter services.
- 4.1.5 The DMO shall not take any punitive action against an Enrolled Member or provider for filing or participating in a Grievance or Appeal.

4.2 Appeals

- 4.2.1 The DMO must have an internal Appeal procedure by which an Appellant may challenge an Adverse Benefit Determination by the DMO.
- 4.2.2 The DMO must provide the Appeal procedure to Enrolled Members and providers. Additionally, the DMO must send written notice of significant changes to the Appeal process to all Enrolled Members and Network Providers at least thirty (30) calendar days prior to implementation.
- 4.2.3 At a minimum, the DMO Appeal process must include the following provisions:
 - a. The following individuals may file an Appeal as the Appellant:
 - 1. The Enrolled Member;
 - 2. The Enrolled Member's parent(s) or legal guardian(s) in the event that the Enrolled Member is a minor or is not legally competent;
 - 3. An attorney authorized to represent the Enrolled Member;

4. Another authorized representative of the Enrolled Member, including the representative of the Enrolled Member's estate, if the Enrolled Member is deceased; or
 5. A provider that is the subject of an Adverse Benefit Determination, or the provider's legal representative or attorney.
- b. The Appellant may file an Appeal with the DMO, orally or in writing, at any time within sixty (60) calendar days from the date on the notice of the Adverse Benefit Determination.
1. The DMO must ensure that oral requests to appeal are treated as Appeals.
 2. Unless an expedited resolution is requested, the DMO must require the oral filing of an Appeal to be followed by a written, signed appeal request.
 3. The DMO must acknowledge each Appeal in writing, unless the Appellant requests an expedited resolution.
- c. Unless the Appellant requests an expedited resolution, the Appeal must be heard and notice of the appeal resolution sent to the Appellant no later than thirty (30) calendar days from receipt of the Appeal.
1. The timeframe for resolution of an Appeal may be extended for up to fourteen (14) calendar days if the Appellant asks for an extension or the DMO documents that additional information is needed and the delay is in the Enrolled Member's best interest.
 2. The DMO must resolve the Appeal as expeditiously as the Enrolled Member's health requires, and not later than the date the extension expires.
 3. If the timeframe is extended other than at the Appellant's request, the DMO must provide oral notice of the reason for the delay to the Appellant by close of business on the day of the determination, and written notice of the reason for the delay to the Appellant within two (2) calendar days of the determination. The DMO must also inform the Appellant of the right to file a Grievance if he or she disagrees with the decision.
- d. If the DMO fails to adhere to the notice and timing requirements for resolution of the appeal, the Appellant is deemed to have completed the DMO's appeal process, and the Appellant may initiate a fair hearing in accordance with Section 4.2.3(l).
- e. The DMO must have an expedited review process for appeal that must be used when taking the time for a standard resolution could seriously jeopardize the Enrolled Member's life, health or ability to maintain or regain maximum function. The expedited review process must:
1. Require that the Appeal be resolved, and notice provided to the Appellant of the resolution as quickly as the Enrolled Member's health requires, but no longer than seventy-two (72) hours after receipt of the appeal.
 2. Require that the Appellant be informed of the limited time available to present evidence and allegations of fact or law and ensure that the Appellant understands the applicable time limits.
 3. If the request for expedited Appeal is denied, the DMO must immediately transfer the Appeal to the timeframe for standard resolution and notify the Appellant of the applicable timeframes. The receipt of the Appeal does not change.
 4. The timeframe for resolving an expedited Appeal may be extended up to

fourteen (14) calendar days, if the Appellant requests the extension or if the DMO shows that there is a need for additional information and that the delay is in the Enrolled Member's best interest. The DMO must resolve the Appeal as expeditiously as the Enrolled Member's health requires, and not later than the date the extension expires. If the timeframe is extended other than at the Appellant's request, the DMO must provide oral notice of the reason for the delay to the Appellant by close of business on the day of the determination, and written notice of the reason for the delay to the Appellant within two (2) calendar days of the determination. The DMO must also inform the Appellant of the right to file a Grievance if he or she disagrees with the decision.

- f. The DMO must provide to the Appellant, free of charge, all documents and records considered or relied upon by the DMO to make the Adverse Benefit Determination that is the subject of the appeal. This includes, without limitation, the Enrolled Member's case file, medical records, or any other applicable documents or records. These documents and records must be provided sufficiently in advance of the Adverse Benefit Determination to allow the Appellant to review the records and documentation in preparation for their Appeal.
- g. The DMO must provide the Appellant a reasonable opportunity to present evidence and testimony and make allegations of fact and law, either in person or in writing, as requested by the Appellant.
- h. The DMO must ensure the decision maker considers all comments, documents, records and other information submitted by the Appellant, without regard as to whether such information was submitted or considered in the initial Adverse Benefit Determination.
- i. Upon request of the Enrolled Member, or his or her parent(s)/legal guardian(s) in the event that the Enrolled Member is a minor or not legally competent, the DMO must continue the Enrolled Member's benefits during the Appeal, if all of the following requirements are met:
 - 1. The request for Appeal is timely;
 - 2. The DMO Appeal involves the termination, suspension or reduction of previously authorized services or treatment;
 - 3. The services were ordered by an authorized provider;
 - 4. The period covered by the original authorization has not expired; and
 - 5. The Enrolled Member, or his or her parent(s)/legal guardian(s) in the event that the Enrolled Member is a minor or not legally competent, timely files for continuation of benefits in accordance with the DMO's policy.
- j. If, at the Enrolled Member's request, the DMO continues or reinstates the benefits while the Appeal is pending, the benefits must be reinstated promptly and continue during the Appeal, until one of the following occurs:
 - 1. The Appellant withdraws the Appeal.
 - 2. The Enrolled Member, or the Enrolled Member's parent/legal guardian in the event that the Enrolled Member is a minor or not legally competent, withdraws the request for continuation of benefits.
 - 3. The appeal resolution is unfavorable to the Enrolled Member and the Appellant fails to request a Fair Hearing and continuation of benefits within

ten (10) calendar days after the resolution notice is sent.

- k. If the final resolution of the Appeal or Fair Hearing is adverse to the Appellant, the DMO may recover the cost of services furnished to the Enrolled Member while the Appeal or Fair Hearing was pending to the extent the services were furnished solely because of the requirements for continuation of benefits.
- l. The DMO must provide the Appellant with written notice of the resolution of the Appeal in a format that has been approved by DHS and includes the following:
 - 1. The resolution of the Appeal and the date it was completed;
 - 2. If not decided wholly in the Appellant’s favor, information on the right to request a Fair Hearing within one hundred twenty (120) calendar days of the decision and how to do so, including the address, phone number and email for Fair Hearings, as shown below:

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

- 3. A statement on the right to request the continuation of benefits during the Fair Hearing process, how to request the continuation of benefits, and the statement that the Enrolled Member may have to pay for the cost of those benefits if the Medicaid Fair Hearing upholds the DMO’s appeal resolution.
- m. For expedited appeals, provide oral notice of the resolution to the Appellant by close of business on the day of the resolution and provide written notice in accordance with paragraph (l), above, to the Appellant within two (2) calendar days of the resolution of the expedited appeal.

4.3 Grievance Procedure

- 4.3.1 The DMO must have an internal grievance procedure that complies with 42 CFR § 438.402.
- 4.3.2 All Enrolled Members and Network Providers must receive information on how to access the DMO’s Grievance Procedure, in accordance with 42 CFR 438.10. Any changes must be approved by DHS.
- 4.3.3 At a minimum, the grievance process must meet the following requirements:
 - a. The following must be allowed to file a Grievance:
 - 1. The Enrolled Member, or his or her parent(s)/legal guardian(s) in the event that the Enrolled Member is a minor or not legally competent;
 - 2. A direct service provider, whether in-network or not; or
 - 3. An authorized representative on behalf of either (1) or (2).
 - b. A Grievance may be filed either orally or in writing.

- c. The DMO must resolve each Grievance as expeditiously as the Enrolled Member's health condition requires, not to exceed ninety (90) calendar days from the date the DMO receives the Grievance, whether orally or in writing.
- d. The timeframe to resolve the Grievance may be extended up to fourteen (14) calendar days if:
 - 1. The Enrolled Member requests the extension; or
 - 2. The DMO determines there is a need for additional information and the delay is in the Enrolled Member's best interest.
- e. If the timeframe is extended not at the request of the Enrolled Member, the DMO must:
 - 1. Make reasonable efforts to give the Enrolled Member prompt oral notice of the delay; and
 - 2. Give the Enrolled Member written notice of the delay within two (2) calendar days of the decision. The written notice must include the reason for the extension and describe the Enrolled Member's right to file a Grievance if he or she disagrees.
- f. The DMO must provide a written resolution of the grievance to the Enrolled Member, that includes a summary of the Grievance received and the right to request an Appeal if the grievance is not resolved entirely in the Enrolled Member's favor.
 - 1. The written resolution must conform to the requirements set out in Section 4.2.3(1), above.
 - 2. The resolution must be written in such a way as not to violate HIPAA.

Section 5: Services

5.1 General Requirements

- 5.1.1 The DMO must provide services to all Enrolled Members in accordance with the terms of the Agreement and this Amendment.
- 5.1.2 The DMO must ensure that services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished.
- 5.1.3 The DMO shall not arbitrarily deny or reduce the amount, duration or scope of a Medically Necessary service solely because of the diagnosis, type of illness, or condition of the Enrolled Member. However, the DMO may place appropriate limits on a service for utilization control, provided the services furnished:
 - a. Reasonably achieve their desired purpose;
 - b. Are authorized in a manner that reflects the Enrolled Member's need for services to treat his or her dental or medical condition.
- 5.1.4 The DMO shall not provide any incentive, monetary, or otherwise, to providers for withholding Medically Necessary services or otherwise to the detriment of the Enrolled Member.
- 5.1.5 If the DMO elects not to provide, reimburse for, or provide coverage of a service because of an objection on moral or religious grounds, it must:

- a. Furnish information about services it elects not to provide prior to signing the Agreement or immediately upon the adoption of such a policy during the contract term; and
 - b. Furnish information about how those services may be accessed by Enrolled Members outside of the DMO.
- 5.1.6 When the DMO makes an Adverse Benefit Determination, the DMO must send notice of the Adverse Benefit Determination to the Enrolled Member and applicable provider as required by 42 CFR 438.404.
- a. The DMO may shorten the period of advance notice to five (5) calendar days before the date of the action, if the DMO has facts indicating that the action should be taken because of probable fraud by the Enrolled Member, and the facts have been verified, if possible, through secondary sources.
 - b. The DMO may send a notice not later than the date of action, if:
 - 1. The Enrolled Member has died;
 - 2. The DMO receives a clear written statement, signed by the Enrolled Member or authorized representative, that:
 - (i) Requests service termination or
 - (ii) Has information that requires services termination or deduction and indicates the Enrolled Member understands that service termination or reduction will result;
 - 2. The Enrolled Member has been admitted to a service location or enrolled in a service program where he or she is ineligible for enrollment in Healthy Smiles.
 - 3. The Enrolled Member's address is determined unknown based on return mail with no forwarding address;
 - 4. The Enrolled Member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
 - c. The notice of Adverse Benefit Determination must contain the following:
 - 1. The type and amount of services requested;
 - 2. The Adverse Benefit Determination taken by the DMO; and
 - 3. A statement of the basis of the Adverse Benefit Determination, including the facts that support the action/decision and the source of those facts.
 - d. The DMO must not terminate or reduce the services until a decision is rendered on Appeal and the notice of resolution is sent in accordance with Section 4.2.3(l) of this Amendment, unless the following requirements are met:
 - 1. The notice of Adverse Benefit Determination informs the Enrolled Member that the services are to be reduced or terminated pending an Appeal decision and informs the Enrolled Member of his or her right to request a continuation of services pending resolution of the Appeal.
 - 2. The DMO must follow the requirements laid out in Section 4.2.3(i)-(j) above, regarding continuation of benefits, pending resolution of an Appeal.
 - e. The notice of Adverse Benefit Determination must include:
 - 1. The reasons for the Adverse Benefit Determination, including the right of the Enrolled Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other

information relevant to the enrollee's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards uses in setting coverage limits;

2. The Enrolled Member's right to request an Appeal of the DMO's Adverse Benefit Determination, including information on exhausting the DMO's one level of Appeal and the right to request a Fair Hearing after receiving notice that the Adverse Benefit Determination is upheld;
3. The procedures for exercising the Enrolled Member's rights to Appeal, in accordance with Section 4.2.3(b) of this Amendment; and
4. The circumstances under which an appeal process can be expedited and how to request that (*See* Section 4.2.3(b) and (e), above).

5.1.7 The DMO must have procedures to coordinate provision of and payment for DMO furnished services with services furnished by:

- a. Any other insurance provider, including Medicare or Third-party insurance;
- b. Any other Medicaid MCO, PAHP, or PIHP (as those are defined by CMS); and
- c. Medicaid in the FFS environment.

5.2 Covered services

5.2.1 The DMO must provide, at a minimum, dental services provided under the Arkansas Medicaid State Plan to all Enrolled Members. Covered Services must be provided in an amount, duration and scope that is no less than what is available under FFS Medicaid.

5.2.2 In accordance with 42 CFR § 438.114, the DMO must cover and pay for Emergency Care for an Enrolled Member regardless of whether the provider that furnishes the services is a Network Provider, as long as the requirements of Section 6.2.3 herein are met.

5.3 Primary Care Dentist

- 5.3.1 The DMO's contracts with PCDs must contain the following provisions, at a minimum:
- a. Those requirements set forth in the Agreement.
 - b. Performance standards, as well as sanctions that could be imposed as a result of failure to meet these standards.
 - c. Section 3.5(B)(4)(e) of the Agreement is hereby deleted.

Section 6: Network and Provider Requirements

6.1 Network Adequacy Standards

- 6.1.1 The DMO's network must be supported by written Provider Agreements as described in Section 6.2. The DMO must submit documentation monthly to DHS, in a format specified by DHS, to demonstrate:
- a. That it offers an appropriate range of Dental Services for anticipated enrollment;
 - b. That it has the capacity to serve the expected enrollment in accordance with DHS's standards for access and timeliness of care found in the Agreement and this Amendment; and
 - c. That it maintains a Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrolled Members.
- 6.1.2 The DMO must regularly and systematically monitor the adequacy of its Network in accordance with the standards set forth in the Agreement and this Amendment. The DMO must submit documentation of Network adequacy as specified by DHS, but no less frequently than the following:
- a. At the beginning of the Agreement term;
 - b. On an annual basis;
 - c. Any time there has been a significant change (as defined by DHS) in the DMO's operations that would affect the adequacy of capacity and services, including changes in DMO services, benefits, geographic service area, composition of or payments to its Network; or
 - d. At the enrollment of a new Medicaid eligibility group in the DMO.
- 6.1.3 The DMO is prohibited from discriminating against any dental provider (i.e., limiting his or her participation, reimbursement, or indemnification) who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.
- 6.1.4 If the DMO's Network is unable to provide Medically Necessary Dental Services covered under the Agreement to an Enrolled Member, the DMO must adequately and timely cover the services out of network for as long as the DMO's Network is unable to provide them. This must be provided at no cost to the Enrolled Member.
- 6.1.5 The DMO must provide for a second opinion of a dental treatment, if requested by an Enrolled Member, from a Network Provider or arrange for the Enrolled Member to obtain a second opinion outside the Network.

6.2 Provider Contracting

- 6.2.1 The DMO must enter into Provider Agreements to ensure Network adequacy under Section 6.1 of this Amendment is met. All Provider Agreements must meet the standards set out in both the Agreement and this Amendment.
- 6.2.2 The DMO must ensure that all Network Providers are enrolled Medicaid providers. If DHS determines a Network Provider is not an enrolled Medicaid provider, DHS will provide the DMO with notification. The DMO must work with the Network Provider to have them

enrolled in Medicaid or disenroll the Network Provider from its Network.

- 6.2.3 The DMO may enter into a provisional Provider Agreement with a provider, for up to 120 calendar days, pending the outcome of the provider's screening, credentialing or revalidation by the DMO, however, the provider must be enrolled with Medicaid to receive payment from the DMO.
- 6.2.4 The DMO may not prohibit or restrict a provider acting within the lawful scope of his or her practice from advising or advocating on behalf of an Enrolled Member who is his or her patient, regarding:
 - a. The Enrolled Member's health status or treatment options, including any alternative treatments that may be self-administered.
 - b. Any information the Enrolled Member needs to decide among all relevant treatment options.
 - c. The risks, benefits, and consequences of treatment or non-treatment.
 - d. The Enrolled Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and the right to express preferences about future treatment options.
- 6.2.5 The DMO must implement written policies and procedures for selection and retention of Network Providers.
 - a. These policies and procedures must not discriminate against providers that serve high-risk populations or specialize in areas that require costly treatment. However, the DMO is not precluded from establishing policies and procedures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrolled Members.
 - b. The DMO's policies and procedures for selection of providers must comply with the Arkansas Any Willing Provider law, Ark. Code Ann. § 23-99-801 et seq.
- 6.2.6 The DMO must inform providers and subcontractors, at the time they enter into a Provider Agreement, about:
 - a. Enrolled Member and Provider Grievance, Appeal, and Fair Hearing procedures and timeframes as specified in 42 CFR § 438.400 through 42 CFR § 438.424 and described in Section 4 of this Amendment.
 - b. The Enrolled Member's and provider's right to file Grievances and Appeals.
 - c. The availability of assistance to the Enrolled Member or provider with filing Grievances and Appeals.
 - d. The Enrolled Member's and provider's right to request a Fair Hearing after the DMO has made a determination on an Appeal which is adverse to the Enrolled Member or provider.
 - e. The Enrolled Member's right to request continuation of benefits that the DMO seeks to reduce or terminate during an Appeal or Fair Hearing filing, if filed within the allowable timeframes, although the Enrolled Member may be liable for the cost of any continued benefits while the Appeal or Fair Hearing is pending, if the final decision is adverse to the Enrolled Member.

- 6.2.7 The DMO may negotiate with its Network Providers a unit-based payment, per diem, performance incentive payment, value-based payment, episode of care payment, bundle or global payment arrangement for services provided to Enrolled Members. All such payment arrangements must meet the requirements set out in the Agreement, including, but not limited to, the prohibitions set out in Section 3.4(C)(2)(c) of the Agreement.
- 6.2.8 The DMO may impose reasonable authorization requirements pursuant to Section 6.3; however, the DMO must disseminate practice guidelines regarding these requirements to all Network Providers.
- 6.2.9 The DMO must make a good faith effort to notify Enrolled Members affected by the termination of a Provider Agreement, within thirty (30) calendar days of the termination, and help the Enrolled Members select a new practitioner.
- 6.2.10 The DMO shall, upon request, make available to DHS, all Provider Agreements and amendments thereto.

6.3 Authorizations of Service

- 6.3.1 The DMO may require prior authorization for Covered Services in accordance with the requirements of the Agreement, this Amendment and 42 CFR Part 438. The DMO must make available the list of services requiring prior authorization to Potential and Enrolled Members, as well as Network Providers and out-of-network providers.
- 6.3.2 The DMO must have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services.
 - a. These written policies and procedures must include mechanisms to ensure consistent application of review criteria for authorizations of services.
 - b. These policies and procedures must include consultation with the requesting provider for Dental Services, when appropriate.
 - c. Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested must be made by an individual who has appropriate expertise in addressing the Enrolled Member's service needs. For Dental Services, the decision must be made by a dentist licensed to practice in the State of Arkansas.
 - d. Compensation to individuals or entities that conduct utilization management activities, including prior authorization reviews, must NOT be structured so as to incentivize denying, limiting, or discontinuing Medically Necessary services to any Enrolled Member.
 - e. When a requesting provider indicates, or the DMO determines, that following the standard timeframe could seriously jeopardize the Enrolled Member's life, health, or ability to attain, maintain or regain maximum function, the DMO must make an expedited authorization decision and provide notices as expeditiously as the Enrolled Member's condition requires, but no later than seventy-two (72) hours after receipt of the request for services.
 - f. Service authorization decisions not reached within defined timeframes specified above constitute a denial and Adverse Benefit Determination. The DMO must

provide notice on of the Adverse Benefit Determination and right to Appeal as required in Section 4.2.

6.4 Provider Support Services

- 6.4.1 The DMO must have a process for handling and addressing the resolution of provider complaints, including those concerning claims and payment of claims.
- 6.4.2 The DMO's process for handling and addressing the resolution of provider complaints must be approved by DHS.
- 6.4.3 The process must include a Provider Support Call Center that meets the same requirements as the Member Support Call Center required by the Agreement.

6.5 Out-of-Network Providers

- 6.5.1 The DMO shall reimburse an out-of-network provider for an Enrolled Member who receives Medically Necessary services on or after the beginning date of the service period for the Agreement.
- 6.5.2 The out-of-network provider must be enrolled with Arkansas Medicaid prior to receiving reimbursement.

6.6 Dental Records

- 6.6.1 The DMO must ensure that each provider furnishing services to Enrolled Members, including PCDs, maintains and shares an Enrolled Member's dental records in accordance with professional standards.
- 6.6.2 The DMO must use and disclose individually identifiable health information, such as dental records or any other health or enrollment information that identifies a particular Enrolled Member, in accordance with the confidentiality requirements in 45 CFR, Parts 160 and 164; 42 CFR § 438.208(b)(6); and 42 CFR § 438.224.
- 6.6.3 The DMO must report to DHS consistent with the terms of the HIPAA Business Associate Agreement between the parties, the discovery of any use or disclosure of personal health information (PHI) that is not in compliance with the Agreement, or state or federal law, in a manner and format prescribed by DHS.

6.7 Practice Guidelines

- 6.7.1 The DMO must adopt dental practice guidelines that are based on valid, reliable clinical evidence or a consensus of providers in the dental field.
- 6.7.2 The practice guidelines must consider the needs of the Enrolled Members.
- 6.7.3 The practice guidelines must be adopted in consultation with Network Providers.
- 6.7.4 The DMO must review and update the practices guidelines regularly, as appropriate, but no less than once a year.

- 6.7.5 The practice guidelines must cover, at a minimum, the following:
- a. Utilization management
 - b. Potential and Enrolled Member education and outreach
 - c. Coverage of services
- 6.7.6 The DMO must disseminate the practice guidelines to all effected providers and, upon request, to Enrolled Members and Potential Members.

Section 7: Payment to Providers

7.1 Claims and Provider Payment

- 7.1.1 Without limiting permissible utilization management practices established in accordance with Section 8.6, the DMO must reimburse providers for the delivery of Medically Necessary Dental Services, including services prior authorized in accordance with Section 6.3 of this Amendment.
- 7.1.2 The DMO may deny claims not submitted for payment by the provider (either by mail or electronically) within 365 days of the date of service.
- 7.1.3 The DMO shall develop and maintain an accurate and efficient system for receiving and adjudicating claims for Medically Necessary Dental Services, operated in accordance with all applicable state and federal requirements, including the Arkansas Medicaid Fairness Act. The claims system must meet the requirements of the Agreement.
- 7.1.4 The DMO must NOT pay for an item or service that is:
- a. Furnished by an individual during any period in which there is a pending investigation of a credible allegation of fraud against the individual or entity requesting reimbursement, unless DHS and OMIG determine that there is good cause not to suspend payments.
 - b. Furnished by an individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX, or pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act.
 - c. Furnished at the medical direction or prescription of a dentist, during the period when the dentist is excluded from participation under title V, XVIII or XX or pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).
- 7.1.5 The DMO cannot make payments for any Provider Preventable Conditions in accordance with 42 CFR § 438.3(g). The DMO must track and report on all provider preventable conditions associated with claims for payment that could otherwise be made. The report must include, at a minimum:
- a. Wrong surgical or invasive procedures performed on an Enrolled Member;
 - b. Surgical or invasive procedure being performed on the wrong body part or the wrong Enrolled Member; or
 - c. A service that has a negative consequence on the Enrolled Member.
- 7.1.6 The DMO must develop and maintain sufficient written documentation to support each service for which payment is made.
- 7.1.7 Nothing in this section precludes the DMO from using different reimbursement amounts for different specialties or different practitioners in the same specialty.

- 7.1.8 The DMO must prohibit balance billing by Network Providers and out-of-network providers for Covered Services. This means that the provider may not bill the Enrolled Member directly for any amount not paid by the DMO for the services provided.
- 7.1.9 The DMO must honor any authorizations for services issued by DHS or its contractors prior to enrollment for any newly Enrolled Members. The DMO shall require the provider to submit documentation of an authorization by DHS or its vendor prior to the effective date of DMO enrollment.

7.2 Third Party Liability

- 7.2.1 The DMO is responsible for Third Party Liability (TPL). Medicaid is the payor of last resort, unless specifically prohibited by applicable state or federal law. Therefore, the DMO must pay for Covered Services only after all other sources of payment have been exhausted.
- 7.2.2 The DMO must take reasonable measures to identify potentially legally liable third-party sources, in accordance with the Agreement.
- 7.2.3 The DMO must identify the existence of potentially liable parties using a variety of methods, including referrals, and data mining. The DMO must not pursue recovery in the following circumstances, unless the case has been referred to the DHS or DHS' authorized representative:
 - a. Motor Vehicle Cases
 - b. Other Casualty Cases
 - c. Tortfeasors
 - d. Restitution Recoveries
 - e. Worker's Compensation Cases
- 7.2.4 Upon identification of a potentially liable third party in any of the above situations, the DMO must, within ten (10) business days, report the potentially liable third party to DHS for determination of a mass tort, total plan case, or joint case.
 - a. A "mass tort case" is a case where multiple plaintiffs or a class of plaintiffs have filed a lawsuit against the same tortfeasor(s) to recover damages arising from the same or similar set of circumstances (e.g. class action lawsuits) regardless of whether any reinsurance or FFS payments are involved.
 - b. A "total plan case" is a case where payments for services rendered to the Enrolled Member are exclusively the responsibility of the DMO; no reinsurance or Fee-For-Service payments are involved.
 - c. By contrast, a "joint" case is one where Fee-For-Service payments and/or reinsurance payments are involved. The DMO must cooperate with DHS's authorized representative in all collection efforts.
- 7.2.5 In "total plan cases", the DMO is responsible for performing all research,

investigation, the mandatory filing of initial liens on cases that exceed \$250, lien amendments, lien releases, and payment of other related costs in accordance with DHS guidelines. The DMO must use the DHS-approved casualty recovery correspondence when filing liens and when corresponding to others in regard to casualty recovery. The DMO may retain up to 100% of its recovery collections if all of the following conditions exist:

- a. Total collections received do not exceed the total amount of the DMO's financial liability for the Enrolled Member,
- b. There are no payments made by DHS related to FFS, or applied DHS administrative costs (i.e., lien filing fee, etc.), and,
- c. Such recovery is not prohibited by state or federal law.

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

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

Section 8: QAPI Strategic Plan and Utilization Management

8.1 Quality Assessment and Performance Improvement (QAPI) Strategic Plan

8.1.1 The DMO must establish and implement a Quality Assessment and Performance Improvement (QAPI) Strategic Plan for the services it furnishes to Enrolled Members. The QAPI, and any amendments thereto, must be approved by DHS prior to implementation, and must meet the requirements of the Agreement and 42 CFR § 438.330.

8.2 Performance Improvement Projects (PIPs)

8.2.1 Each PIP must:

- a. Be designed to achieve significant improvement, sustained over time, in dental health outcomes and/or Enrolled Member satisfaction;
- b. Include measurements of performance using objective quality indicators;
- c. Implement interventions to achieve improvement in the access to and quality of care;
- d. Evaluate the effectiveness of the interventions based on the performance measures collected;
- e. Include planning and initiation of activities for increasing or sustaining improvement.

8.2.2 The PIP must address:

- a. The collection and submission of performance measurement data, including any required by CMS or DHS;
- b. The mechanisms to detect both under and over-utilization of services; and
- c. Mechanisms to assess the quality and appropriateness of care furnished to Enrolled Members with special health care needs, as defined by the state in the quality strategy.

8.3 Provider Agreement Arrangements to Improve Quality

8.3.1 Consistent with Section 6.2.7 of this Appendix, the DMO may utilize Provider Incentive Plans to make incentive payments to Network Providers under the Provider Agreement that are based on value. The DMO must make available to DHS, CMS, or their agents any Provider Incentive Plans currently in use.

- a. Incentive payments cannot be based on volume to increase inappropriate utilization (including denial of services).
- b. The incentive payment may not condition participation in the Network on the Network Provider entering into or adhering to intergovernmental transfer agreements.
- c. Provider Incentive Plans cannot allow for payments directly or indirectly through a subcontractor or delegate to induce a reduction or limit of Medically Necessary services to an Enrolled Member.
- d. If the Provider Incentive Plan places the Network Provider at substantial financial risk pursuant to 42 CFR § 422.208(a)(d)) for services that the Network Provider does not furnish itself, the DMO must ensure that all Network Providers at substantial risk have either aggregate or per-patient stop-loss protection in accordance with 42 CFR § 422.208(f).

- 8.3.2 Withhold arrangements may be part of the Provider Agreement. If the DMO utilizes withholding arrangements, the following provisions apply:
- a. The arrangement must be for a fixed period;
 - b. Performance must be measured during the rating period under the contract in which the withhold arrangement is applied;
 - c. The arrangement may not be renewed automatically;
 - d. The arrangement must be made available to both public and private contractors under the same terms of performance;
 - e. The arrangement must not condition DMO participation in the withhold arrangement on the DMO entering into or adhering to intergovernmental transfer agreements; and
 - f. The arrangement must be necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the state's quality strategy.

8.4 Quality Metrics

- 8.4.1 Failure to meet the Quality Measures, as outlined in the Agreement, will result in corrective action or sanctions being taken, up to and including recoupment or capping enrollment, as outlined in Attachment A.
- 8.4.2 The DMO must submit quarterly reports on the quality of the DMO's dental program to DHS, as outlined in the Agreement.

8.5 Encounter Data

- 8.5.1 The DMO is required to submit all Encounter Data for all services provided to Enrolled Members, including value-added services, as required by the Managed Care regulations in 42 CFR § 438.818, the Agreement and this Amendment. The Encounter Data must include characteristics of the Enrolled Member and the provider and must meet data quality standards, as established by CMS and DHS to ensure complete and accurate data for program administration.
- 8.5.2 Weekly Encounter Data submissions must include information on denied claims. The submission of denied claims will begin upon both (a) mutual agreement of all parties and (b) a written statement from DHS' vendors that all systems are ready to exchange denied claims.
- 8.5.3 The accuracy of the Encounter Data must be closely monitored and enforced because Encounter Data is used as the basis for the following by DHS:
- a. Actuarially sound Capitated Payments to the DMO for all Covered Services;
 - b. Determination of the DMO's compliance with the MLR requirement set out in Section 12.2 of the Amendment.
 - c. Determination that the DMO has made adequate provisions against the risk of insolvency.
 - d. Certification that the DMO has complied with the state's requirements of

availability and accessibility of services, including network adequacy.

8.5.4 The DMO must certify all Encounter Data, to the extent required by 42 CFR 438.606. Such certification must be submitted to DHS with the certified data and must be based on the knowledge, information and belief of the Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Medical Officer (CMO) or an individual who has written delegated authority to sign for, and directly reports to the CEO or CFO that all data submitted in conjunction with the Encounter Data and all documents requested by DHS are accurate, truthful, and complete. The DMO must provide the certification at the same time it submits the certified data in the format and within the timeframe required by DHS.

8.6 Utilization Management

8.6.1 The DMO may conduct pre-payment, concurrent, or post-payment medical reviews of all claims, including outlier claims.

8.6.2 Erroneously paid claims are subject to recoupment.

8.6.3 When the DMO requires a concurrent medical review for payment of services, if the DMO is unable to determine services are Medically Necessary through its inability to perform a concurrent medical review process, the lack of medical necessity determination shall not constitute a basis for denial of payment or recoupment of paid claims.

8.6.4 If the DMO determines services are Medically Necessary through prior authorization, the DMO may not later take the position that the services were not Medically Necessary through post-payment review, unless:

- a. The prior authorization was based upon misrepresentation by act or omission;
- b. The services billed were not provided; or
- c. An unexpected change occurred that rendered the services not Medically Necessary.

Section 9: Reporting Requirements

9.1 General Requirements

- 9.1.1 The reporting requirements set out in Section 9 are in addition to other reporting requirements found in the Agreement and do not supplant or supersede those other requirements.
- 9.1.2 Reports shall be submitted in a manner and format agreed upon by the parties, unless otherwise specified herein.
- 9.1.3 DHS shall have the right to amend the list of required reports or the reporting schedule at any time during the term of the Agreement upon notice to the DMO.
- 9.1.4 DHS shall have the right to request ad hoc reports, as needed to meet the objectives of the Healthy Smiles program.
- 9.1.5 Call center reports required under the Agreement must be submitted for both the Enrolled Member Support Call Center and the Provider Support Call Center.

9.2 Adverse Benefit Determinations Records

- 9.2.1 The DMO must maintain an electronic record of all Adverse Benefit Determinations.
 - a. The record must be kept current and be made available to DHS upon request.
 - b. Each long entry must contain, at a minimum:
 - 1. Date of the request for services;
 - 2. Name and Medicaid ID of Enrolled Member;
 - 3. Name of the provider making the request;
 - 4. Date of the Adverse Benefit Determination;
 - 5. Reason for the Adverse Benefit Determination;
 - 6. Name of DMO employee or contractor who made the Adverse Benefit Determination; and
 - 7. Date the notice of Adverse Benefit Determination was sent to the requesting provider and Enrolled Member.

9.3 Medical Loss Ratio Report

- 9.3.1 The DMO must submit a report detailing the calculation of its MLR according to Section 12.2 of this Amendment. This report must be submitted on the 15th day of August in the year following the completion of each calendar year.

Section 10: Program Integrity

10.1 Prohibited Relationships

- 10.1.1 The DMO must not have a relationship for the administration, management, or provision of Dental Services (or the establishment of policies or provisions of operation support for such Dental Services), either directly or indirectly, with any individual or entity that is:
- a. Excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act;
 - b. Listed on the Arkansas Medicaid Excluded Providers List;
 - c. Convicted of crimes described in section 1128(b)(8)(B) of the Social Security Act;
 - d. Debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order 12549;
- 10.1.2 For purposes of this Section, "have a relationship" includes:
- a. A director, officer, owner, or partner of the DMO;
 - b. A subcontractor or delegate of the DMO;
 - c. A person with beneficial ownership of five percent (5%) or more of the DMO entity's equity;
 - d. A participating provider or person with an employment, consulting, or other arrangement with the DMO for the provision of items and services that are significant and material to the DMO entity's obligations under the Agreement; and
 - e. An employee of the DMO.
- 10.1.3 If the DMO determines it has a relationship, as that is defined in Section 10.1.2 above, with someone who is excluded from DMO participation according to Section 10.1.1, the DMO must disclose such relationship immediately to DHS and OMIG, in writing, along with any remedial actions being taken by the DMO.
- 10.1.4 On at least a monthly basis and at the time that the DMO engages the individual or during renewal of agreements, the DMO must disclose individuals they have a relationship with, as defined above, against
- a. The federal List of Excluded Individuals and Entities (LEIE) and the federal System for Award Management (SAM) (includes the former Excluded Parties List System (EPLS)) or their equivalent, to identify excluded parties; and
 - b. DHS listing of suspended and terminated providers at the DHS website below, to ensure the DMO does not include any non-Medicaid eligible providers in its Network:
<https://dhs.arkansas.gov/dhs/portal/Exclusions/PublicSearch/>.
- 10.1.5 The DMO must not be controlled by a sanctioned individual who is excluded under

10.2 Fraud and Abuse Prevention

10.2.1 The DMO must have a written Program Integrity Plan (Integrity Plan) designed to reduce the incidence of fraud, waste, and abuse and must comply with all state and federal program integrity requirements, including but not limited to the applicable provisions of the Social Security Act, §§ 1128, 1902, 1903, and 1932; 42 CFR §§ 431, 433, 434, 435, 438, 441, 447, 455; 45 CFR Part 74, chapters 409, 414, 458, 459, 460, 461, 626, 641, the Agreement and all applicable state laws.

- a. The Integrity Plan must have internal controls, policies, and procedures in place to prevent, reduce, detect, investigate, correct and report known or suspected fraud, waste, and abuse activities.
- b. The Integrity Plan must have a clear procedure and policy to report instances of fraud, waste, and abuse.
- c. In accordance with Section 6032 of the federal Deficit Reduction Act of 2005, the DMO must make available to all DMO employees a copy of the written fraud, waste, and abuse policies. If the DMO has an employee handbook, the DMO must include specific information about Section 6032, the DMO's policies, and the rights of employees to be protected as whistleblowers.

10.2.2 The DMO must have a written compliance and antifraud plan (compliance plan), including its fraud, waste, and abuse policies and procedures. The compliance plan must comply with 42 CFR § 438.608 and include an organizational chart listing DMO's personnel who are responsible for the investigation and reporting of possible overpayment, abuse, waste, or fraud. The compliance plan must have a description of the DMO's procedures for:

- a. Mandatory reporting of possible overpayment, abuse, waste, or fraud to DHS and OMIG;
- b. A summary of the results of the investigations of fraud, waste, abuse, or overpayment which were conducted during the previous fiscal year by the DMO's fraud investigative unit;
- c. Enforcement of standards through well-publicized statutory requirements, the Agreement requirements, and related disciplinary guidelines;
- d. A description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to:
- e. Prior authorization;
- f. Utilization management;
- g. Subcontract and Provider Agreement provisions;
- h. Provisions from the provider and the member handbooks; and
- i. Standards for a code of conduct.

10.2.3 At a minimum, the DMO must ensure that:

- a. All suspected or confirmed instances of internal and external fraud, waste, and abuse relating to the provision of, and payment for, Medicaid services including but not limited to DMO employees/management, providers,

- subcontractors, vendors, delegated entities, or members under state and/or federal law be reported to DHS and OMIG immediately upon detection;
- b. All Provider Agreements entered into by the DMO with Network Providers must, at a minimum, require that the Network Provider comply with all applicable state and federal laws, as well as the requirements of this Section of the Amendment;
 - c. Any final resolution reached by the DMO regarding a suspected case of waste, abuse, or fraud must include a written statement that provides notice to the provider or Enrolled Member that the resolution in no way binds the State of Arkansas nor precludes the State of Arkansas from taking further action for the circumstances that brought rise to the matter; and
 - d. The DMO, its subcontractors, and all Network Providers, upon request and as required by DHS, OMIG, other state agents, and/or federal law, must:
 1. Make available to all authorized federal and state oversight agencies and their agents, including but not limited to DHS, the Arkansas Attorney General, and OMIG any and all administrative, financial, and medical/case records and data relating to the delivery of items or services for which Medicaid monies are expended, and
 2. Allow access to all authorized federal and state oversight agencies and their agents, including but not limited to DHS, the Arkansas Attorney General, and OMIG to any place of business and all medical/case records and data, as required by state and/or federal laws. Access must be during Normal Business Hours, except under special circumstances when DHS, the Arkansas Attorney General, or OMIG must have After Hours admission. DHS, OMIG, or the Arkansas Attorney General must determine the need for special circumstances.

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

- a. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements.
- b. A Compliance Officer (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the CEO and the Board of Directors (BoD).
- c. A Regulatory Compliance Committee (RCC) of the BoD and at the senior management level charged with overseeing the organization's compliance with the requirements under the Agreement
- d. A system for training and education for the CO, the organization's senior management, and the organization's employees for the federal and state standards and requirements, under the Agreement.
- e. Effective lines of communication between the CO and the organization's

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

10.3 DMO and Subcontractor Responsibilities

- 10.3.1 The DMO or subcontractor, to the extent that the subcontractor is delegated responsibility by the DMO for coverage of services and payment of claims under the Agreement, must implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to DHS and OMIG.
- 10.3.2 The DMO or subcontractor, to the extent that the subcontractor is delegated responsibility by the DMO for coverage of services and payments of claims under the Agreement, must implement and maintain arrangements or procedures for prompt notification to DHS when it receives information about changes in an Enrolled Member's circumstances that may affect the Enrolled Member's eligibility, including changes in the Enrolled Member's residence or the death of an Enrolled Member.
- 10.3.3 The DMO or subcontractor, to the extent that the subcontractor is delegated responsibility by the DMO for coverage of services and payments of claims under the Agreement, must implement and maintain arrangements or procedures for notification to DHS and OMIG when it receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the DMO program, including the termination of the Provider Agreement with the DMO.
- 10.3.4 The DMO or subcontractor, to the extent that the subcontractor is delegated responsibility by the DMO for coverage of services and payments of claims under the Agreement, must implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Enrolled Members and the application of such verification processes on a regular basis.
- 10.3.5 For DMOs that make or receive annual payments under this contract of at least \$5,000,000, the DMO or subcontractor, to the extent that the subcontractor is delegated responsibility by the DMO for coverage of services and payments of claims under the Agreement, must implement and maintain written policies for all

employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act (FCA) and other Federal and State laws, including information about rights of employees to be protected as whistleblowers.

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

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

10.4 DHS Responsibilities

10.4.1 If DHS learns that the DMO has a prohibited relationship, as defined in Section 10.1.1, or if the DMO has a relationship with an individual who is an affiliate of such an individual, DHS may continue the Agreement if the DMO terminates the prohibited relationship within thirty (30) calendar days, unless the Secretary directs otherwise.

10.4.2 If DHS learns that the DMO has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act, DHS may continue the Agreement if the DMO terminates the prohibited relationship within thirty (30) calendar days, unless the Secretary directs otherwise.

10.4.3 If DHS learns that the DMO has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act, DHS may not renew or extend the Agreement, unless the Secretary provides to DHS and to Congress a written statement describing compelling reasons that exist for renewing or extending the Agreement despite the prohibited affiliation.

10.5 Program Integrity Overpayment Recovery

10.5.1 The DMO shall check with OMIG before initiating repayment of any program integrity-related funds to ensure that repayment is permissible.

10.5.2 DHS or OMIG shall have the right to take disciplinary action against any Provider identified by the DMO, DHS, or OMIG as engaging in inappropriate or abusive billing or service provision practice.

10.5.3 If a fraud referral from the DMO generates an investigation, and corresponding legal action results in a monetary recovery to DHS, the reporting DMO will be entitled to share in such recovery following final resolution (settlement agreement/final court judgment). The State shall retain its costs of pursuing the action, including any costs associated with DHS, OMIG, or MFCU operations associated with the investigation and its actual documented loss (if any). The State shall pay to the DMO the remainder of the recovery, not to exceed the DMO's actual documented loss. Actual documented loss of the DMO may be determined by paid false or fraudulent claims, canceled checks, or other similar documentation which objectively verifies the dollar amount of loss.

10.5.4 If the State makes a recovery from a fraud investigation in which the DMO has sustained a documented loss but the case did not result from a referral made by the DMO, the State shall not be obligated to repay any monies recovered to the DMO but may do so at its discretion.

Section 11: Administration and Management

11.1 Organizational Qualifications

11.1.1 The DMO must inform DHS if it has been accredited by a private independent accrediting entity and authorize the accrediting entity to provide DHS a copy of the its most recent accreditation review, including:

- a. The accreditation status, survey type and level, as applicable;
- b. Accreditation results, including recommended actions or improvements, corrective action plans (CAPs), and summaries of findings; and
- c. The expiration of the accreditation.

11.1.2 DHS will make the accreditation status of the DMO available to the general public on the Arkansas Medicaid website for Healthy Smiles.

11.2 Organizational Charts

11.2.1 The DMO must submit an organizational chart to DHS that identifies the staff required in the Agreement. The DMO must notify DHS of any changes to the organizational chart within five (5) business days and submit a new organizational chart reflecting these changes.

11.3 Required Disclosures

11.3.1 The DMO must report the following:

- a. The name and address of any person (individual or corporation) with an ownership or control interest in the DMO or its subcontractors. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box.
- b. The date of birth and Social Security Number (SSN) of any individual with an ownership or control interest in the DMO or its subcontractors.
- c. Other tax identification number of any corporation with an ownership or control interest in the DMO; and any subcontractor in which the DMO has a five percent (5%) or more interest.
- d. Information on whether an individual or corporation with an ownership or control interest in the DMO is related to another person with ownership or control interest in the DMO as a spouse, parent, child, or sibling.
- e. Information on whether a person or corporation with an ownership or control interest in any subcontractor in which the DMO has a five percent (5%) or more interest is related to another person with ownership or control interest in the DMO as a spouse, parent, child, or sibling.
- f. The name of any other disclosing entity in which an owner of the DMO has an ownership or control interest.
- g. The name, address, date of birth, and SSN of any managing employee of the DMO.

11.3.2 The DMO and its subcontractors must disclose to DHS, any persons or corporations with an ownership or control interest in the DMO that:

- a. Has direct, indirect, or combined direct/indirect ownership interest of five

- percent (5%) or more of the DMO's equity;
- b. Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the DMO if that interest equals at least five percent (5%) of the value of the DMO's assets;
- c. Is an officer or director of the DMO, if organized as a corporation; or
- d. Is a partner in the DMO, if organized as a partnership.

11.3.3 The DMO and its subcontractors must disclose the information required in Section 11.3.2 at the following times:

- a. When the DMO submits a proposal in accordance with DHS's procurement process.
- b. When the DMO executes the Agreement with DHS.
- c. When DHS renews or extends the Agreement.
- d. Within thirty-five (35) calendar days after any change in ownership of the DMO.

11.3.4 The DMO must report to DHS, OMIG, and, upon request, to the Secretary of the Department of Health and Human Services (DHHS), the Inspector General of the DHHS, and the Comptroller General a description of transactions between the DMO and a party in interest (as defined in Section 1318(b) of the Public Health Service Act), including the following transactions:

- a. Any sale or exchange, or leasing of any property between the DMO and such a party;
- b. Any furnishing for consideration of goods, services (including management services), or facilities between the DMO and such a party, but not including salaries paid to employees for services provided in the normal course of their employment;
- c. Any lending of money or other extension of credit between the DMO and such a party.

11.3.5 The DMO must annually: measure and report to DHS on its performance, using the standard measures required by DHS; submit to DHS specified data that enables DHS to calculate the DMO's performance using the standard measures identified by DHS in Section 8-, Attachment A, and Attachment B; OR perform a combination of these activities. 42 CFR § 438.330(c)(1) and (2).

11.3.6 The DMO must retain, and require subcontractors to retain, as applicable, the following information: Enrolled Member Grievance and Appeal records in 42 CFR § 438.416, base data in 42 CFR § 438.5(c), MLR reports in 42 CFR § 438.8(k), and the data, information, and documentation specified in 42 CFR §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years.

11.4 Delegation of DMO Responsibilities

11.4.1 The DMO may delegate performance of work required under the Agreement through subcontract or delegation agreement with written prior approval by DHS. Any subcontract or agreement must:

- a. Comply with all applicable state and federal laws, including, without limitation,

42 CFR 438.230 and all other applicable Medicaid laws and regulations, other sub-regulatory guidance, and all provisions of the Agreement and the Amendment.

- b. Obtain written approval of the subcontract or agreement from DHS prior to implementation of any subcontract or agreement entered into after the Effective Date of the Appendix. DHS reserves the right to inspect any existing subcontracts for compliance with the terms of the Amendment.

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

11.4.3 All subcontracts shall comply with the applicable provisions of federal and state law, regulations, and policies.

11.4.4 A subcontract or delegation agreement that delegates activities under the Agreement or this Amendment, or any amendments thereto, must be in writing, signed, and dated prior to work under the subcontract or agreement beginning. The subcontractor or delegate must meet all the requirements and obligations of the DMO related to the activities delegated under the subcontract or delegation agreement.

11.4.5 The DMO shall not include provisions in any subcontract or delegation agreement that contain compensation terms that discourage Network Providers from serving any specific eligibility category.

11.4.6 The DMO shall maintain a fully executed original or electronic copy of all subcontracts or delegation agreements, which shall be available to DHS within five (5) business days of a request by DHS to inspect.

- a. Subcontract or delegation agreement terms, conditions, and other information may be designated as confidential, but may not be withheld from DHS.
- b. DHS will not disclose information designated as confidential without the prior written consent of the DMO, except as required by law.

11.4.7 The DMO must document compliance certification (business-to-business) testing of transaction compliance with HIPAA for any subcontractor or delegate that receives Enrolled Member data.

11.4.8 The DMO may not use a subcontract or delegation agreement to make a specific payment directly or indirectly under a Provider Incentive Plan, as described in Section 8.3.1, as an inducement to reduce or limit Medically Necessary services to an Enrolled Member.

- 11.4.9 All subcontractors or delegates, and all employees of the subcontractor or delegate, must meet the following requirements:
- a. Eligible for participation in the Medicaid program; however, Medicaid participation in Medicaid FFS is not required;
 - b. Pass a background check based on the nature and scope of the work the subcontractor or delegate will perform;
 - c. Not debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations or guidelines issued under Executive Order 12549; and
 - d. Not debarred, suspended, or otherwise excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act or listed on the Arkansas Medicaid Excluded Provider's List.

11.4.11 For all subcontracts or delegation agreements that contain a capitated or risk-sharing arrangement, the subcontract or agreement must include the following provisions:

- a. A provision requiring the subcontractor or delegate to provide a "claim for payment" for the capitated amount or risk-sharing payment;
- b. A provision requiring the submission of a claim or encounter which conforms to the Arkansas DHS claim and encounter format for Dental Services provided to a DMO Enrolled Member regardless of whether the pre-paid Capitated Payment amount or shared risk/shared savings payment includes the claim or encounter amount;
- c. Subcontractor claims, or encounters submitted to the DMO shall be subject to review under federal or state fraud and abuse statutes, rules, and regulations.

11.4.12 DHS encourages the use of minority or female-owned business enterprise subcontractors or delegates.

11.5 Delegation of Administrative Services

11.5.1 The DMO Project Director (Administrator) must retain the authority to direct and prioritize any delegated administrative services functions or responsibilities performed by the subcontractor or delegate;

11.5.2 If the DMO delegates administrative duties or responsibilities, then the DMO shall establish in the subcontract or delegation agreement the activities and reporting responsibilities delegated to the subcontractor or delegate;

11.5.3 The subcontract or delegation agreement shall include language for revoking delegation or imposing other sanctions if the contractor's or delegate's performance is inadequate or below required service levels;

- 11.5.4 It shall be the DMO's responsibility to evaluate subcontractor or delegate performance and determine if service level performance meet requirements;
- 11.5.5 The DMO shall notify DHS of any deficiencies identified and CAPs developed as a result of ongoing monitoring or performance reviews;
- 11.5.6 DHS may request the DMO perform additional reviews, if necessary, to assure the subcontractor or delegate maintains adequate service levels and complies with the requirements found in the Agreement;
- 11.5.7 If at any time during the contract period, the subcontractor or delegate is found to be in significant non-compliance with its contract with the DMO, the Healthy Smiles Waiver, the Agreement or this Amendment, or any other applicable state or federal law, the DMO shall notify DHS;
- 11.5.8 The DMO shall require subcontractors and delegates who perform administrative services to adhere to screening and disclosure requirements as required by DHS or the State of Arkansas.

11.6 Information Management and Systems (IT Systems)

- 11.6.1 The DMO must have information management processes and information systems (IT Systems) that comply with Section 6504(a) of the Affordable Care Act (ACA). This means that it must have a claims processing and retrieval system that is capable of collecting data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by DHS to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act.
- 11.6.2 The IT Systems must conform to HIPAA and HITECH standards for data and document management.
 - a. This includes the ability to transmit, receive and process data in HIPAA compliant formats that are in use as of the Agreement execution date.
 - b. All HIPAA-conforming transactions between DHS and the DMO must be subjected to the highest level of compliance as measured using an industry standard HIPAA compliance checker application.
- 11.6.3 Beginning upon the signing of the Amendment, any new IT Systems must be approved by DHS prior to implementation or use of the new IT Systems. The DMO must provide details of the test regions and environments of its core production IT Systems, including a live demonstration to DHS representatives, to enable DHS to determine the readiness of the DMO's IT Systems.
- 11.6.4 The DMO's IT Systems must conform to future federal and DHS-specific standards for data exchange as of the date stipulated by CMS, or as otherwise agreed to by DHS and the DMO.
- 11.6.5 The DMO must ensure that critical systems functions are available to Enrolled

Members and providers 24/7, except during periods of scheduled system unavailability agreed upon by DHS and the DMO.

- a. The DMO must make DHS aware of the nature and availability of these functions prior to extending access to these functions to Enrolled Members and/or providers.
- b. If at any point there is a problem with a critical systems function, the DMO must provide to DHS full written documentation that includes a CAP that describes how problems with critical systems functions will be restored and prevented from occurring again.
 1. The CAP must be delivered to DHS within five (5) business days of the critical systems function problem or failure.
 2. Failure to submit a CAP or to show progress in implementing the CAP may subject the DMO to sanctions, in accordance with Section 14.1 of this Amendment.

11.6.6 The DMO must develop a Business Continuity-Disaster Recovery Plan (BC-DR) that is continually ready to be invoked.

- a. The BC-DR must be reviewed and prior-approved by DHS. Changes in the plan are due to DHS within ten (10) business days after the change and are subject to review and approval by DHS.
- b. At a minimum, the DMO's BC-DR must address the following scenarios:
 1. The central computer installation and resident software are destroyed or damaged;
 2. System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage;
 3. System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of data maintained in a live or archival system;
 4. Unavailability of critical functions caused by events outside of a DMO's span of control; and
 5. System interruption or failure resulting from network, operating hardware, software, or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system but do prevent access to the system, i.e., cause unscheduled system unavailability; and
 6. Malicious acts, including malware or manipulation.
- c. The DMO must periodically, but no less than annually, perform comprehensive tests of its BC-DR through simulated disasters and lower level failures in order to demonstrate to DHS that it can restore system functions per the standards outlined in the Agreement. In the event that the DMO fails to demonstrate in the tests of its BC-DR that it can restore system functions per the standards outlined in the Agreement, the DMO must submit to DHS a CAP that describes how the failure will be resolved. The CAP must be delivered within ten (10) business days of the conclusion of

the test.

- 11.6.7 When there are unexpected or unscheduled IT Systems outages that are caused by the failure of systems and technologies within the DMO's control, these outages must be corrected, and the IT Systems restored within forty-eight (48) hours of the official declaration of system unavailability. However, the DMO will not be responsible for correcting systems and technologies failures that are outside of its control.
- 11.6.8 The DMO and DHS or its agent must make predominant use of secure file transfer protocol (SFTP) and electronic data interchange (EDI) in their exchanges of data. Additionally, the DMO must encourage Network Providers to participate in DHS's Direct Secure Messaging (DSM) service when it is implemented.
- 11.6.9 If the DMO uses social networking or smartphone/tablet applications (apps), the DMO must develop and maintain appropriate policies and procedures that are submitted to DHS for review and approval.
- a. Any app must be approved by DHS prior to utilization by the DMO.
 - b. If the DMO uses apps to allow Enrolled Members direct access to DHS approved materials, the DMO must comply with the following:
 1. The app must disclaim that use is not private and that no PHI or personally identifying information should be published on the app by the DMO or the end user; and
 2. The DMO must ensure that software applications obtained, purchased, leased, or developed are based on secure coding guidelines.
 - c. DHS will monitor all social networking activities and apps to ensure compliance with all DMO provider manual and DMO provider agreement terms. The DMO may be subject to sanctions in accordance with Section 14.1 of this Amendment for any prohibited activity that is found.

Section 12: Payment under the Agreement

12.1 Capitation Payments

12.1.1 DHS will make Capitated Payments to the DMO for all Medicaid-eligible Enrolled Members in accordance with Attachment D.

- a. Capitated Payments must be actuarially sound, and guarantee cost effectiveness of the Healthy Smiles Program.
- b. DHS will notify the DMO of the Capitated Payments and any changes thereto prior to implementation of those payments. The DMO will have the opportunity to respond prior to implementation of the rates.
- c. DHS must consider any comments made by the DMO to the rates; however, the DMO will be required to accept the DHS proposed Capitated Payments to participate in the Healthy Smiles program.

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

12.2 Medical Loss Ratio (MLR)

12.2.1 The DMO shall track and report to DHS actual medical expenditures against an MLR of eighty-five percent (85%). The report shall be made in accordance with Section 9.3 of this Amendment.

12.2.2 The MLR will be monitored per 42 CFR 438.8, and the MLR will be used to enforce a rebate at the end of the year.

12.2.3 The risk corridor set forth in Section 3.16(H) of the Agreement will no longer be enforced.

12.2.4 The MLR report submitted to DHS must include:

- a. Total incurred claims;
- b. Expenditures on quality improvement activities;
- c. Expenditures on program integrity activities, including permissible fraud prevention activities;
- d. Non-claims costs;
- e. Premium revenue;
- f. Taxes;
- g. Licensing fees;
- h. Regulatory fees;
- i. Methodologies for allocation of expenditures;
- j. Any credibility adjustments applied;
- k. The calculated MLR;
- l. Any remittance owed to the state, if applicable;
- m. A comparison of the information reported with the audited financial report;
- n. A description of the aggregation method used to calculate total incurred

- claims; and
- o. The number of Enrolled Member months.

12.2.5 Each DMO expense must be included only under one type of expense (services/quality improvement or administrative) unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense may be prorated between expense types.

- a. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.
- b. Allocation between expense types must be based on a generally accepted accounting method that is expected to yield the most accurate results.
- c. Share expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.
- d. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and may not be apportioned to any other entity.

12.2.6 The DMO may add a credibility adjustment, based on the methodology in 42 CFR 438.8(h)(4), to the calculated MLR, if the MLR reporting year experience is partially credible. If the DMO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standard. The credibility adjustment cannot be added to the calculated MLR, if the MLR reporting year is fully credible. The credibility adjustment shall be added to the MLR calculation before the MLR report is submitted.

12.2.7 The DMO shall aggregate data for all Medicaid eligibility groups covered under the Agreement, unless separate reporting is otherwise required.

12.2.8 The DMO must require any third-party vendor claims adjudication activities to provide all underlying data associated with MLR reporting to the DMO within enough time to calculate the MLR and validate the accuracy of MLR reporting in accordance with Section 9.3 of this Amendment.

12.2.9 If the state makes a retroactive change to the Capitation Payment for an MLR reporting year, and the MLR report has already been submitted to DHS, the DMO must:

- a. Re-calculate the MLR for all MLR reporting years affected by the change; and
- b. Submit a new MLR report meeting the applicable requirements in Section 12.2 of this Amendment.

Section 13: Liability of Enrolled Members

- 13.1 Enrolled Members shall not be held liable for the DMO's debts in the event the DMO becomes insolvent.
- 13.2 Enrolled Members shall not be liable for Covered Services provided to them, for which DHS does not pay the DMO, or for which DHS or the DMO does not pay the provider that furnished the service under a contractual, referral, or other arrangement, including a Provider Agreement.
- 13.3 Enrolled Members shall not be liable for Covered Services provided furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the enrollee would owe if the DMO covered the services directly.

Section 14: Sanctions

14.1 Failure to meet the requirements set out in the Agreement or this Amendment may subject the DMO to the sanctions set out in Attachment B, incorporated herein by reference.

Section 15: Miscellaneous Provisions

15.1 Choice of Law and Venue

15.1.1 The Agreement and this Amendment will be governed by, construed and enforced in accordance with the laws of the State of Arkansas applicable to contracts to be performed solely within the State.

15.2 Severability

15.2.1 If any statute or regulation is enacted which requires a change in the Agreement, this Amendment, or any attachment thereto, then both parties will deem the Agreement, this Amendment, or any attachment thereto, as applicable to the required change, to be automatically amended to comply with the newly enacted statute or regulation as of its effective date.

15.2.2 If any provision of this Amendment (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both DHS and the DMO will be relieved of all obligations arising under such provision. If the remainder of the Agreement is capable of performance, it will not be affected by such declaration or finding and will be fully performed.

15.3 Sovereign Immunity

15.3.1 The State and DHS in no way waive the protections of Sovereign Immunity by any language contained in the Amendment.

15.4 Amendments

15.4.1 The Agreement may be amended only in writing. All amendments, including this Amendment, are fully incorporated into the Agreement and effective upon the date of signing by both parties.

15.5 Termination of the Agreement

15.5.1 DHS may terminate the Agreement, and place Enrolled Members into a different DMO or provide Medicaid benefits through other State authority, if DHS determines that the DMO has failed to carry out the substantive terms of the Agreement or meet the applicable requirements of sections 1932, 1903(m), or 1905(t) of the Social Security Act.

15.5.2 This Agreement may be terminated by the DMO upon giving one hundred twenty (120) calendar days advanced written notice to DHS.

- a. Termination of this Agreement shall not discharge the DMO of obligations with respect to services or items furnished or authorized prior to termination, including retention of records and verification of overpayments or underpayments.
- b. The DMO will be responsible for all necessary activities to close out the Agreement, including those laid out in the Agreement and this Amendment.
- c. In the event of such termination and in accordance with the terms of the Agreement, the DMO shall be entitled to payment for work or services satisfactorily performed through the effective date of cancellation or

termination of the Agreement.

15.5.3 Termination of the Agreement by the DMO will require prior notification to DHS. The DMO must submit notification and a detailed Termination Plan to DHS at least, but no later than, one-hundred twenty (120) calendar days prior to the effective date.

- a. The name and title of the DMO's designated Coordinator must be included in the Termination Plan.
- b. The Coordinator will be the individual responsible for ensuring ongoing communication with DHS during the activities required to fully terminate the contract as well as ensuring transition of Enrolled Members to a new DMO.

15.5.4 If the Agreement is terminated by the DMO, the DMO must notify all Enrolled Members of such termination at least forty-five (45) calendar days in advance of the effective date of termination of the Agreement. This notice must be made available in an accessible format in accordance with Section 3.1.4 of the Amendment.

Section 16: Signatures

The named parties to this Amendment have approved the terms and conditions herein, and all attachments hereto, and by their signatures below hereby agree to the terms and conditions set forth herein.

Arkansas Department of Human Services

Dental Managed Care Organization:

(Name)

By: _____

By: _____

Name: _____

Name: _____

Title: _____

Title: _____

Date: _____

Date: _____