Texas Health & Human Services Commission

HHSC Dental Contract Terms and Conditions

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Article 1: Introduction

Section 1.01 Purpose.

The purpose of this Contract is to set forth the terms and conditions for the Dental Contractor's participation as a dental indemnity insurer or single-service health maintenance organization, also referred to as a "dental maintenance organization" or "DMO,'' for the statewide Dental Program. Under the terms of this Contract, the Dental Contractor will provide comprehensive Medically Necessary Covered Dental Services to eligible Medicaid and CHIP Members through a Network of licensed dentists contracted with the Dental Contractor.

Section 1.02 Risk-based Contract.

This is a risk-based contract.

Section 1.03 Inducements.

In making the award of this Contract, HHSC relied on Dental Contractor's assurances of the following:

(a) Dental Contractor is an established dental indemnity insurance provider or DMO that arranges for the delivery of Medically Necessary Covered Dental Services, and:

  (1) Is currently licensed as such in the State of Texas and is fully authorized to conduct business in the Service Area; or

  (2) Will be fully authorized by TDI to conduct business in the Service Area no later than 120 days after the Contract's Effective Date;

(b) Dental Contractor and its Material Subcontractors have the skills, qualifications, expertise, financial resources, and experience necessary to provide the Services and Deliverables described in this Contract in an efficient, cost-effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities;

(c) Dental Contractor has thoroughly reviewed, analyzed, and understood the RFP, has timely raised all questions or objections to the RFP, and has had the opportunity to review and fully understand HHSC's current Dental Program and operating environment for the activities that are the subject of this Contract and the needs and requirements of HHSC during the Contract term;

(d) Dental Contractor has had the opportunity to review and understand HHSC's stated objectives in entering into this Contract and, based on such review and understanding, Dental Contractor currently has the capability to perform in accordance with the terms and conditions of this Contract;

(e) Dental Contractor also has reviewed and understands the risks associated with the Dental Program as described in the RFP, including the risk of non-appropriation of funds.

Accordingly, on the basis of the terms and conditions of this Contract, HHSC desires to engage Dental Contractor to perform the Services and provide the Deliverables described in this Contract under the terms and conditions set forth in this Contract.

Section 1.04 Construction of the Contract.

(a) Scope of Introductory Article.

The provisions of any introductory article to the Contract are intended to be a general introduction and are not intended to expand the scope of the Parties' obligations under the Contract or to alter the plain meaning of the terms and conditions of the Contract.

(b) References to the "State."

References in the Contract to the "State" mean the State of Texas unless otherwise specifically indicated and must be interpreted, as appropriate, to mean or include HHSC and other agencies of the State of Texas that may participate in the administration of the Dental Program, provided, however, that no provision will be interpreted to include any entity other than HHSC as the contracting agency.

(c) Severability.

If any provision of this Contract is construed to be illegal or invalid, such interpretation will not affect the legality or validity of any of its other provisions. The illegal or invalid provision will be deemed stricken and deleted to the same extent and effect as if never incorporated in this Contract, but all other provisions will remain in full force and effect.

(d) Survival of terms.

Termination or expiration of this Contract for any reason will not release either Party from any liabilities or obligations set forth in this Contract that:

(1) The Parties have expressly agreed will survive any such termination or expiration; or

(2) Arose prior to the effective date of termination and remain to be performed, or by their nature would be intended to be applicable following any such termination or expiration.

(e) Headings.

The article, section, and paragraph headings in this Contract are for reference and convenience only and may not be considered in the interpretation of this Contract.

(f) Global drafting conventions.

(1) The terms "include," "includes," and "including" are terms of inclusion, and where used in this Contract, are deemed to be followed by the words "without limitation."

(2) Any references to "sections," "appendices," "exhibits" or "attachments" are deemed to be references to sections, appendices, exhibits, or attachments to this Contract.

(3) Any references to laws, rules, regulations, and manuals in this Contract are deemed references to these documents as amended, modified, or supplemented from time to time during the term of this Contract.

Section 1.05 No Implied Authority.

The authority delegated to Dental Contractor by HHSC is limited to the terms of this Contract. HHSC is the state agency designated by the Texas Legislature to administer Medicaid and CHIP, and no other agency of the State grants Dental Contractor any authority related to these programs unless directed through HHSC. Dental Contractor may not rely upon implied authority, and specifically is not delegated authority under this Contract to:

(a) Make public policy;

(b) Promulgate, amend, or disregard administrative regulations or program policy decisions made by State and federal agencies responsible for administration of HHSC Programs; or

(c) Unilaterally communicate or negotiate with any federal or State agency or the Texas Legislature on behalf of HHSC regarding the HHSC Programs.

Dental Contractor is required to cooperate to the fullest extent possible to assist HHSC in communications and negotiations with state and federal governments and agencies concerning matters relating to the scope of the Contract and the Dental Program, as directed by HHSC.

Section 1.06 Legal Authority.

(a) HHSC is authorized to enter into this Contract under Chapters 531 and 533, Texas Government Code; Section 2155.144, Texas Government Code; or Chapter 62, Texas Health & Safety Code. Dental Contractor is authorized to enter into this Contract pursuant to the authorization of its governing board or controlling owner or officer.

(b) The person or persons signing and executing this Contract on behalf of the Parties, or representing themselves as signing and executing this Contract on behalf of the Parties, warrant and guarantee that he, she, or they have been duly authorized to execute this Contract and to validly and legally bind the Parties to all of its terms, performances, and provisions.

Section 1.07 Loss of Program Authority.

Should any part of the Scope of Work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Dental Contractor must do no work on that part after the effective date of the loss of program authority. HHSC must adjust capitation rates, or non-risk payments as applicable, to remove costs that are specific to any program or activity that is no longer authorized by law. If the Dental Contractor works on a

program or activity no longer authorized by law after the date the legal authority for the work ends, the Dental Contractor will not be paid for that work. If HHSC paid the Dental Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to HHSC. However, if the Dental Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and HHSC included the cost of performing that work in its payments to the Dental Contractor, the Dental Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

Article 2: Definitions

As used in this Contract, the following terms and conditions have the meanings assigned below:

Abuse means provider practices that are inconsistent with sound fiscal, business, medical, or dental practices and result in an unnecessary cost to the Dental Program, or in reimbursement for services that fail to meet professionally recognized standards for dental care. It also includes member practices that result in unnecessary cost to the Dental Program.

Account Name means the name of the individual who lives with the child(ren) and who applies for the CHIP coverage on behalf of the child(ren).

Adjudicate means to deny or pay a Clean Claim.

Adverse Benefit Determination means:
(1) the denial or limited authorization of a Member or Provider requested Services, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
(2) the reduction, suspension, or termination of a previously authorized service;
(3) the denial in whole or in part of payment for service;
(4) the failure to provide services in a timely manner as determined by the State;
(5) the failure of a Dental Contractor to act within the timeframes set forth in the Contract and 42 C.F.R. § 438.408(b); or

(6) the denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Affiliate means any individual or entity that meets any of the following criteria:

(a) Owns or holds more than a five percent interest in the Dental Contractor, either directly, or through one or more intermediaries;

(b) In which the Dental Contractor owns or holds more than a five percent interest either directly, or through one or more intermediaries;

(c) Any parent entity or subsidiary entity of the Dental Contractor, regardless of the organizational structure of the entity;

(d) Any entity that has a common parent with the Dental Contractor, either directly, or through one or more intermediaries;

(e) Any entity that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the Dental Contractor; or,

(f) Any entity that would be considered to be an affiliate by any Securities and Exchange Commission or Internal Revenue Service regulation, Federal Acquisition Regulations, or by another applicable regulatory body.

Agency Sensitive Information means information that is not subject to specific legal, regulatory or other external requirements, but is considered HHS sensitive and is not readily available to the public. "Agency Sensitive Information" could be subject to disclosure under the Texas Public Information Act, but disclosure should be controlled due to sensitivity

Allowable Expenses means all expenses related to the Contract between HHSC and the Dental Contractor that are incurred during the Contract Term, are not reimbursable or recovered from another source, and that conform with the Chapter 6.1 of Attachment "C".

Appeal (CHIP only) means the formal process by which the Dental Contractor or its Utilization Review agent addresses Adverse Determinations.

Auxiliary Aids and Services means an accommodation that ensures that no individual with a disability is excluded, denied services, segregated, or otherwise treated differently than other individuals that do not need such accommodations and includes:

(a) Qualified interpreters or other effective methods of making aurally delivered materials understood by persons with hearing impairments;

(b) Taped texts, large print, Braille, or other effective methods to ensure visually delivered materials are available to individuals with visual impairments; and

(c) Other effective methods to ensure that materials, delivered both aurally and visually, are available to those with cognitive or other Disabilities affecting communication.

Batch Processing is a technique that allows providers to send billing information all at once in a "batch" rather than in separate individual transactions.

Benchmark means a target or standard based on historical data, or an objective, or goal.

Breach means the unauthorized acquisition, access, use, or disclosure of protected health information in a manner as described in 45 C.F.R. § 164.402.

Business Continuity Plan (BCP) means a day-to- day plan that provides for a quick and smooth restoration of MIS operations after a disruptive event, and includes business impact analysis, BCP development, testing, awareness, training, and maintenance.

Business Day means any day other than a Saturday, Sunday, or a State or federal holiday on which HHSC's offices are closed.

CAHPS means the Consumer Assessment of Healthcare Providers and Systems. This survey is conducted annually by the EQRO.

Case-by-case Services means additional services for coverage beyond those specified in Attachments B-2 and B-2.1; however, services required by EPSDT are not considered Case-by-case Services

Case Head means the head of the household that is applying for Medicaid.

C.F.R. means the Code of Federal Regulations.

Children's Health Insurance Program (CHIP) means the health insurance program authorized and funded pursuant to Title XXI, Social Security Act (42 U.S.C. §§ 1397aa-1397jj) and administered by HHSC.

CHIP Program means the State of Texas program in which HHSC contracts with Dental Contractors to provide, arrange for, and coordinate Medically Necessary Covered Dental Services for enrolled CHIP members.

Claims Administrator means a HHSC-contracted entity, often referred to as the Texas Medicaid and Healthcare Partnership (TMHP), performing provider enrollment, and claims, and Encounter processing for the Dental Program.

Clean Claim means a claim submitted by a dental provider for dental services rendered to a Dental Member, with documentation reasonably necessary for the Dental Contractor to adjudicate and accurately report the claim. A Clean Claim must meet all requirements for accurate and complete data as defined in the appropriate 837- (claim type) encounter guides as follows:

(1) 837 Dental Implementation Guide; and

(2) 837 Dental Companion Guide;

CMS means the Centers for Medicare and Medicaid Services, which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid and CHIP.

Competent Interpreter means a person who is proficient in both English and the other language being used and has had orientation or training in the ethics of interpreting, including accuracy and impartiality in interpretation.

Complainant means a Dental Member or a treating Dental Provider or other individual designated to act on behalf of the Dental Member who filed the Complaint.

Complaint means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the Dental Contractor, about any matter related to the Dental Contractor other than an Adverse Benefit Determination. Complaint has the same meaning as grievance, as provided by 42 C.F.R. § 438.400(b). Possible subjects for Complaints include the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Member's rights, regardless of whether remedial action is requested. Complaint includes the Member's right to dispute an extension of time (if authorized by law) proposed by the Dental Contractor to make an authorization decision. There is no exception for an Initial Contact Complaint

A Complainant's oral or written dissatisfaction with an Adverse Benefit Determination is considered a request for a Dental Contractor Appeal.

Comprehensive Care Program see Texas Health Steps.

Confidential Information means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to Dental Contractor or that Dental Contractor may create, receive, maintain, use, disclose, or have access to on behalf of HHS that consists of or includes any or all of the following:

(1) Education records as defined in the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g; 34 C.F.R. Part 99

(2) Federal Tax Information as defined in Internal Revenue Code § 6103 and Internal Revenue Service Publication 1075;

(3) Personal Identifying Information (PII) as defined in Texas Business and Commerce Code, Chapter 521;

(4) Protected Health Information (PHI) in any form including without limitation, Electronic Protected Health Information or Unsecured Protected Health Information as defined in 45 C.F.R. § 160.103;

(5) Sensitive Personal Information (SPI) as defined in Texas Business and Commerce Code, Chapter 521;

(6) Social Security Administration Data, including without limitation Medicaid information, means disclosures of information made by the Social Security Administration or CMS from a federal system of records for administration of federally funded benefit programs under the Social Security Act, 42 U.S.C., Chapter 7;

(7) All privileged work product;

(8) All information designated as confidential under the constitution and laws of the State of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

Consolidated FSR Reporting or **Consolidated Basis** means FSR reporting results for the Dental Program and any other managed care or capitated contract with HHSC operated by the Dental Contractor or its Affiliates, including those under separate contracts between the Dental

Contractor or its Affiliates and HHSC. Consolidated FSR Reporting does not include revenues or expenses from any of the Dental Contractor's or its Affiliates' business activities or operations outside of their contracts with HHSC.

Consumer Assessment of Healthcare Providers and Systems means the survey conducted annually by the EQRO.

Contract or Agreement means this formal, written, and legally enforceable contract between the Parties, and all amendments and attachments thereto.

Contract Term means the Initial Contract Period plus any Contract extensions.

Contractor or **Dental Contractor** means the Dental Contractor that is a party to this Contract.

Copayment (CHIP only) means the amount that a member is required to pay when utilizing certain CHIP Medically Necessary Covered Dental Services.

Corrective Action Plan means the detailed written plan required by HHSC to correct or resolve a deficiency or event causing the assessment of a remedy or damage against Dental Contractor.

Covered Services or Covered Dental Services means dental services the Dental Contractor must arrange to provide to Dental Members, including all services required by the Contract and State and federal law.

Credentialing means the process of collecting, assessing, and validating qualifications and other relevant information pertaining to a dental provider to determine eligibility and to deliver Medically Necessary Covered Dental Services.

Cultural Competency means the ability of individuals and systems to provide services effectively to people of various cultures, races, ethnic backgrounds, and religions in a manner that recognizes, values, affirms, and respects the worth of those served people and protects and preserves their dignity.

Date of Disenrollment means the last day of the last month for which the Dental Contractor receives payment for a Dental Member.

Day means a calendar day unless specified otherwise.

Default Enrollment means the processes established by HHSC to assign an enrollee, who has not selected a Dental Contractor or Main Dentist, to a Dental Contractor or Main Dentist. See 1 Tex. Admin. Code § 353.403 for Medicaid default enrollment processes, and 1 Tex. Admin. Code § 370.303 for CHIP default enrollment processes.

Deliverable means a written or recorded work product or data prepared, developed, or procured by Dental Contractor as part of the Services under the Contract for the use or benefit of HHSC or the State.

Dental Administrative Services means the performance of services or functions other than the direct delivery of Medically Necessary Covered Dental Services necessary for the management of the delivery of and payment for Medically Necessary Covered Dental Services, including Network, quality management, service authorization, claims processing, and MIS operation and

reporting. This term also includes the infrastructure development for, preparation of, and delivery of, all required Deliverables under the Contract, outside of the Medically Necessary Covered Dental Services.

Dental Contractor or Contractor means the Dental Contractor that is a party to this Contract

Dental Contractor Internal Appeal means the formal process by which a Member or his or her representative requests a review of the Dental Contractor's Action by the Dental Contractor.

Dental Contractor Internal Appeal and Complaint System means the process the Dental Contractor implements to handle Dental Contractor Internal Appeals of a Complaint or Adverse Benefit Determination, as well as the process to collect and track information about the Dental Contractor Internal Appeals of a Complaint or Adverse Benefit Determination.

Dental Health-related Materials are materials developed by the Dental Contractor or obtained from a third party relating to the prevention, diagnosis or treatment of a dental condition.

Dental Member means a person who has met Medicaid or CHIP dental services eligibility criteria and is enrolled with a Dental Contractor.

Dental Program means the State of Texas' managed care program in which HHSC contracts with a Dental Contractor to provide, arrange for, and coordinate Medically Necessary Covered Dental Services and benefit limitations for Texas Children's Medicaid Dental Services and CHIP Dental Services.

Dental Reporting Regions means state-wide regions desginated by HHSC, which will be used to measure the Network adequacy of each Dental Contractor. These state-wide regions mirror the designated service areas under HHSC's managed care programs, as included in Attachment M.

Diagnostic means an assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a provider to determine existing pathology or disease or lack thereof.

Disability means a physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working.

Disability-related Access means that facilities are readily accessible to and usable by individuals with disabilities, and that Auxiliary Aids and Services are provided to ensure effective communication, in compliance with Title III of the Americans with Disabilities Act.

Disaster Recovery Plan means the document developed by the Dental Contractor that outlines details for the restoration of the MIS in the event of an emergency or disaster.

Discovery/Discovered has the meaning assigned by 45 C.F.R. § 164.410.

DMO means dental maintenance organization.

EDI means electronic data interchange.

Effective Date means the effective date of this Contract.

Effective Date of Coverage means the first day of the month for which the Dental Contractor has received payment for a Dental Member.

Eligibles means Medicaid or CHIP-eligible individuals residing in the State of Texas.

Emergency Dental Services mean covered inpatient and outpatient services needed to evaluate or stabilize an emergency dental condition furnished by a provider qualified to furnish these services under this title. This is a Non-capitated Service for the Dental Contractor.

Encounter means a Medically Necessary Covered Dental Service or group of Medically Necessary Covered Dental Services delivered by a Provider to a Dental Member during a visit between the Dental Member and Provider, including Value-added Services.

Encounter Data means a representation of a claim received and adjudicated by a Dental Contractor without alteration or omission, unless specifically directed by HHSC. The data must include information on receipt of items or services including billing and rendering provider.

Enrollment Report/File means the daily or monthly list of Eligibles that are enrolled with the Dental Contractor as Members on the day or for the month the report is issued.

EPSDT means the federally mandated Early and Periodic Screening, Diagnosis and Treatment program contained at 42 U.S.C. § 1396d(r). HHSC refers to EPSDT as Texas Health Steps.

Expedited Appeal means an appeal to the Dental Contractor in which the decision is required quickly based on the Dental Member's health status, and the amount of time necessary to participate in a standard Appeal could jeopardize the Member's life, or health, or ability to attain, maintain, or regain maximum function.

Experience Rebate means the portion of the Dental Contractor's Net Income Before Taxes that may be returned to the State in accordance with **Section 10.08** "Experience Rebate" below.

External Medical Review (EMR) - is an independent review of the relevant information the Dental Contractor used related to an Adverse Benefit Determination based on functional necessity or medical necessity. EMRs are conducted by third party organizations, known as Independent Review Organizations (IROs), contracted by HHSC.

External Quality Review Organization (EQRO) means the entity that contracts with HHSC to provide external review of access to and quality of dental care provided to Dental Members.

Expiration Date means the expiration date of this Contract, as specified in the HHSC Dental Program Contract.

Farmworker Child(ren) (FWC) means a child or children birth through age 17 of a Migrant Farmworker.

Federal Poverty Level (FPL) means the Federal Poverty Level updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 U.S.C. § 9902(2) and as in effect for the applicable budget period used to determine an individual's eligibility in accordance with 42 C.F.R. § 435.603(h).

Fee-for-Service (FFS) means the traditional Medicaid Health Care Services payment system under which providers receive a payment for each unit of service, after the service is provided, according to rules adopted pursuant to Chapter 32 Texas Human Resources Code.

Financial Statistical Report (FSR) means a report designed by HHSC, and submitted to HHSC by the Dental Contractor in accordance with Contract requirements. The FSR is a form of modified income statement, subject to audit, and contains revenue, cost, and other data, as defined by the Contract. Not all incurred expenses may be included in the FSR.

First Dental Home is a group of benefits designed to establish a Dental Home, provide preventive care, identify oral health problems, provide treatment, and parental or guardian oral health anticipatory guidance to eligible Medicaid members 6 months through 35 months of age.

Force Majeure Event means any failure or delay in performance of a duty by a Party under this Contract that is caused by fire, flood, hurricane, tornadoes, earthquake, an act of God, an act of war, riot, civil disorder, or any similar event beyond the reasonable control of such Party and without the fault or negligence of such Party.

FQHC means a Federally Qualified Health Center, certified by CMS to meet the requirements of Section 1861(aa)(3) of the Social Security Act as a federally qualified health center, that is enrolled as a provider in the Texas Medicaid program.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person and includes any act that constitutes fraud under applicable federal or state law.

FSR Reporting Period is the period of months that are measured on a given FSR. Generally, the FSR Reporting Period is a twelve-calendar-month period corresponding to the State Fiscal Year, but it can vary by Contract and by year. If an FSR Reporting Period is not defined in the Contract, then it will be deemed to be the twelve months following the end of the prior FSR Reporting Period.

Health and Human Services Commission (HHSC) means the administrative agency within the executive department of Texas state government established under Chapter 531, Texas Government Code or its designee, or authorized agent, including but not limited to, the Texas Health and Human Services agencies.

Healthcare Effectiveness Data and Information Set (HEDIS), is a registered trademark of NCQA and is a set of standardized performance measures.

HHS Agency means the Texas Health and Human Service agencies subject to HHSC's oversight under Chapter 531, Texas Government Code, and their successor agencies.

HHSC Administrative Services Contractor (ASC) means an entity performing administrative services functions, including Member eligibility and enrollment functions, for the Dental Program under a separate contract with HHSC.

HHSC Enrollment Broker (EB) means a State-contracted entity performing administrative services associated with Dental Member enrollment functions for the Dental Program.

HHSC Office of the Inspector General In accordance with Texas Government Code § 531.102, the HHSC Office of Inspector General is responsible for the prevention, detection, audit, inspection, review, and investigation of Fraud, Waste, and Abuse in the provision and delivery of all health and human services in the State, including services through any state-administered health or human services program that is wholly or partly federally funded or services provided by the Department of Family and Protective Services, and the enforcement of State law relating to the provision of those services.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (August 21, 1996), as amended or modified.

Independent Review Organization (IRO) is a third-party organization contracted by HHSC that conducts an External Medical Review (EMR) during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity.

Indian Health Care Provider has the meaning assigned to it in 42 C.F.R. § 438.14. and means a health care program operated by the Indian Health Service (IHS) or by an Indian tribe, tribal organization, or urban Indian organization, otherwise known as an I/T/U as those terms are defined in section 4 of the Indian Health Care Improvement Act, 25 U.S.C. § 1603.

Information Resources means the procedures, equipment, and software that are employed, designed, built, operated, and maintained to collect, record, process, store, retrieve, display, and transmit information, and associated personnel including consultants and contractors as defined in 44 U.S.C. § 3502, NIST SP 800-53 rev 4.

Information Technology Conduit Services Provider means an entity that transports information but does not access it other than on a random or infrequent basis as necessary for the performance of the transportation service or as required by law.

Initial Contact Complaint means a Complaint that is resolved within one Business Day.

Initial Contract Period means the Effective Date of the Contract through August 31, 2023.

Inquiry means a request by a member or Provider for information about HHS programs or services.

Internal Dental Contractor Appeal (Medicaid only) means the formal process by which an eligible Medicaid member or his or her representative request a review of a Complaint or the Dental Contractor's Action.

Joint Interface Plan (JIP) means a document used to communicate basic system interface information. This information includes: file structure, data elements, frequency, media, type of file, receiver and sender of the file, and file identification.

Key Personnel means the critical management and technical positions identified by the Dental Contractor in accordance with **Article 4.02** below**.**

Legally Authorized Representative (LAR) means the Dental Member's representative defined by State or federal law, including Tex. Occ. Code § 151.002(6), Tex. Health & Safety Code § 166.164, and Tex. Estates Code Ch. 752.

Limited English Proficient (LEP) has the meaning assigned to it in 42 C.F.R. § 438.10 and means potential members and Dental Members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English.

Linguistic Access means translation and interpreter services for written and spoken language to ensure effective communication, and includes sign language interpretation, and the provision of other Auxiliary Aids and Services to persons with Disabilities.

Main Dental Home Provider, Main Dentist or Dental Home means the ongoing relationship between the dentist and the member, inclusive of all aspects of oral health care delivered in a comprehensive continually accessible, coordinated, and family-centered way and includes referrals to dental specialists when appropriate.

Main Dentist means a provider who has agreed with a Dental Contractor to provide a Main Dental Home to Dental Members and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to Dental Members, maintaining the continuity of Dental Member care, and initiating referral for care. Provider types that can serve as Main Dental Home Providers are FQHCs, RHCs, and individuals who are general dentists or pediatric dentists.

Major Population Group means any population, which represents at least 10% of the Dental Program population in the Service Area.

Major Systems Change means a change that affects a mission critical component of the system, or a change which requires more than 4 hours planned outage to implement, or other specified timeframe in the Contract.

Management Information System (MIS) means the information systems and subsystems, applications, and automations used to support the delivery of managed care services.

Marketing means any communication from the Dental Contractor to a Medicaid or CHIP Eligible who is not enrolled with the Dental Contractor that can reasonably be interpreted as intended to influence the Eligible to:

(a) Enroll with the Dental Contractor; or

(b) Not enroll in or to disenroll from another Dental Contractor.

Marketing Materials means materials that are produced in any medium by or on behalf of the Dental Contractor and can reasonably be interpreted as intending to market to potential members. Health-related materials are not Marketing Materials.

Material Subcontract means any contract, Subcontract, or agreement between the Dental Contractor and another entity that meets any of the following criteria:

(a) The other entity is an Affiliate of the Dental Contractor;

(b) The Subcontract is considered by HHSC to be for a key type of service or function, including:

(1) Administrative Services, including third party administrator, Network administration, and claims processing;

(2) Delegated Networks, including behavioral health, dental, pharmacy, and vision;

(3) Management services, including management agreements with parent;

(4) Reinsurance; or

(5) Call lines, including nurse and medical consultation; or

(c) Any other Subcontract that exceeds, or is reasonably expected to exceed, the lesser of

(1) $500,000 per year, or

(2) One percent of the Dental Contractor's annual revenues under this Contract. Any Subcontracts between the Dental Contractor and a single entity that are split into separate agreements by time period, Program, or otherwise, will be consolidated for the purpose of this definition.

For the purposes of this Contract, Material Subcontracts do not include contracts with any non-Affiliates for any of the following, regardless of the value of the contract: utilities (e.g., water, electricity, telephone, Internet, trash), mail or shipping, office space, maintenance, security, or computer hardware.

Material Subcontractor means any entity with a Material Subcontract with the Dental Contractor. For the purposes of this Contract, Material Subcontractors do not include Providers in the Dental Contractor's Provider Network. Material Subcontractors may include, Affiliates, subsidiaries, and affiliated and unaffiliated third parties.

Medicaid means the medical assistance entitlement program authorized and funded pursuant to Title XIX, Social Security Act (42 U.S.C. §§ 1396 *et seq*.) and administered by HHSC.

Medically Necessary has the meaning defined in 1 Tex. Admin. Code. § 353.2 (Medicaid) and 1 Tex. Admin. Code. § 370.4 (CHIP).

Medically Underserved Areas (MUA) means areas or populations designated by the Health Resources and Services Administration as having: too few primary care providers, high infant mortality, high poverty or high elderly population. MUAs may be a whole county or a group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts in which residents have a shortage of personal health services.

Member means a person who has met Medicaid or CHIP eligibility criteria and is enrolled in the Dental Contractor's dental plan.

Member Advocate means the person with the primary responsibility for providing advocacy and assistance to Dental Members.

Member Materials means all written materials produced or authorized by the Dental Contractor and distributed to Dental Members or potential members containing information concerning the

Dental Program. Member Materials include, but are not limited to, Member ID cards, Member handbooks, Provider directories, and Marketing Materials.

Member Month means one Dental Member enrolled with the Dental Contractor during any given month. The total Member Months for each month of a year comprise the annual Member Months.

Migrant Farmworker means a migratory agricultural worker, generally defined as an individual:

(a) Whose principal employment is in agriculture on a seasonal basis;

(b) Who has been so employed within the last 24 months;

(c) Who performs an activity directly related to the production or processing of crops, dairy products, poultry, or livestock for initial commercial sale or as a principal means of personal subsistence; and

(d) Who establishes, for the purposes of such employment, a temporary abode.

National CLAS Standards means *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (the *National CLAS Standards*). These standards were developed by the U.S. Department of Health and Human Services - Office of Minority Health and are "intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services." Originally developed in 2000, the CLAS Standards were updated in 2013. For the list of CLAS Standards, see the Think Cultural Health website: https://www.thinkculturalhealth.hhs.gov/clas/standards.

Net Income Before Taxes or **Pre-tax Income** means an aggregate excess of Revenues over Allowable Expenses.

Network means all Dental Providers that have a Provider Contract with the Dental Contractor, or any Subcontractor, for the delivery of Medically Necessary Covered Dental Services to the Dental Contractor's members.

Non-capitated Services benefits of Texas Medicaid or CHIP that are excluded from Medically Necessary Covered Dental Services.

Non-emergency Medical Transportation (NEMT) Services means non-emergency transportation-related services available under the Medicaid state plan.

Nonmedical Transportation (NMT) Services has the meaning assigned by Tex. Gov't Code § 533.00258(a)(1).

Non-provider Subcontracts means contracts between the Dental Contractor and a third party that performs a function, excluding delivery of Medically Necessary Covered Dental Services that the Dental Contractor is required to perform under its Contract with HHSC.

Open Panel means Main Dentists who are accepting new patients for the Dental Program.

Open Practice means specialist dental providers who are accepting new patients for the Dental Program.

Operational Start Date means the first day on which the Dental Contractor is responsible for providing Medically Necessary Covered Dental Services to Dental Members in exchange for a Premium Payment under the Contract.

Operations Phase means the period of time when the Dental Contractor is responsible for providing the Medically Necessary Covered Dental Services and all related Contract functions and begins on the Operational Start Date.

Out-of-Network (OON) means an appropriately licensed individual, facility, agency, institution, organization, or other entity that has not entered into a contract with the Dental Contractor for the delivery of Medically Necessary Covered Dental Services to the Dental Contractor's Dental Members.

Overpayment means any payment made to a Network Provider by a MCO, PIHP, or PAHP to which the Network Provider is not entitled to under Title XIX or Title XXI of the Act or any payment to a MCO, PIHP, or PAHP by HHSC to which the MCO, PIHP, or PAHP is not entitled to under Title XIX or Title XXI of the Act.

Parties mean HHSC and the Dental Contractor, collectively.

Party means HHSC or the Dental Contractor, individually.

Pended Claim means a claim for payment that requires additional information before the claim can be adjudicated as a Clean Claim.

Person-Centered means the opportunity to achieve greater independence and community integration, through exercising self-direction, incorporation of individual perceptions and experiences, personal preferences and choices, and control with respect to services and providers, while ensuring medical and non-medical needs are met via means that are exclusively for the benefit of the individual in reaching their personal outcomes and allowing them to have the quality of life and level of independence they desire.

Population Risk Group means a distinct group of Dental Members identified by age, age range, gender, type of program, eligibility category, or other criteria established by HHSC.

PPACA means the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), together known as the Affordable Care Act (ACA).

Premium Payment means the aggregate amount paid by HHSC to the Dental Contractor on a monthly basis for the provision of Medically Necessary Covered Dental Services to enrolled Dental Members, including associated administrative services, in accordance with the Premium Rates in the Contract.

Premium Rate means a fixed predetermined fee paid by HHSC to the Dental Contractor each month in accordance with the Contract, for each enrolled Dental Member in a defined Rate Cell, in exchange for the Dental Contractor arranging for or providing a defined set of Medically

Necessary Covered Dental Services to such a Dental Member, regardless of the amount of Medically Necessary Covered Dental Services used by the enrolled Dental Member that are within the defined limits as stated in the Medically Necessary Covered Dental Services described in **Section 2.5.4** of the Statement of Work.

Prevalent Language has the meaning assigned to it in 42 C.F.R. § 438.10 and means a non-English language determined to be spoken by a significant number or percentage of potential members and Dental Members that are LEP. For the purposes of the Contract the terms "significant number or percentage" will mean ten percent of the population in a Service Area who speak the non-English language.

Preventive means aspects of oral health concerned with promoting good oral health and function by preventing or reducing the onset or development of oral diseases or deformities, and the occurrences of orofacial injuries.

Program means a managed care program operated by HHSC for either Children's Medicaid Dental Services or CHIP Dental Services.

Proposal means the submission by the Dental Contractor in response to the RFP.

Provider means an appropriately credentialed and licensed dentist facility, agency, institution, organization, or other entity, and its employees and subcontractors, who has a Provider Contract with the Dental Contractor for the delivery of Medically Necessary Covered Dental Services to Dental Members.

Provider Contract means a contract entered into by a direct provider of dental services and the Dental Contractor, or an intermediary entity, for the provision of Covered Dental Services to the Dental Contractor's Members.

Provider Materials means all written materials produced or authorized by the Dental Contractor or its administrative services Subcontractors concerning the Dental Program that are distributed to Providers and include the Dental Contractor's Provider Manual, training materials regarding the Dental Contractor's Dental Program requirements, and mass communications directed to all or a large group of Providers, e-mail or fax "blasts". Provider Materials do not include written correspondence between the Dental Contractor or its administrative services Subcontractors and a Provider regarding individual business matters.

Public Information means information that:

(a) Is collected, assembled, or maintained under a law or ordinance or in connection with the transaction of official business by a governmental body or for a governmental body; and

(b) The governmental body owns or has a right of access to.

Quality Improvement means a system to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

Rate Cell means a Population Risk Group for which a Premium Rate has been determined.

Real-Time Captioning also known as Communication Access Real-Time Translation (CART) means a process by which a trained individual uses a shorthand machine, a computer, and real-time translation software to type and simultaneously translate spoken language into text on a computer screen. Real Time Captioning is provided for individuals who are deaf, have hearing impairments, or have unintelligible speech. It is usually used to interpret spoken English into text English; but may be used to translate other spoken languages into text.

Readily Accessible has the meaning assigned to it in 42 C.F.R. § 438.10 and means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, and section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor version.

Readiness Review means HHSC or its agent's process of review, assessment, and determination of Dental Contractor's ability, preparedness, and availability to fulfill its obligations under the Contract.

Request for Proposals (RFP) means the procurement solicitation instrument issued by HHSC under which the Contract is awarded, and all RFP addenda, corrections or modifications.

Retaliation means an action, including refusal to renew or termination of a contract against a Provider because the Provider filed a complaint against the Dental Contractor or appealed an Action of the Dental Contractor on behalf of a Member.

Revenue means all revenue received by the Dental Contractor pursuant to the Contract during the Contract Term, including retroactive adjustments made by HHSC and includes any funds earned on Medicaid or CHIP managed care funds such as investment income and earned interest. Revenue excludes any reinsurance recoveries, which shall be shown in the FSR as a contra-cost, or reported offset to reinsurance expense. Revenues are reported at gross, and are not netted for any reinsurance premiums paid. See also the **Chapter 6 of the UMCM.**

Risk means the potential for loss as a result of expenses and costs of the Dental Contractor exceeding payments made by HHSC under the Contract.

Rural Health Clinic (RHC) means an entity that meets all of the requirements for designation as a rural health clinic under Section 1861(aa)(1) of the Social Security Act and approved for participation in the Texas Medicaid Program.

Scope of Work means the description of Services and Deliverables specified in the Contract, and any agreed modifications thereto.

SDX means State Data Exchange.

Security Plan means a document that contains detailed management, operational, and technical information about a system, its security requirements, and the controls implemented to provide protection against risks and vulnerabilities.

Service Area means geographic area wherein the Dental Program's Medically Necessary Covered Dental Services are available to Dental Members, which is statewide and includes all counties in the State of Texas.

Services mean the tasks, functions, and responsibilities assigned and delegated to the Dental Contractor under the Contract.

Significant Traditional Provider **(STP)** means dental providers identified by HHSC as having provided a significant level of care to Medicaid or CHIP clients.

Software means all operating system and applications software used by the Dental Contractor to provide the Services under the Contract.

Specialty Provider means a pediatric dentist, endodontist, oral surgeon, orthodontist, periodontist, or prosthodontist.

SSA means the Social Security Administration.

State Fair Hearing means the process adopted and implemented by HHSC in 1 Tex. Admin Code Chapter 357, in compliance with federal regulations and state rules relating to Medicaid Fair Hearings.

State Fiscal Year (SFY) means a 12-month period beginning on September 1st and ending on August 31.

Subcontract means any written Contract between the Dental Contractor and another party to fulfill the requirements of the Contract.

Subcontractor has the same meaning as assigned in 42 C.F.R. § 438.2.

Subsidiary means an Affiliate controlled by such person or entity directly, or indirectly through one or more intermediaries.

Supplemental Security Income (SSI) means a Federal income supplement program funded by general tax revenues, not Social Security taxes, designed to help aged, blind, and disabled people with little or no income by providing cash to meet basic needs for food, clothing, and shelter.

TDD means telecommunication device for the deaf. It is interchangeable with the term Teletype machine or TTY.

TDI means the Texas Department of Insurance.

Texas Health Steps is the name adopted by the State of Texas for the federally mandated EPSDT program, and includes the State's Comprehensive Care Program extension to EPSDT, which adds benefits to the federal EPSDT requirements contained in 42 U.S.C. § 1396d(r), and defined and codified at 42 C.F.R. §§ 440.40 and 441.56-62. HHSC's administrative rules governing Texas Health Steps and Comprehensive Care Program services are contained in 25 T.A.C. Chapter 33, relating to Early and Periodic Screening, Diagnosis and Treatment.

Texas Health Steps Outreach and Informing Unit means the HHSC Texas Health Steps vendor contracted to provide outreach and education to parents, caretakers, and older children about Texas Health Steps benefits and services.

Texas Medicaid Provider Procedures Manual means the policy and procedures manual published by or on behalf of HHSC that contains policies and procedures required of all health and dental care providers who participate in the Texas Medicaid program.

Texas Public Information Act refers to the provisions of Chapter 552 of the Texas Government Code.

Therapeutic means beneficial therapy or treatment, including the following categories of service: restorative, endodontic, periodontic, prosthodontic, oral and maxillofacial surgery, and orthodontic.

Third Party Liability (TPL) means the legal responsibility of another individual or entity to pay for all or part of the services provided to Dental Members under the Contract. See 1 T.A.C. §§ 354.2301 *et seq*., relating to Third Party Resources.

Third Party Recovery (TPR) means the recovery of payments on behalf of a Dental Member by HHSC or the Dental Contractor from an individual or entity with the legal responsibility to pay for the Medically Necessary Covered Dental Services.

TP 13 means Type Program 13 that is a Medicaid program eligibility type assigned to persons determined eligible for federal SSI assistance by the Social Security Administration (SSA). If a subsequent eligibility system uses a different identifier for this eligibility type, references to TP 13 include the subsequent identifier.

Transition Phase includes all activities the Dental Contractor is required to perform between the Effective Date and the Operational Start Date resulting from an award through procurement or an assignment and assumption due to termination, merger, or acquisition.

Transition Plan means the written proposal for readiness developed by the Dental Contractor, approved by HHSC, to be employed during the Transition Phase.

Turnover Phase includes all activities the Dental Contractor is required to perform prior to, upon, and following the termination of the Contract or the Expiration Date in order to close-out the Contract and transition Contract activities and operations to HHSC or a subsequent contractor.

Turnover Plan means the written proposal developed by the Dental Contractor, approved by HHSC, to be employed during the Turnover Phase.

Uniform Managed Care Manual (UMCM) means the manual published by or on behalf of HHSC that contains policies and procedures required of the Dental Contractor. The UMCM, as amended or modified, is incorporated by reference into the Contract.

Utilization Review means the system for retroactive, prospective, or concurrent review of the appropriateness of dental services being provided or proposed to be provided to a Dental Member. The term does not include elective requests for clarification of coverage.

Value-added Services (VAS) may be actual dental services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improve oral health outcomes among Dental Members. VAS must promote oral health, healthy lifestyles, or other initiatives approved

by HHSC. If approved by HHSC, VAS may also include transportation. Best practice approaches to delivering Medically Necessary Covered Dental Services are not considered VAS.

Waste means practices that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items, or services.

Article 3. General Contract Terms and Conditions

Section 3.01 Contract Elements.

(a) Contract documentation.

The Contract between the Parties will consist of the Dental Program Contract documents and all attachments and amendments to these documents.

(b) Order of documents.

In the event of any conflict or contradiction between or among these Contract documents, the documents must control in the following order of precedence:

(1) The final executed HHSC Dental Contract signature document, and all amendments thereto;

(2) Contract **Attachment A** – "HHSC's Dental Contract Terms and Conditions," and all amendments thereto;

(3) Contract **Attachment B** – "Scope of Work," and all attachments and amendments thereto;

(4) Contract **Attachment C -** HHSC's UMCM, and amendments thereto; and

(5) Contract **Attachment D** – "Dental Contractor's Proposal."

Section 3.02 Term of the Contract.

The term of the Contract will begin on the Effective Date and will conclude on the expiration date. The Parties may renew the Contract for a period or periods, but the Contract Term may not exceed a total of eight operational years. Subject to the provisions of **Section 12.04(e)**, all reserved contract extensions beyond the expiration date will be subject to good faith negotiations between the Parties and mutual agreement to the extensions.

Section 3.03 Funding.

This Contract is expressly conditioned on the availability of state and federal appropriated funds. The Dental Contractor will have no right of action against HHSC in the event that HHSC is unable to perform its contractual obligations as a result of the suspension, termination, withdrawal, or failure of funding to HHSC, or lack of sufficient funding of HHSC for any Services or Deliverables contained within the scope of the Contract. If funds become unavailable, the provisions of **Article 12** ("Remedies and Disputes") will apply. HHSC will use all reasonable efforts to ensure that such funds are available and will negotiate in good faith with

Dental Contractor to resolve any claims for payment by the Dental Contractor that represent accepted Services or Deliverables that are pending at the time funds become unavailable. HHSC will use best efforts to provide reasonable advance written notice to Dental Contractor upon learning that funding for the Contract may be unavailable.

Section 3.04 Delegation of Authority.

Whenever, by any provision of the Contract, any right, power, or duty is imposed or conferred on HHSC, the right, power, or duty so imposed or conferred is possessed and exercised by HHSC's Executive Commissioner unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of HHSC. The Executive Commissioner will reduce any such delegation of authority to writing and HHSC will provide a copy to Dental Contractor on request.

Section 3.05 No Waiver of Sovereign Immunity.

The Parties expressly agree that no provision of the Contract is in any way intended to constitute a waiver by HHSC or the State of any immunities from suit, or from liability that HHSC or the State may have by operation of law.

Section 3.06 Force Majeure.

Neither Party will be liable for any failure or delay in performing its obligations under the Contract if such failure or delay is due to a Force Majeure Event. The existence of such causes of delay or failure will extend the period of performance in the exercise of reasonable diligence until after the causes of delay or failure have been removed. Each Party must inform the other in writing with proof of receipt within five Business Days of the existence of a Force Majeure Event.

Section 3.07 Publicity.

(a) Dental Contractor may use the name of HHSC, the State of Texas, any HHS agency, and the name of the HHSC Dental Program in any media release, public announcement, or public disclosure relating to the Contract or its subject matter only if, at least seven Days prior to distributing the material, the Dental Contractor submits the information to HHSC for review and comment. The Dental Contractor may not use the submitted information without prior approval from HHSC. HHSC reserves the right to object to and require changes to the publication if, at HHSC's sole discretion, it determines that the publication does not accurately reflect the terms of the Contract or the Dental Contractor's performance under the Contract.

(b) Dental Contractor will provide HHSC at least three copies of any information described in subsection 3.07(a) prior to public release. Dental Contractor will provide additional copies at HHSC's request.

(c) The requirements of subsection 3.07(a) do not apply to:

(1) Proposals or reports submitted to HHSC, an administrative agency of the State, or a governmental agency, or unit of another state, or the federal government;

(2) Information concerning the Contract's terms, subject matter, and estimated value:

(i) In any report to a governmental body to which the Dental Contractor is required by law to report such information, or

(ii) That the Dental Contractor is otherwise required by law to disclose.

(3) Member Materials: the Dental Contractor must comply with the UMCM's provisions regarding the review and approval of Member Materials.

Section 3.08 Assignment.

(a) Assignment by Dental Contractor.

Dental Contractor must not assign all or any portion of its rights under or interests in the Contract without prior written consent of HHSC. Any written request for assignment must be accompanied by written acceptance by the party to whom the assignment is made. Except where otherwise agreed in writing by HHSC, assignment will not release Dental Contractor from its obligations pursuant to the Contract.

(b) Assignment by HHSC.

Dental Contractor understands and agrees HHSC may, in one or more transactions, assign, pledge, transfer, or hypothecate the Contract. This assignment will only be made to another State agency or a non-State agency that is contracted to perform agency support.

(c) Assumption.

Each party to whom an assignment is made (an "Assignee") must assume all of the assigned interests in and responsibilities under the Contract and any documents executed with respect to the Contract, including without limitation, its obligation for all or any portion of the purchase payments, in whole or in part.

Section 3.09 Cooperation with Other Vendors and Prospective Vendors.

HHSC may award supplemental contracts for work related to the Contract, or any portion thereof. Dental Contractor will reasonably cooperate with such other vendors and will not commit or permit any act that may interfere with the performance of work by any other vendor.

Section 3.10 Renegotiation and Reprocurement Rights.

(a) Renegotiation of Contract terms.

Notwithstanding anything in the Contract to the contrary, HHSC may at any time during the term of the Contract exercise the option to notify Dental Contractor that HHSC has elected to renegotiate certain terms of the Contract. Upon Dental Contractor's receipt of any notice pursuant to this section, Dental Contractor and HHSC will undertake good faith negotiations of

the subject terms of the Contract, and may execute an amendment to the Contract in accordance with Article 8 "Amendments and Modifications".

(b) Reprocurement of the services or procurement of additional services.

Notwithstanding anything in the Contract to the contrary, whether or not HHSC has accepted or rejected Dental Contractor's Services or Deliverables provided at any time during the Contract Term, HHSC may at any time issue requests for proposals or offers to other potential contractors for performance of any portion of the Services covered by the Contract or services similar or comparable to the Services performed by Dental Contractor under the Contract.

(c) Termination rights upon reprocurement.

If HHSC elects to procure the Services or Deliverables or any portion of the Services or Deliverables from another vendor in accordance with this Section, HHSC will have the termination rights set forth in Article 12 "Remedies and Disputes".

Section 3.11 RFP Errors and Omissions.

Dental Contractor will not take advantage of any errors or omissions in the RFP or the resulting Contract. Dental Contractor must promptly notify HHSC of any such errors or omissions that are discovered.

Section 3.12 Attorneys' Fees.

In the event of any litigation, appeal, or other legal action to enforce any provision of the Contract, Dental Contractor agrees to pay all reasonable expenses of such action, if HHSC is the prevailing Party.

Section 3.13 Preferences Under Service Contracts.

Dental Contractor is required in performing the Contract to purchase products and materials produced in the State when they are available at a price and time comparable to products and materials produced outside the State.

Section 3.14 Time of the Essence.

In consideration of the need to ensure uninterrupted and continuous Services to Dental Program Members, time is of the essence in the performance of the Services under the Contract.

Section 3.15 Notice.

(a) Any notice or other legal communication required or permitted to be made or given by either Party pursuant to the Contract will be in writing, and will be deemed to have been given:

(1) Three Business Days after the date of mailing if sent by registered or certified U.S. mail, postage prepaid, with return receipt requested;

(2) When transmitted if sent by facsimile, provided a confirmation of transmission is produced by the sending machine; or

(b) When delivered if delivered personally or sent by express courier service.

(c) The notices described in this section may not be sent by electronic mail.

(d) All notices must be sent to the program contact identified in the Contract. In addition, legal notices must be sent to the legal contact identified in the Contract.

(e) Routine communications that are administrative in nature will be provided in a manner agreed to by the Parties.

Article 4. Contract Administration and Management

Section 4.01 Qualifications, Retention and Replacement of Dental Contractor Employees.

Dental Contractor agrees to maintain the organizational and administrative capacity and capabilities to carry out all duties and responsibilities under the Contract. The personnel Dental Contractor assigns to perform the duties and responsibilities under the Contract will be properly trained and qualified for the functions they are to perform. Notwithstanding transfer or turnover of personnel, Dental Contractor remains obligated to perform all duties and responsibilities under this Contract without degradation and in accordance with the terms of this Contract.

Section 4.02 Dental Contractor's Key Personnel.

(a) Designation of Key Personnel.

Dental Contractor must designate key management and technical personnel who will be assigned to the Contract. For the purposes of this requirement, Key Personnel are those with management responsibility or principal technical responsibility for the following functional areas:

(1) Member services;

(2) Management Information Systems;

(3) Claims processing,

(4) Network development and management;

(5) Benefit administration and utilization and care management;

(6) Quality Improvement;

(7) Financial functions;

(8) Reporting;

(9) Security Official as required in 45 C.F.R. § 164.308(a)(2); and Privacy Official as required in 45 C.F.R. § 164.530(a)(2).

(10) Executive Directors, as defined in Section 4.03;

(11) Dental Director, as defined in **Section 4.04 below ("Dental Director")**; and

(12) Special Investigative Unit (SIU)

(b) Support and Replacement of Key Personnel.

Dental Contractor must maintain, throughout the Contract Term, the ability to supply its Key Personnel with the required resources necessary to meet Contract requirements and comply with applicable law. Dental Contractor must ensure project continuity by timely replacement of Key Personnel, if necessary, with a sufficient number of persons having the requisite skills, experience and other qualifications. Regardless of specific personnel changes, Dental Contractor must maintain the overall level of expertise, experience, and skill reflected in Dental Contractor's Proposal.

(c) Notification of replacement of Key Personnel.

Dental Contractor must notify HHSC in writing within 15 Business Days of any change in Key Personnel. Hiring or replacement of Key Personnel must conform to all Contract requirements. If HHSC determines that a satisfactory working relationship cannot be established between certain Key Personnel and HHSC, it will notify the Dental Contractor in writing. Upon receipt of HHSC's notice, HHSC and Dental Contractor will attempt to resolve HHSC's concerns on a mutually agreeable basis.

Section 4.03 Executive Director.

(a) Dental Contractor must employ a qualified individual to serve as the Executive Director for the Dental Program. The Executive Director must be employed full-time by Dental Contractor, be primarily dedicated to the Dental Program, and must hold a Senior Executive or Management position in Dental Contractor's organization, except that Dental Contractor may propose an alternate structure for the Executive Director position, subject to HHSC's prior review and written approval.

(b) The Executive Director must be authorized and empowered to represent Dental Contractor regarding all matters pertaining to the Contract prior to such representation. The Executive Director must act as liaison between Dental Contractor and HHSC and must have responsibilities that include, but are not limited to:

(1) Ensuring Dental Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

(2) Receiving and responding to all inquiries and requests made by HHSC related to the Contract, in the timeframes and formats specified by HHSC. Where practicable, HHSC will consult with Dental Contractor to establish timeframes and formats reasonably acceptable to the Parties;

(3) Attending and participating in regular meetings or conference calls with HHSC;

(4) Attending and participating in regular HHSC Regional Advisory Committees (RACs) for managed care. The Executive Director may designate key personnel to attend a RAC if the Executive Director is unable to attend;

(5) Making best efforts to promptly resolve any issues identified either by Dental Contractor or HHSC that may arise and are related to the Contract;

(6) Meeting with HHSC representative(s) on a periodic or as needed basis to review Dental Contractor's performance and resolve issues, and

(7) Meeting with HHSC at the time and place requested by HHSC, if HHSC determines that Dental Contractor is not in compliance with the requirements of the Contract.

Section 4.04 Dental Director.

(a) Dental Contractor must have a qualified full-time individual to serve as the Dental Director for the Dental Program. The Dental Director must be currently licensed in Texas as a Doctor of Dentistry with no restrictions or other licensure limitations. The Dental Director must comply with applicable federal and state statutes and regulations.

(b) The Dental Director, or his or her designee meeting the qualifications described in Section 4.04(a), must be available during normal business hours for Utilization Review decisions, and must be authorized and empowered to represent Dental Contractor regarding clinical issues, Utilization Review and quality of care inquiries.

Section 4.05 Responsibility for Dental Contractor Personnel and Subcontractors.

(a) Dental Contractor employees and Subcontractor employees will not be considered employees of HHSC or the State; but will be considered for all purposes as Dental Contractor's employees or its Subcontractor's employees, as applicable.

(b) Except as expressly provided in the Contract, neither Dental Contractor nor any of Dental Contractor's employees or Subcontractors may act in as agents or representatives of HHSC or the State.

(c) Dental Contractor agrees that anyone employed by Dental Contractor to fulfill the terms of the Contract is an employee of Dental Contractor and remains under Dental Contractor's sole direction and control. Dental Contractor assumes sole and full responsibility for its acts and the acts of its employees and Subcontractors.

(d) Dental Contractor agrees that any claim on behalf of any person arising out of employment or alleged employment by Dental Contractor, including, but not limited to, claims of discrimination against Dental Contractor, its officers, or its agents, is the sole responsibility of Dental Contractor and not the responsibility of HHSC. Dental Contractor will indemnify and hold harmless the State from any and all claims asserted against the State arising out of such employment or alleged employment by Dental Contractor. Dental Contractor understands that any person who alleges a claim arising out of employment or alleged employment by Dental Contractor will not be entitled to any compensation, rights, or benefits from HHSC including, but not limited to, tenure rights, medical and hospital care, sick and annual or vacation leave, severance pay, or retirement benefits.

(e) Dental Contractor agrees to be responsible for the following in respect to its employees:

(1) Damages incurred by Dental Contractor's employees within the scope of their duties under the Contract; and

(2) Determination of the hours to be worked and the duties to be performed by Dental Contractor's employees.

(f) Dental Contractor agrees and will inform its employees and Subcontractor(s) that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to them by Dental Contractor pursuant to the Contract or any judgment rendered against the Dental Contractor. HHSC's liability to the Dental Contractor's employees, agents, and Subcontractors, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Prac. & Rem. Code §§ 101.001 et seq.).

(g) Dental Contractor understands that HHSC does not assume liability for the actions of, or judgments rendered against, Dental Contractor, its employees, agents, or Subcontractors. Dental Contractor agrees that it has no right to indemnification, or contribution from HHSC for any such judgments rendered against Dental Contractor or its Subcontractors.

Section 4.06 Cooperation with HHSC and State Administrative Agencies.

(a) Cooperation with other HHSC Dental Contractors.

Dental Contractor agrees to reasonably cooperate and work with the State's contractors, including other Dental Contractors, Subcontractors and third-party representatives as requested by HHSC. To the extent permitted by HHSC's financial and personnel resources, HHSC agrees to reasonably cooperate with Dental Contractor and to use its best efforts to ensure that other HHSC contractors reasonably cooperate with the Dental Contractor.

(b) Cooperation with state and federal administrative agencies.

Dental Contractor must ensure that Dental Contractor personnel cooperate with HHSC or other state or federal administrative agency personnel at no charge to HHSC for purposes relating to the administration of the Dental Program including, but not limited to the following purposes:

(1) The investigation and prosecution of fraud, abuse, and waste in the HHSC programs;

(2) Audit, inspection, or other investigative purposes; and

(3) Testimony in judicial or quasi-judicial proceedings relating to the Services or Deliverables under this Contract or other delivery of information to HHSC or other agencies' investigators or legal staff.

(4) Conduct of Dental Contractor personnel and Subcontractors.

Section 4.07 Conduct of Dental Contractor Personnel and Subcontractors.

(a) While performing the Services, Dental Contractor's personnel and Subcontractors must:

(1) Comply with applicable State laws, rules, and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations; and

(2) Otherwise conduct themselves in a businesslike and professional manner.

(b) If HHSC determines in good faith that a particular employee or Subcontractor is not conducting himself or herself in accordance with the Contract, HHSC may provide Dental Contractor with notice and documentation concerning such conduct. Upon receipt of such notice, Dental Contractor must promptly investigate the matter and take appropriate action that may include:

(1) Removing the employee or Subcontractor from the project;

(2) Providing HHSC with written notice of such removal; and

(3) Replacing the employee or Subcontractor with a similarly qualified individual or Subcontractor acceptable to HHSC.

(c) Nothing in the Contract will prevent Dental Contractor, at the request of HHSC, from replacing any personnel who are not adequately performing their assigned responsibilities or who, in the reasonable opinion of HHSC's project manager, after consultation with Dental Contractor, are unable to work effectively with the members of HHSC's staff. In such event, Dental Contractor will provide replacement personnel with equal or greater skills and qualifications as soon as reasonably practicable. Replacement of Key Personnel will be subject to HHSC review. The Parties will work together in the event of any such replacement so as not to disrupt the overall project schedule.

(d) Dental Contractor agrees that anyone employed or retained by Dental Contractor to fulfill the terms of the Contract remains under Dental Contractor's sole direction and control.

(e) Dental Contractor must have policies regarding disciplinary action for all employees who have failed to comply with federal or state laws and the Dental Contractor's standards of conduct, policies and procedures, and contract requirements. Dental Contractor must have policies regarding disciplinary action for all employees who have engaged in illegal or unethical conduct.

Section 4.08 Subcontractors and Agreements with Third Parties.

(a) Dental Contractor remains fully responsible for the obligations, services, and functions performed by its Subcontractors to the same extent as if such obligations, services, and functions were performed by Dental Contractor's employees, and for purposes of the Contract such work will be deemed work performed by Dental Contractor. The Dental Contractor must ensure its contracts with Subcontractors comply with all of the requirements of 42 C.F.R. 438.230. HHSC reserves the right to require the replacement of any Subcontractor found by HHSC to be unacceptable and unable to meet the requirements of the Contract, and to object to the selection of a Subcontractor.

(b) Dental Contractor must:

(1) Actively monitor the quality of care and Services, as well as the quality of reporting data, provided under a Subcontract;

(2) Provide HHSC with a copy of TDI filings of delegation agreements;

(3) Unless otherwise provided in this Contract, provide HHSC with written notice no later than:

(i) 3 Business Days after receiving notice from a Material Subcontractor of its intent to terminate a Subcontract;

(ii) 180 Days prior to the termination date of a Material Subcontract for MIS systems operation or reporting;

(iii) 90 Days prior to the termination date of a Material Subcontract for non-MIS Dental Administrative Services; and

(iv) 30 Days prior to the termination date of any other Material Subcontract.

HHSC may grant a written exception to these notice requirements if, in HHSC's reasonable determination, Dental Contractor has shown good cause for a shorter notice period.

(c) During the Contract Term, Readiness Reviews by HHSC or its designated agent may occur if:

(1) A new Material Subcontractor is employed by Dental Contractor;

(2) An existing Material Subcontractor provides services in a new area;

(3) An existing Material Subcontractor changes locations or changes its MIS and or operational functions;

(4) An existing Material Subcontractor changes one or more of its MIS subsystems, claims processing or operational functions; or

(5) A Readiness Review is requested by HHSC.

Dental Contractor must submit information required by HHSC for each proposed Material Subcontractor as indicated in **RFP Section 2.4**, "Transition Phase Scope." Refer to **RFP Sections 2.5.2**, "Additional Operational Readiness Reviews and Monitoring Efforts," and **2.5.29**, "Management Information System (MIS) Requirements" for additional information regarding Dental Contractor Readiness Reviews during the Contract Term.

(d) Dental Contractor must not disclose HHSC's or the State's Confidential Information to a Subcontractor unless Subcontractor has agreed in writing to protect the confidentiality of such Confidential Information in the manner required of Dental Contractor under the Contract.

(e) Dental Contractor must identify any Subcontractor that is a subsidiary or entity formed after the Effective Date of the Contract, whether or not an Affiliate of the Dental Contractor. Dental Contractor must substantiate the proposed Subcontractor's ability to perform the subcontracted Services, and certify to HHSC that no loss of service will occur as a result of the performance of such Subcontractor. Dental Contractor will be the sole point of contact with regard to contractual matters.

(f) Except as provided herein, all Subcontracts must be in writing and must provide HHSC the right to examine the Subcontract and complete and unredacted originals or copies of all Subcontractor records and information relating to the Contract and the Subcontract. This requirement does not apply to agreements with non-affiliate utility or mail service providers.

If Dental Contractor intends to report compensation or any other payments paid to any third party, including an Affiliate as an Allowable Expense under the Contract, and the amounts paid to the third party exceed $200,000, or are reasonably anticipated to exceed $200,000, in a SFY, or in any contiguous twelve-month period, then Dental Contractor's agreement with the third party must be in writing. The agreement must provide HHSC the right to examine the agreement and complete and unredacted originals or copies of all records and information relating to the agreement.

For any third party agreements not in writing valued under $200,000 per SFY that are reported as Allowable Expenses, the Dental Contractor must maintain standard financial records and data sufficient to verify the accuracy of those expenses in accordance with the requirements of Article 9, "Audit & Financial Compliance." Any agreements that are, or could be interpreted to be, with a single party, must be in writing if the combined total is more than $200,000. This would include payments to individuals or entities that are related to each other.

(g) A Subcontract or any other agreement in which Dental Contractor receives rebates, recoupments, discounts, payments, incentives, fees, free goods, bundling arrangements, retrocession payments, as described in **Chapter 6 of the UMCM**, or any other consideration from a Subcontractor or any other third party, including Affiliates as related to the Contract must be in writing. Dental Contractor must allow HHSC and the Office of the Attorney General to examine the Subcontract or agreement and complete and unredacted originals or copies of all related records and information.

(h) All Subcontracts or agreements described in subsections (f) and (g) must show the dollar amount or the value of any consideration that Dental Contractor pays to or receives from the Subcontractor or any other third party.

(i) Dental Contractor must submit a copy of each Material Subcontract and any agreement covered under subsection (g) executed prior to the Effective Date of the Contract to HHSC no later than 30 days after the Effective Date of the Contract. For Material Subcontracts or Section 4.08(g) agreements executed or amended after the Effective Date of the Contract, the Dental Contractor must submit a copy to HHSC no later than 5 Business Days after execution or amendment.

(j) HHSC reserves the right to reject any Subcontract or require changes to any provisions that do not comply with the requirements or duties and responsibilities of the Contract or create significant barriers for HHSC in monitoring compliance with the Contract.

(k) Dental Contractor and its Subcontractors must provide all information required under Section 4.08 to HHSC, or to the Office of the Attorney General, if requested, at no cost.

Section 4.09 HHSC's Ability to Contract with Subcontractors.

Dental Contractor may not limit or restrict, through a covenant not to compete, employment contract or other contractual arrangement, HHSC's ability to contract with Subcontractors or former employees of the Dental Contractor.

Section 4.10 This Section Intentionally Left Blank.

Section 4.11 Prohibition Against Performance Outside the United States.

(a) All work performed under this Agreement must be performed exclusively within the United States.

(1) All information obtained by the Dental Contractor or a Subcontractor under the Contract must be stored and maintained within the United States.

(2) The performance of any work or the maintenance of any information relating or obtained pursuant to this Contract is forbidden to occur outside of the United States.

(b) For the purpose of this Contract "within the United States" and "outside the United States" means the following:

(1) As used in this **Section 4.11**, the term "within the United States" means any location inside the territorial boundaries comprising the republic of the United States of America, including any of the 48 coterminous states in North America, the states of Alaska and Hawaii, and the District of Columbia.

(2) Conversely, the phrase "outside the United States" means any location that is not within the territorial boundaries comprising the republic of the United States of America, including any of the 48 coterminous states in North America, the states of Alaska and Hawaii, and the District of Columbia.

(c) Maintenance of Confidential Information.

(1) The Dental Contractor and all Subcontractors, vendors, agents, and service providers of or for the Dental Contractor must not allow any Confidential Information that the Dental Contractor receives from or on behalf of HHSC to be moved outside the United States by any means, physical or electronic, at any time, for any period of time, for any reason.

(2) The Dental Contractor and all Subcontractors, vendors, agents, and service providers of or for the Dental Contractor must not permit any person to have remote access to HHSC information, systems, or Deliverables from a location outside the United States.

(d) Performance of Work.

(1) Subject to the exceptions specified in this subparagraph, the Dental Contractor and all Subcontractors, vendors, agents, and service providers of or for the Dental Contractor must perform all services under this Contract, including all tasks, functions, and responsibilities assigned and delegated to the Dental Contractor under this Contract, within the United States.

(i) This obligation includes, but is not limited to, all Services, including information technology services, processing, transmission, storage, archiving, data center services, disaster recovery sites and services, customer support, medical, dental, laboratory and clinical services.

(ii) All custom software prepared for performance of the Contract, and all modifications of custom, third party, or vendor proprietary software, must be performed within the United States.

(2) Subject to the exceptions specified in this subparagraph, the Dental Contractor and all Subcontractors, vendors, agents, and service providers of or for the Dental Contractor must not permit any person to perform work under the Contract from a location outside the United States.

(e) Exceptions.

(1) COTS software. The foregoing requirements will not preclude the acquisition or use of commercial off-the-shelf software that is developed outside the United States or hardware/ that is generically configured outside the United States.

(2) Foreign-made products and supplies. The forgoing requirements will not preclude the Dental Contractor from acquiring, using, or reimbursing products or supplies that are manufactured outside the United States, provided such products or supplies are commercially available within the United States for acquisition or reimbursement by HHSC.

Section 4.12 Employment Verification (E-Verify Program).

(a) Dental Contractors must confirm the eligibility of all persons employed by the Dental Contractor to perform duties within Texas and all persons, including subcontractors, assigned by the Dental Contractor to perform work pursuant to the Contract.

(b) The Dental Contractor may not knowingly have a relationship with the following:

(1) An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(2) An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, of a person described in (b) (1) of this section.

A relationship as described in this section is as follows:

(1) A director, officer, or partner of the Dental Contractor.
(2) A subcontractor of the Dental Contractor as governed by 42 C.F.R. § 438.230.
(3) A person with ownership of 5 percent or more of the Dental Contractor.

(4) A person with an employment, consulting or other arrangement with the Dental Contractor for the provision of items and services that relate to the Dental Contractor's obligations under its contract with the State.

(c) The Dental Contractor must confirm the identity and determine the exclusion status, any subcontractor of the Dental Contractor (as governed by 42 C.F.R. § 438.230), as well as any person with an ownership or control interest, or who is an agent or managing employee of the Dental Contractor as defined in (b) of this section upon contract execution and through checks of federal databases that include the:

(1) U.S. Department of Health and Human Services, Office of Inspector General's List of Excluded Individuals and Entities (LEIE);
(2) System for Awards Management (SAM) [the successor to the Excluded Parties List System (EPLS)];
(3) Social Security Administration's Death Master File (SSA-DMF); and
(4) National Plan & Provider Enumeration System.

(d) The Dental Contractor must consult the databases upon contracting and no less frequently than monthly thereafter. If the Dental Contractor finds a party that is excluded, it must promptly notify the entity and take action consistent with 42 C.F.R. § 438.610(c).

(e) The Dental Contractor must maintain records demonstrating compliance with this section in accordance with Section 9.01 below.

By entering into this Contract, Dental Contractor certifies and ensures that it utilizes and will continue to utilize, for the term of this Contract, the U.S. Department of Homeland Security's verify system to determine the eligibility of all persons, including Subcontractors, assigned by the Dental Contractor to perform work pursuant to the Contract.

Article 5. Member Eligibility, Enrollment, and Disenrollment

Section 5.01 Eligibility Determination and Disenrollment

The HHSC Enrollment Broker determines Medicaid and CHIP eligibility. Should a Member become ineligible for Medicaid, HHSC will disenroll the Member from the managed care plan. If a Dental Contractor becomes aware that a Member has moved outside of the Dental Contractor service area or that a Member is no longer Medicaid-eligible, for example the Member has moved outside of the state or is deceased, the Dental Contractor must inform HHSC within 10 Business Days.

Section 5.02 General Information Concerning Member Enrollment and Disenrollment.

(a) HHSC or the HHSC Enrollment Broker will enroll and disenroll eligible individuals in the Dental Program. The HHSC Enrollment Broker will use HHSC's default assignment

methodologies, as described in 1 Tex. Admin. Code § 353.403 and § 370.303, to enroll individuals who do not select a Dental Plan or Main Dentist. Once an eligible individual is enrolled, a file is sent to the Dental Contractor to notify the Dental Contractor that the individual is enrolled as a Medicaid or CHIP Member. The Dental Contractor is not allowed to induce or accept disenrollment from a Member. The Dental Contractor must refer the Member to the HHSC Enrollment Broker for information regarding enrollment or disenrollment.

(b) HHSC makes no guarantees or representations to the Dental Contractor regarding the number of eligible Members who will ultimately be enrolled into the Dental Contractor's plan, or the length of time Members will remain enrolled in the Dental Contractor's plan. The Dental Contractor has no ownership interest in its Member base, and therefore cannot sell or transfer this base to another entity.

(c) The HHSC Enrollment Broker will electronically transmit to the Dental Contractor new Member information and change information applicable to active Members.

Section 5.03 Medicaid Member Enrollment and Disenrollment.

(a) Medicaid Members are given the opportunity to request a termination or change enrollment from one dental plan to another. A Medicaid Member can request to change dental plans for any reason during the first 90 days of enrollment in a dental plan, and once thereafter. A Medicaid Member can also request to change dental plans for "good cause" at any time. HHSC or its designee will determine "good cause" events that qualify a Member to change dental plans. If a Member requests a change, the change will be prospective, and the effective date will be the first day of the month in which the Member appears on the Member eligibility file for the receiving dental plan.

(b) In cases where a Member loses Medicaid eligibility, if Medicaid eligibility is re-instated or re-established within 6 months from the date of loss, HHSC will retroactively restore a Member's managed care enrollment to avoid a gap in coverage. In these cases, the HHSC Enrollment Broker will retroactively enroll the Member into the same dental plan the Member was in before losing coverage. The retro-enrolled Members will be sent on a daily file to the Dental Contractor and the Dental Contractor must upload the daily Enrollment File into its system within 24 hours of receipt.

(c) A Medicaid Dental Contractor has a limited right to request a Member be disenrolled from Dental Contractor without the Member's consent. HHSC must approve any Dental Contractor request for disenrollment of a Member for cause. HHSC may permit disenrollment of a Member under the following circumstances:

(1) Member misuses or loans Member's membership card to another person to obtain services.

(2) Member's behavior is disruptive or uncooperative to the extent that Member's continued enrollment in the Dental Contractor seriously impairs Dental Contractor's or Provider's ability to provide services to either the Member or other Members, and Member's

behavior is not related to a developmental, intellectual, or physical disability or behavioral health condition.

(3) Member steadfastly refuses to comply with managed care restrictions.

(4) Dental Contractor must take reasonable, documented measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

(d) HHSC must notify the Member of HHSC's decision to disenroll the Member if all reasonable measures have failed to remedy the problem.

(e) If the Member disagrees with the decision to disenroll the Member from Dental Contractor, HHSC must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's Fair Hearing process.

(f) Dental Contractor cannot request a disenrollment based on adverse change in the Member's health status or utilization of services that are Medically Necessary for treatment of a member's condition.

(g) Members taken into conservatorship by the Department of Family and Protective Services (DFPS) will be disenrolled from the Dental Contractor effective the date of conservatorship and enrolled in the STAR Health Program unless otherwise determined by DFPS.

Section 5.04 CHIP Eligibility and Enrollment.

(a) Children enrolled in the CHIP Program with incomes at or below the Medicaid eligibility threshold receive Dental Program coverage for 12 months. Children enrolled in CHIP with incomes above the Medicaid eligibility threshold receive Dental Program coverage for up to 12 months and are required to verify income eligibility at month 6 of their 12-month coverage period. Should a Member become ineligible for CHIP, HHSC will disenroll the Member from the managed care plan. If a Dental Contractor becomes aware that a Member is no longer CHIP-eligible, for example the Member has moved outside of the state or is deceased, the Dental Contractor must inform HHSC within five Business Days.

(b) CHIP Members are given the opportunity to request a termination or change enrollment from one dental plan to another within the first 90 days after Dental Program coverage begins. If a Member requests a change from one dental plan to another, the change will be prospective, and the effective date will be the first day of the month in which the Member appears on the Member eligibility file for the receiving dental plan.

(c) HHSC Enrollment Broker enrolls and disenrolls Members from dental plans. HHSC Enrollment Broker will not allow Members to change dental plans after their first 90 days of coverage unless granted an exception for a "good cause" event. HHSC and the HHSC Enrollment Broker determine "good cause" events that qualify a CHIP Member to change dental plans. Additionally, HHSC Enrollment Broker will not allow CHIP Members who have exhausted their annual benefit limits to change dental plans.

Section 5.05 Default Enrollment.

The following special Default Enrollment process will apply to and be calculated separately for Medicaid and CHIP program recipients.

(a) Special Default Enrollment Process.

(1) Prior to the Operational Start Date, HHSC's Administrative Service Contractor will notify all Dental Members and new enrollees of their choice in dental plans. If a Dental Member does not select a dental plan by the due date established by HHSC, the Dental Member will remain with the Dental Member's current dental plan. If a new enrollee does not select a dental plan by the due date established by HHSC, HHSC will utilize the following special default enrollment process:

i. if the new enrollee has a dental plan affiliation within the last 12 months, assign the new enrollee to the affiliated dental plan;

ii. if a household member of the new enrollee is enrolled in a dental plan, assign the new enrollee to the household member's dental plan; or

iii. if the new enrollee does not have a dental plan affiliation within the last 12 months or a household member that is enrolled in a dental plan, assign the new enrollee to any dental plan below the minimum enrollment threshold in an equal manner.

(2) HHSC will assign new enrollees to a dental plan accordance with this subsection until all dental plans meet the minimum enrollment threshold. The minimum enrollment threshold is 300,000 Members in Medicaid and 80,000 Members in CHIP.

(3) During this maintenance period, if one or more dental plans' enrollment falls below the threshold, HHSC will enroll all individuals who have not made a dental plan selection into these dental plans on a Round Robin basis until they reach the required Member threshold again it will receive 100 percent of the unassociated Member default enrollments until the threshold is reached. If more than one plans' enrollment falls below the threshold, the default population will be split between the plans.

(4) To offset incumbent plans' advantage with prior coverage and household associations, an incremental default process will begin for the incoming plan and continue through operational year one after the enrollment threshold is met.

(5) The default process will incrementally decrease the percentage of unassociated defaults from the initial 100 percent of unassociated defaults down to 33.33 percent over the remaining months of operational year one. The incremental decline will be calculated by dividing 66.67 percent (incumbents' portion of the unassociated defaults) by the number of remaining months left in operational year one. If the incoming plan reaches the enrollment ceiling of one-third of the total dental managed care enrollment population in either Medicaid or CHIP, HHSC will stop the incremental default process for that program and begin the ongoing standard default process, described below in Section 5.05(c), in which all plans receive an equal distribution of the default pool. If the

incoming plan fails to meet the enrollment thresholds during year one, the incremental default process will not go into effect.

(6) Medicaid and CHIP default processes will be evaluated separately. For example, if the enrollment minimum threshold is reached in Medicaid but not in CHIP, the initial default process will continue in CHIP and Medicaid will move to an incremental approach.

(7) HHSC reserves the right to revisit these processes if monitoring of enrollment trends or other factors indicate an adjustment to the default enrollment strategy is needed (e.g., due to a significant shift in enrollments).

(8) HHSC will provide notice to the dental plans at least 30 Days in advance of any changes to the final default enrollment strategy outlined above.

(b) Standard Default Enrollment Process.

(1) The standard default enrollment process is a process by which HHSC, on a monthly basis:

i. determines the total number of Dental Members who have not selected a dental plan; and

ii. from this total number, assigns an equal number of Dental Members to each dental plan to the extent possible.

(2) HHSC uses the standard default enrollment process if:

(i) in operational year one, all of the dental plans meet Indie the enrollment ceiling of one-third of the total dental managed care enrollment population in either Medicaid or CHIP (as applicable, Medicaid and CHIP ceilings are treated separately); or

(ii) in a year other than operational year one:

(A) all dental plans meet the enrollment threshold; or
(B) all dental plan's six-month maintenance period have expired.

(c) Changing Assigned Dental Plan.

Defaulted Dental Members may change their assigned dental plan under the conditions described in **Section 5.03** for Medicaid members and **Section 5.04** for CHIP members.

Article 6. Service Levels and Performance Measurement

Section 6.01 Performance Measurement.

(a) Satisfactory performance of this Contract will be measured by:

(b) Adherence to this Contract, including all representations and warranties;

(c) Compliance with project work plans, schedules, and milestones as proposed by Dental Contractor in its Proposal and as revised by Dental Contractor and finally approved by HHSC;

(d) Delivery of the Services and Deliverables in accordance with the Contract's requirements;

(e) Results of audits performed by HHSC or its representatives in accordance with **Article 9** ("Audit and Financial Compliance");

(f) Timeliness, completeness, and accuracy of required Deliverables; and

(g) Achievement of contractual performance measures.

Article 7. Governing Law and Regulations

Section 7.01 Governing Law and Venue.

This Contract is governed by the laws of the State of Texas and interpreted in accordance with Texas law. Provided Dental Contractor first complies with the procedures set forth in **Section 12.13** ("Dispute Resolution,") proper venue for claims arising from this Contract will be in the State District Court of Travis County, Texas.

Section 7.02 Dental Contractor Responsibility for Compliance with Laws and Regulations.

(a) Dental Contractor must comply, to the satisfaction of HHSC, with all provisions set forth in this Contract, and all provisions of state and federal laws, rules, regulations, federal waivers, policies and guidelines that govern the performance of the Services including, but not limited to, all applicable provisions of the following:

(1) Titles XIX and XXI of the Social Security Act;

(2) The Immigration and Nationality Act (8 U.S.C. §§ 1101 *et seq.*) and all subsequent immigration laws and amendments.

(3) The Patient Protection and Affordable Care Act ("PPACA"; Public Law 111-148);

(4) The Health Care and Education Reconciliation Act of 2010 ("HCERA"; Public Law 111-152) 42 C.F.R. Part 455;

(5) Health Insurance Portability and Accountability Act (Public Law 104-191) 45 C.F.R. Parts 160-164;

(6) Clinical Laboratory Improvement Amendments (CLIA, 42 C.F.R. Part 493) (for purposes of the Contract, the Dental Contractor must require its Providers to agree that the Dental Contractor and HHSC are "authorized persons");

(7) 42 C.F.R. Parts 417, 438, 455, and 457, as applicable;

(8) 45 C.F.R. Parts 74 and 92;

(9) 48 C.F.R. Part 31;

(10) 2 C.F.R. Part 200;

(11) Chapters 62, 63, 109, and 181 Texas Health and Safety Code;

(12) Chapter 531 and 533, Texas Government Code;

(13) Chapter 35ATexas Penal Code;

(14) Chapters 32 and 36 Texas Human Resources Code, except as provided in Section 2.5.17, the Texas Dental Practice Act requiring all dental services to be provided by licensed Texas dentists and auxiliary personnel working under the supervision of licensed Texas dentists;

(15) 1 Tex. Admin. Code Chapter 353;

(16) 1 Tex. Admin. Code Chapter 354, Subchapters B and J;

(17) 1 Tex. Admin. Code. Chapters 361, 370, 371, 391, and 392;

(18) Consent Decree and Corrective Action Orders, Frew, et al. v. Smith, et al., (applies to Medicaid only);

(19) The Dental Contractor is prohibited from requiring a Network Provider who is a governmental entity to agree to indemnify the Dental Contractor if such indemnification by the governmental entity is prohibited by law.

(b) The Parties acknowledge that the federal or state laws, rules, regulations, policies, or guidelines that affect the performance of the Services may change from time to time or be added, judicially interpreted, or amended by competent authority. Dental Contractor acknowledges that the Dental Program will be subject to continuous change during the term of the Contract and, except as provided in **Section 8.02**. Dental Contractor has provided for or will provide for adequate resources, at no additional charge to HHSC, to reasonably accommodate such changes. The Parties further acknowledge that Dental Contractor was selected, in part, because of its expertise, experience, and knowledge concerning applicable federal or state laws, rules, regulations, policies, or guidelines that affect the performance of the Services. In keeping with HHSC's reliance on this knowledge and expertise, Dental Contractor is responsible for identifying the impact of changes in applicable federal or state legislative enactments and regulations that affect the performance of the Services or the State's use of the Services. Dental Contractor must timely notify HHSC of such changes and must work with HHSC to identify the impact of such changes on how the State uses the Services.

(c) HHSC will notify Dental Contractor of any changes in applicable law, rule, regulation, policy, or guidelines that HHSC becomes aware of in the ordinary course of its business.

(d) The Dental Contractor is responsible for compliance with changes in federal and state law that occur during the course of the contract term. If there are any conflicts between rules promulgated by CMS, including the C.F.R., and this Contract, then the federal rule takes precedence over the Contract and the Dental Contractor must comply with the C.F.R unless CMS has waived applicability of the C.F.R. provision to Texas Medicaid via a waiver.

(e) Dental Contractor is responsible for any fines, penalties, or disallowances imposed on the State or Dental Contractor arising from any noncompliance with the laws and regulations relating to the delivery of the Services or Deliverables by the Dental Contractor, its Subcontractors or agents.

(f) Dental Contractor is responsible for ensuring each of its employees, agents, or Subcontractors who provide Services or Deliverables under the Contract is properly licensed, certified, and/or has proper permits to perform any activity related to the Services or Deliverables.

(g) Dental Contractor warrants that the Services and Deliverables will comply with all applicable federal, state, and county laws, regulations, codes, ordinances, guidelines, and policies. Dental Contractor will indemnify HHSC from and against any losses, liability, claims, damages, penalties, costs, fees, or expenses arising from or in connection with Dental Contractor's failure to comply with or violation of any such law, rule, regulation, code, ordinance, or policy.

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Section 7.04 This Section Intentionally Left Blank.

Section 7.05 Compliance with State and Federal Anti-discrimination Laws.

(a) Dental Contractor agrees to comply with state and federal anti-discrimination laws, including without limitation:

(1) Title VI of the Civil Rights Act of 1964 (42 U.S.C. §§ 2000d *et seq*.);

(2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794);

(3) Americans with Disabilities Act of 1990 (42 U.S.C. §§ 12101 *et seq*.);

(4) Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-6107);

(5) Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681-1688 regarding education programs and activities);

(6) Food and Nutrition Act of 2008 (7 U.S.C. §§ 2011 *et. seq*.); and

(7) The HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

Dental Contractor agrees to comply with all amendments to the above-referenced laws, and all requirements imposed by the regulations issued pursuant to these laws. These laws provide in part that no persons in the United States may, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service or other benefits provided by Federal or State funding, or otherwise be subjected to discrimination.

(b) Dental Contractor agrees to comply with Title VI of the Civil Rights Act of 1964, and its implementing regulations at 45 C.F.R. Part 80 or 7 C.F.R. Part 15, prohibiting a contractor

from adopting and implementing policies and procedures that exclude or have the effect of excluding or limiting the participation of clients in its programs, benefits, or activities on the basis of national origin. Applicable state and federal civil rights laws require contractors to provide alternative methods for ensuring access to services for applicants and recipients who cannot express themselves fluently in English. Dental Contractor agrees to ensure that its policies do not have the effect of excluding or limiting the participation of persons in its programs, benefits, and activities on the basis of national origin. Dental Contractor also agrees to take reasonable steps to provide services and information, both orally and in writing, in appropriate languages other than English, in order to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities.

(c) Dental Contractor agrees to comply with Section 1557 of the Patient Protection and Affordable Care Act;

(d) Dental Contractor agrees to comply with Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16. These provide in part that any organization that participates in programs funded by direct financial assistance from the United States Department of Agriculture or the United States Department of Health and Human Services must not, in providing services, discriminate against a program beneficiary or prospective program beneficiary on the basis of religion or religious belief.

(e) Upon request, Dental Contractor will provide HHSC Civil Rights Office with copies of all of the Dental Contractor's civil rights policies and procedures.

(f) Dental Contractor must notify HHSC's Civil Rights Office of any civil rights complaints received relating to its performance under this Agreement. This notice must be delivered no more than ten Days after receipt of a complaint. Notice provided pursuant to this section must be directed to:

HHSC Civil Rights Office

701 W. 51st Street, Mail Code W206

Austin, Texas 78751

Phone Toll Free: (888) 388-6332

Phone: (512) 438-4313

TTY Toll Free: (877) 432-7232

Fax: (512) 438-5885.

Section 7.06 Environmental Protection Laws.

Dental Contractor must comply with the applicable provisions of federal environmental protection laws as described in this Section:

(a) Pro-Children Act of 1994.

Dental Contractor must comply with the Pro-Children Act of 1994 (20 U.S.C. §§ 6081 *et seq*.), as applicable, regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products.

(b) National Environmental Policy Act of 1969.

Dental Contractor must comply with any applicable provisions relating to the institution of environmental quality control measures contained in the National Environmental Policy Act of 1969 (42 U.S.C. §§ 4321 *et seq*.) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality").

(c) Clean Air Act and Water Pollution Control Act regulations.

Dental Contractor must comply with any applicable provisions relating to required notification of facilities violating the requirements of Executive Order 11738 ("Providing for Administration of the Clean Air Act and the Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, or Loans").

(d) State Clean Air Implementation Plan.

Dental Contractor must comply with any applicable provisions requiring conformity of federal actions to State (Clean Air) Implementation Plans under § 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§ 740 *et seq*.).

(e) Safe Drinking Water Act of 1974.

Dental Contractor must comply with applicable provisions relating to the protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (21 U.S.C. § 349; 42 U.S.C. §§ 300f to 300j-9).

Section 7.07 HIPAA.

(a) Dental Contractor must comply with applicable provisions of HIPAA. This includes the requirement that the Dental Contractor's MIS system comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to HIPAA. Dental Contractor must comply with HIPAA EDI requirements.

(b) Additionally, Dental Contractor must comply with HIPAA notification requirements, including those set forth in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. §§ 17931 *et seq*. If, in HHSC's determination, Dental Contractor has not provided notice in the manner or format prescribed by the HITECH Act, then HHSC may require the Dental Contractor to provide this notice.

(c) Dental Contractor must notify HHSC of all breaches or potential breaches of unsecured protected health information, as that term is defined by the HITECH Act. As noted in **Article 2**, "Definitions," Confidential Information includes HIPAA-defined protected health information. Therefore, any breach of that information is also subject to the requirements, including notice requirements, in **Article 11**, "Disclosure & Confidentiality of Information."

(d) The Dental Contractor must use or disclose protected health information as authorized and in response to another HIPAA-covered entity's inquiry about a Member for authorized purposes of treatment, payment, healthcare operations, or as required by law under HIPAA.

(e) The Dental Contractor must comply with rights of individual access by a Member or a Member's Legally Authorized Representative to Member's protected health information. The Dental Contractor may permit limited disclosures of protected health information as permissible under HIPAA for a family member, other relative, or close personal friends of the Member or anyone identified in the Member's protected health information directly relevant to the Member's involvement with the Member's healthcare or payment related to the Member's healthcare. The Dental Contractor should refer to 45 C.F.R. § 164.510(b) and related regulatory guidance for additional information.

Section 7.08 Privacy, Security and Breach Notification Laws

(a) The Dental Contractor must comply with all applicable privacy, security and breach notification laws and regulations, including the following, if applicable to the type of Confidential Information and the authorized purpose for which it is being used:

(1) 1 Tex. Admin. Code Chapter 202, Subchapter B;

(2) The Privacy Act of 1974;

(3) OMB Memorandum 17-12;

(4) The Federal Information Security Management Act of 2002 (FISMA);

(5) The Health Insurance Portability and Accountability Act of 1996 (HIPAA);

(6) Internal Revenue Publication 1075 - Tax Information Security Guidelines for Federal, State, and Local Agencies;

(7) National Institute of Standards and Technology (NIST) Special Publication 800-66 Revision 1 - An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security Rule;

(8) NIST Special Publications 800-53 and 800-53A - Recommended Security Controls for Federal Information Systems and Organizations, as currently revised;

(9) NIST Special Publications 800-47 - Security Guide for Interconnecting Information Technology Systems;

(10) NIST Special Publication 800-88, Guidelines for Media Sanitization;

(11) NIST Special Publication 800-111, Guide to Storage of Encryption Technologies for End User Devices containing PHI;

(12) Family Educational Rights and Privacy Act

(b) Any other State or Federal law, regulation, or administrative rule relating to the specific HHS program area that the Dental Contractor supports on behalf of HHS.

(c) The Dental Contractor must notify HHSC of all Breaches or potential Breaches of Confidential Information in compliance with applicable laws and regulations as specified in **Article 11** of this Contract.

Section 7.09 Historically Underutilized Business Participation Requirements.

(a) Definitions.

For purposes of this Section:

(1) "Historically Underutilized Business" or "HUB" means a minority or women-owned business as defined by Texas Government Code, Chapter 2161.

(2) "HSP" means a HUB Subcontracting Plan for Dental Administrative Services.

(b) HUB Requirements.

(1) In accordance with Attachment G, the Dental Contractor must submit an HSP with its Proposal for HHSC's approval and maintain the HSP thereafter.

(2) The Dental Contractor must report to HHSC's contract manager and HUB Office monthly, in the format required by **Chapter 5.4.4.5 of the UMCM,** its use of HUB Subcontractors to fulfill the subcontracting opportunities identified in the HSP.

(3) The Dental Contractor must obtain prior written approval from the HHSC HUB Office before making any changes to the HSP. The proposed changes must comply with HHSC's good faith effort requirements relating to the development and submission of HSPs.

(4) The Dental Contractor must submit a revised HSP to the HHSC HUB Office when it: changes the dollar amount of, terminates, or modifies an existing Subcontract for Dental Administrative Services; or enters into a new Subcontract for Dental Administrative Services. All proposed changes to the HSP must comply with the requirements of this Agreement.

(5) HHSC will determine if the value of Subcontracts to HUBs meet or exceed the HUB subcontracting provisions specified in the Dental Contractor's HSP. If HHSC determines that the Dental Contractor's subcontracting activity does not demonstrate a good faith effort, the Contractor may be subject to provisions in the Vendor Performance and Debarment Program (1 Tex. Admin. Code § 20.585), and subject to remedies for breach.

Section 7.10 Compliance with Fraud, Waste, and Abuse Requirements.

Dental Contractor, Dental Contractor's personnel, and all Subcontractors must comply with all fraud, waste, and abuse requirements found in HHS Circular C-027. The Dental Contractor must comply with Circular C-027 requirements in addition to other fraud, waste, and abuse provisions in the contract and in state and federal law.

Article 8. Amendments and Modifications

Section 8.01 Mutual Contract.

This Contract may be amended at any time by mutual agreement of the Parties. The amendment must be in writing and signed by individuals with authority to bind the Parties.

Section 8.02 Changes in Law or Contract.

If federal or state laws, rules, regulations, policies or guidelines are adopted, promulgated, judicially interpreted or changed, or if contracts are entered or changed, the effect of which is to alter the ability of either Party to fulfill its obligations under this Contract, the Parties will promptly negotiate in good faith appropriate modifications or alterations to the Contract and any schedules or attachments made a part of this Contract. Such modifications or alterations must be in writing and signed by individuals with authority to bind the Parties, equitably adjust the terms and conditions of this Contract, and must be limited to those provisions of this Contract affected by the change.

Section 8.03 Modifications as a Remedy.

This Contract may be modified under the terms of **Article 12** ("Remedies and Disputes").

Section 8.04 Modification Process.

(a) If HHSC seeks modifications to the Contract as a condition of any Contract extension, HHSC's notice to Dental Contractor will specify those modifications to the Scope of Work, the Contract pricing terms, or other Contract terms and conditions.

(b) Dental Contractor must respond to HHSC's proposed modification within the timeframe specified by HHSC, generally within ten Business Days of receipt. Upon receipt of Dental Contractor's response to the proposed modifications, HHSC may enter into negotiations with Dental Contractor to arrive at mutually agreeable Contract amendments. In the event that HHSC determines that the Parties will be unable to reach agreement on mutually satisfactory contract modifications, then HHSC may provide written notice to Dental Contractor of its intent to terminate the Contract or not to extend the Contract beyond the Contract Term then in effect.

Section 8.05 Modification of HHSC Uniform Managed Care Manual.

(a) HHSC will provide Dental Contractor with at least ten Business Days advance written notice before implementing a substantive and material change in the HHSC Uniform Managed Care Manual (UMCM). For purposes herein, this would refer to a change that materially and substantively alters the Dental Contractor's ability to fulfill its obligations under the Contract. The UMCM, and all modifications thereto, are incorporated by reference into this Contract. HHSC will provide Dental Contractor with a reasonable amount of time to comment on such changes, generally at least five Business Days. HHSC is not required to provide advance written notice of changes that are not material and substantive in nature, such as corrections of clerical errors or policy clarifications.

(b) The Parties agree to work in good faith to resolve disagreements concerning material and substantive changes to the UMCM. If the Parties are unable to resolve issues relating to material and substantive changes, then either Party may terminate the agreement in accordance with **Article 12** ("Remedies and Disputes").

(c) Changes will be effective on the date specified in HHSC's written notice, which will not be earlier than the Dental Contractor's response deadline, and such changes will be incorporated into the HHSC UMCM. If the Dental Contractor has raised an objection to a material and substantive change to the UMCM and submitted a notice of termination in accordance with **Section 12.04(e)**, HHSC will not enforce the change during the period of time between the receipt of the notice and the date of Contract termination.

Section 8.06 Required Compliance with Amendment and Modification Procedures.

No different or additional services, work, or products will be authorized or performed except as authorized by this Article. No waiver of any term, covenant, or condition of this Contract will be valid unless executed in compliance with this Article. Dental Contractor will not be entitled to payment for any services, work or products that are not authorized by a properly executed Contract amendment or modification.

Article 9. Audit and Financial Compliance and Litigation Hold

Section 9.01 Record Retention and Audit.

(a) The State, CMS, the OIG, the Comptroller, the Attorney General and their designees have the right to investigate, audit, inspect, and review complete and unredacted originals or copies of records and information related to this Contract of the Dental Contractor or to contracts between the Dental Contractor and the Dental Contractor's Subcontractors for ten years from the final date of the Contract Term or from the date of any audit, whichever is later.

(b) Dental Contractor agrees to maintain, and require its Subcontractors to maintain, records, books, documents, and information (collectively "records") that are adequate to ensure that the services provided and are made payments in accordance with the requirements of this Contract, including **Chapter 18 of the UMCM** and applicable Federal and State requirements (e.g., 45 C.F.R. § 74.53). Such records must be retained by Dental Contractor and its Subcontractors for a period of ten years after the Contract Expiration Date or until the resolution of all litigation, claims, financial management reviews or audits pertaining to this Contract, whichever is longer.

(c) The Dental Contractor and the Dental Contractor's Subcontractors must retain, as applicable, enrollee grievance and appeal records under 42 C.F.R. § 438.16, base data in 42 C.F.R. § 438.5(c), MLR reports under 42 C.F.R. § 438.8(k), and the data, information, and documentation specified under 42 C.F.R. § 438.604, § 438.606, § 438.608, and § 438.610 for a period no less than ten years from the expiration date of this Contract or from the date of the completion of any audit, whichever is later.

(d) Additionally, Dental Contractor agrees to retain and to require its Subcontractors to retain all records in accordance with any litigation hold that is provided to them by HHSC and actively participate in the discovery process if required to do so, at no additional charge to HHSC. Litigation holds may require the Dental Contractor or its Subcontractors to keep the records longer than other records retention schedules. The Dental Contractor will be required to retain all records subject to the litigation hold until notified by HHSC when the litigation hold ends and then other approved records retention schedule(s) may resume. If Dental Contractor or its Subcontractors fail to retain the pertinent records after receiving a litigation hold from HHSC, the Dental Contractor agrees to pay to HHSC all damages, costs, and expenses incurred by HHSC arising from such failure to retain.

This Article survives any termination or expiration of the Contract.

Section 9.02 Access to Records, Books, and Documents.

(a) Upon reasonable notice, Dental Contractor must provide, and cause its Subcontractors to provide, at no cost to the officials and entities identified in this Section prompt, reasonable, and adequate access to complete and unredacted originals or copies of any records and information that are related to the scope of this Contract.

(b) Dental Contractor and its Subcontractors must provide the access described in this Section upon HHSC's request. This request may be for, but is not limited to, the following purposes:

(1) examination;

(2) audit;

(3) investigation;

(4) inspection;

(5) contract administration; or

(6) the making of copies, excerpts, or transcripts.

(c) The access required must be provided to the following officials and/or entities:

(1) The United States Department of Health and Human Services or its designee;

(2) The Comptroller General of the United States or its designee;

(3) Dental Program personnel from HHSC or its designee, including HHSC's independent auditor;

(4) The Office of Inspector General;

(5) The Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;

(6) Any independent verification and validation contractor or quality assurance contractor acting on behalf of HHSC;

(7) The Office of the State Auditor of Texas or its designee;

(8) A State or Federal law enforcement agency;

(9) A special or general investigating committee of the Texas Legislature or its designee; and

(10) Any other State or Federal entity identified by HHSC, or any other entity engaged by HHSC.

(d) Dental Contractor agrees to provide the access described wherever Dental Contractor maintains such books, records, and supporting documentation. Dental Contractor further agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described in this Section. Dental Contractor will require its Subcontractors to provide comparable access and accommodations.

(e) Upon request, the Dental Contractor must provide complete and unredacted originals or copies of the records and information described in this Section free of charge to HHSC and the entities described in subsection (c).

(f) In accordance with Texas Government Code § 533.012(e), any records and information submitted to HHSC or the Texas Attorney General's Office pursuant to Texas Government Code § 533.012(a)(1) are confidential and are not subject to disclosure under the Texas Public Information Act.

Section 9.03 Audits of Services, Deliverables and Inspections.

(a) Upon reasonable notice from HHSC, Dental Contractor will provide, and will cause its Subcontractors to provide, such investigators, auditors, reviewers, and inspectors as HHSC may from time to time designate, with access to:

(1) service locations, facilities, or installations;

(2) complete and unredacted originals or copies of records and information related to this Contract; and

(3) software.

Reasonable notice may include time-limited or immediate requests for information.

(b) The access described in this Section will be for the purpose of examining, inspecting, auditing, reviewing, or investigating:

(1) Dental Contractor's capacity to bear the risk of potential financial losses;

(2) The Services and Deliverables provided;

(3) A determination of the amounts payable under this Contract;

(4) A determination of the allowability of costs reported under this Contract;

(5) An examination of Subcontract terms and/or transactions;

(6) An assessment of financial results under this Contract;

(7) Detection of fraud, waste, or abuse;

(8) Other purposes HHSC deems necessary to perform its regulatory function and/or enforce the provisions of this Contract.

(c) Dental Contractor must provide, as part of the Services, any assistance that such investigators, auditors, reviewers, and inspectors reasonably may require to complete such investigations, audits, reviews, or inspections.

(d) If, as a result of an investigation, audit, inspection, or review of payments made to the Dental Contractor, HHSC discovers a payment error or overcharge, HHSC will notify the Dental Contractor of such error or overcharge. HHSC will be entitled to recover such funds as an offset to future payments to the Dental Contractor, or to collect such funds directly from the Dental Contractor. Dental Contractor must return funds owed to HHSC within 30days after receiving notice of the error or overcharge, or interest will accrue on the amount due. HHSC will assess any such interest at 12 per cent per annum, compounded daily. In the event that an audit reveals that errors in reporting by the Dental Contractor have resulted in errors in payments to the Dental Contractor or errors in the calculation of the Experience Rebate, the Dental Contractor will indemnify HHSC for any losses resulting from such errors, including the cost of the investigation, audit, inspection or review. If the interest rate stipulated hereunder is found by a court of competent jurisdiction to be outside the range deemed legal and enforceable, then the rate hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

Section 9.04 SAO Audit.

The Dental Contractor understands that acceptance of funds under this Contract acts as acceptance of the authority of the State Auditor's Office ("SAO"), or any successor agency, to conduct an investigation in connection with those funds. The Dental Contractor further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested at no cost. The Dental Contractor will ensure that this clause concerning the authority to audit funds and the requirement to cooperate is included in any Subcontract, and in any third party agreements described in **Section 4.08**.

Section 9.05 Response and Compliance with Findings.

(a) Dental Contractor must take action to ensure its or a Subcontractor's compliance, or correction of any finding of noncompliance, with any law, regulation, audit requirement, or generally accepted accounting principle relating to the Services and Deliverables or any other deficiency contained in any investigation, audit, review, or inspection conducted under this Article. This action will include Dental Contractor's delivery to HHSC, for HHSC'S approval, a Corrective Action Plan that addresses deficiencies identified in any investigation, audit, review, or inspection within 30 Days of the close of the investigation, audit, review, or inspection.

(b) Dental Contractor must bear the expense of compliance with any finding of noncompliance under this Section that is:

(1) Required by Texas or Federal law, regulation, rule, court order, or other audit requirement relating to Dental Contractor's business;

(2) Performed by Dental Contractor as part of the Scope of Work; or

(3) Necessary due to Dental Contractor's noncompliance with any law, regulation, rule, court order, or audit requirement imposed on Dental Contractor.

(c) As part of the Scope of Work, Dental Contractor must provide to HHSC upon request a copy of those portions of Dental Contractor's and its Subcontractors' internal audit reports relating to the Services and Deliverables provided to HHSC under this Contract.

Section 9.06 Notification of Legal and Other Proceedings, and Related Events.

The Dental Contractor must notify HHSC of all proceedings, actions, and events as specified in **Chapter 5 of the UMCM**.

Article 10. Terms and Conditions of Payment

Section 10.01 Calculation of Monthly Premium Payment.

(a) This is a risk-based contract. For each Program, HHSC will pay the Dental Contractor monthly Premium Payments set forth in the Dental Program Contract, based on the number of eligible enrolled Members. HHSC will calculate the monthly Premium Payments by multiplying the number of Members in each Rate Cell category by the Premium Rate for each Rate Cell. In consideration of the Monthly Premium Payments, the Dental Contractor agrees to provide the Services and Deliverables described in this Contract.

(b) The Dental Contractor must provide timely financial and statistical information necessary in the Premium Rate determination process. Encounter Data provided by Dental Contractor must conform to all HHSC requirements. Encounter Data containing non-compliant information, including, but not limited to, inaccurate Member identification numbers, inaccurate provider identification numbers, or diagnosis or procedures codes insufficient to adequately describe the diagnosis or procedure performed, will not be considered in the Dental Contractor's experience for rate-setting purposes.

(c) Information or data, including complete and accurate Encounter Data, as requested by HHSC for rate-setting purposes, must be provided to HHSC: (1) within 30 days of receipt of the letter from HHSC requesting the information or data; and (2) no later than March 31st of each year.

(d) The fixed monthly Premium Rate consists of the following components:

(1) An amount for the dental services performed during the month;

(2) An amount for administering the program, and

(3) An amount for the Dental Contractor's risk margin.

Premium Rates for each Program may vary by Dental Contractor. HHSC will employ or retain qualified actuaries to perform data analysis and calculate the Premium Rates for each rate period.

(e) Dental Contractor understands and expressly assumes the risks associated with the performance of the duties and responsibilities under this Contract, including the failure, termination or suspension of funding to HHSC, delays or denials of required approvals, and cost overruns not reasonably attributable to HHSC.

Section 10.02 Time and Manner of Payment.

(a) During the Contract Term and beginning after the Operational Start Date, HHSC will pay the monthly Premium Payments by the 10th Business Day of each month.

(b) The Dental Contractor must accept Premium Payments by direct deposit into the Dental Contractor's account.

(c) HHSC may adjust the monthly Premium Payment to the Dental Contractor in the case of an overpayment to the Dental Contractor, for Experience Rebate amounts due and unpaid (including any interest thereon), or if money damages (including any associated interest) are assessed in accordance with **Article 12**, "Remedies and Disputes."

(d) HHSC's payment of monthly Premium Payments is subject to availability of appropriations. If appropriations are not available to pay the full monthly Premium Payment, HHSC may:

(1) Equitably adjust the Premium Payments for all participating Dental Contractors, and reduce scope of service requirements as appropriate in accordance with **Article 8** "Amendments and Modifications," or

(2) Terminate the Contract in accordance with **Article 12** "Remedies and Disputes."

Section 10.03 Certification of Premium Rates.

HHSC will employ or retain a qualified actuary to certify the actuarial soundness of the Premium Rates, and all revisions or modifications thereto.

Section 10.04 Modification of Premium Rates.

The Parties expressly understand and agree that the agreed Premium Rates are subject to modification in accordance with **Article 8** "Amendments and Modifications," if changes in state or federal laws, rules, regulations, guidelines, policies, or court orders affect the rates or the actuarial soundness of the rates. HHSC will provide the Dental Contractor notice of a modification to the Premium Rates at least 60 days prior to the effective date of the change, unless HHSC determines that circumstances warrant a shorter notice period. If the Dental Contractor does not accept the rate change, either Party may terminate the Contract in accordance with **Article 12** "Remedies and Disputes."

Section 10.05 CHIP Premium Rates Structure.

(a) CHIP Rate Cells.

CHIP Premium Rates are defined on a per Member per month basis by the Rate Cells. CHIP Rate Cells are based on the Member's age group as follows:

(1) Under age one;

(2) Ages one through 5;

(3) Ages 6 through 14; and

(4) Ages 15 through 18.

These Rate Cells are subject to change after Rate Period 1.

(b) CHIP Premium Rates for Rate Period1.

The CHIP Premium Rates for Rate Period 1 will be included in the negotiated HHSC Dental Program Contract.

(c) CHIP Premium Rate development.

HHSC will establish base Premium Rates by analyzing Encounter Data and financial data. This analysis will include a review of historical enrollment and claims experience information; any changes to Medically Necessary Covered Dental Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information. HHSC may modify the base Premium Rates using diagnosis based risk adjusters to yield the final Premium Rates.

(d) Acuity Adjustment

HHSC may evaluate and implement an acuity adjustment methodology, or alternative reasonable methodology, that appropriately reimburses the Dental Contractor for acuity and cost differences that deviate from that of the community average, if HHSC in its sole discretion determines that such a methodology is reasonable and appropriate. The community average is a uniform rate for all Dental Contractor s in a Service Area and is determined by combining all the experience for all Dental Contractors in a Service Area to get an average rate for the Service Area.

(e) Value-Added Services.

Value-added Services will not be included in the rate-setting process.

(f) Case-by-case Services.

Case-by-case Services will not be included in the rate setting process.

Section 10.06 Medicaid Premium Rates Structure

(a) Medicaid Rate Cells.

Medicaid Premium Rates are defined on a per Member per month basis by the Rate Cells. Medicaid Rate Cells are:

(1) Under age one;

(2) Ages one through 5;

(3) Ages 6 through 14;

(4) Ages 15-18; and

(5) Ages 19 through 20.

(b) Medicaid Premium Rate development.

HHSC will establish base Premium Rates by analyzing historical Medicaid Encounter Data and financial data. This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information.

(c) Acuity adjustment.

HHSC may evaluate and implement an acuity adjustment methodology, or alternative reasonable methodology, that appropriately reimburses the Dental Contractor for acuity and cost differences that deviate from that of the community average, if HHSC in its sole discretion determines that such a methodology is reasonable and appropriate. The community average is a uniform rate for all Dental Contractors in a Service Area, and is determined by combining all the experience for all Dental Contractors in a Service Area to get an average rate for the Service Area.

(d) Value-Added Services.

Value-added Services will not be included in the rate-setting process.

(e) Case-by-case Services.

Case-by-case Services will not be included in the rate setting process

Section 10.07 Adjustments to Premium Payments

(a) Adjustment.

HHSC may adjust a payment made to the Dental Contractor for a Member if:

(1) A Member's eligibility status or program type is changed, corrected as a result of error, or is retroactively adjusted;

(2) The Member is enrolled into the Dental Contractor in error;

(3) The Member moves outside the United States;

(4) The Member dies before the first day of the month for which the payment was made; or

(5) The payment has been denied by the CMS in accordance with the requirements of 42 C.F.R. § 438.730.

(b) Appeal of adjustment.

The Dental Contractor may appeal the adjustment of premiums in the above circumstances using the HHSC dispute resolution process set forth in **Section 12.13**, ("Dispute Resolution").

Section 10.08 Experience Rebate

(a) Dental Contractor's duty to pay.

At the end of each FSR Reporting Period, the Dental Contractor must pay an Experience Rebate for the Program to HHSC as detailed in ATTACHMENT M, EXPERIENCE REBATE PROPOSAL SUBMISSION. The Net Income Before Taxes and total Revenues are as measured by the Financial-Statistical Report (FSR) as reviewed and confirmed by HHSC. The final amount used in the calculation of the percentage may be impacted by the Loss Carry Forward; see **Section 10.08 (c).**

With the exception of the Dual Demonstration, the percentages are calculated on a Consolidated Basis, and include the consolidated Net Income Before Taxes for all of the Dental Contractor's HHSC capitated managed care contracts, including any separate capitated managed care contracts with the Dental Contractor's parent or other affiliated legal entities.

(b) Net Income Before Taxes.

(1) The Dental Contractor must compute the Net Income Before Taxes in accordance with the HHSC **Chapter 5 and 6 of the UMCM** and applicable federal regulations. The Net Income Before Taxes will be confirmed by HHSC or its agent for the FSR Reporting Period relating to all Revenues and Allowable Expenses incurred pursuant to the Contract. HHSC reserves the right to modify the UMCM in accordance with **Section 8.05**, "Modification of the HHSC Uniform Managed Care Manual."

(2) For purposes of calculating Net Income Before Taxes, certain items are omitted from the calculation, as they are not Allowable Expenses; these include:

(i) the payment of an Experience Rebate;

(ii) any interest expense associated with late or underpayment of the Experience Rebate;

(iii) financial incentives;

(iv) financial disincentives, including without limitation any incentives described in **Section 2.6** of the RFP; and

(v) The liquidated damages, and any interest expense associated, as described in Attachment "C."

See **Chapter 6 of the UMCM.**

(3) Financial incentives are true net bonuses and will not be reduced by the potential increased Experience Rebate payments. Financial disincentives are true net disincentives and will not be offset in whole or in part by potential decreases in Experience Rebate payments.

(4) For FSR reporting purposes, financial incentives incurred must not be reported as an increase in Revenues or as an offset to costs, and any financial incentive award of such will not

increase reported income. Financial disincentives incurred must not be included as reported expenses, and must not reduce reported income. The reporting or recording of any of these incurred items will be done on a memo basis, which is below the income line, and will be listed as separate items.

(c) Carry forward of prior FSR Reporting Period losses.

(1) General.

Losses incurred on a Consolidated Basis by the Dental Contractor for a given FSR Reporting Period may be carried forward to the next FSR Reporting Period and applied as an offset against consolidated pre-tax net income for determination of any Experience Rebate due. These prior losses may be carried forward for up to two contiguous FSR Reporting Periods.

When a loss in a given FSR Reporting Period is carried forward and applied against profits either or both of the next two FSR Reporting Periods, the loss must first be applied against the first subsequent FSR Reporting Period. The profit in the first subsequent FSR Reporting Period is reduced to a zero pre-tax income; any additional loss then remaining unapplied may be carried forward to any profit in the next subsequent FSR Reporting Period. In this case, the revised income in the third FSR Reporting Period would be equal to the cumulative income of the three contiguous FSR Reporting Periods. The loss cannot be carried forward to the fourth FSR Reporting Period or beyond.

Losses incurred in the last or next-to-last FSR Reporting Period of a prior contiguous contract with HHSC may be carried forward up to two FSR Reporting Periods, into the first or potentially second FSR Reporting Period of this Contract, if the losses meet all other requirements of both the prior and current contracts.

(2) Basis of consolidation.

In order for a loss to be eligible for potential carryforward as an offset against future income, the Dental Contractor must have a negative Net Income Before Taxes for an FSR Reporting Period on a Consolidated Basis.

(d) Settlements for payment.

(1) There may be one or more Dental Contractor payment(s) of the State share of the Experience Rebate on income generated for a given FSR Reporting Period. The first scheduled payment (the "Primary Settlement") will equal 100 percent of the State share of the Experience Rebate as derived from the FSR, and will be paid on the same day the 90-day FSR Report is submitted to HHSC.

The "Primary Settlement," as utilized herein, refers strictly to what should be paid with the 90-day FSR, and does not refer to the first instance in which the Dental Contractor may tender a payment. For example, the Dental Contractor may submit a 90-day FSR indicating no Experience Rebate is due, but then submit a 334-day FSR with a higher income and a corresponding Experience Rebate payment. In such case, this initial payment would be subsequent to the Primary Settlement.

(2) The next scheduled payment will be an adjustment to the Primary Settlement, if required, and will be paid on the same day that the 334-day FSR Report is submitted to HHSC, if the adjustment is a payment from the Dental Contractor to HHSC. **Section 10.08(e)** describes the interest expenses associated with any such payment after the Primary Settlement.

The Dental Contractor may make non-scheduled payments at any time to reduce the accumulation of interest under **Section 10.08(e).** For any nonscheduled payments prior to the 334-day FSR, the Dental Contractor is not required to submit a revised FSR, but is required to submit an Experience Rebate calculation form and an adjusted summary page of the FSR. The FSR summary page is labeled "Summary Income Statements (Dollars), All Coverage Groups Combined (FSR, Part I)."

(3) HHSC or its agent may audit or review the FSRs. If HHSC determines that corrections to the FSRs are required, based on an HHSC audit/review or other documentation acceptable to HHSC, then HHSC will make final adjustments. Any payment resulting from an audit or final adjustment will be due from the Dental Contractor within 30 days of the earlier of:

(i) The date of the management representation letter resulting from the audit; or

(ii) The date of any invoice issued by HHSC.

Payment within this 30-day timeframe will not relieve the Dental Contractor of any interest payment obligation that may exist under **Section 10.08(e**).

(4) In the event that any Experience Rebates and/or corresponding interest payments owed to the State are not paid by the required due dates, then HHSC may offset such amounts from any future Capitation Payments, or collect such sums directly from the Dental Contractor. HHSC may adjust the Experience Rebate if HHSC determines the Dental Contractor has paid amounts for goods or services that are not reasonable, necessary, allocable, and allowable in accordance with the HHSC UMCM Chapters 5 and 6 the Federal Acquisition Regulations (FAR), or other applicable federal or state regulations. HHSC has final authority in auditing and determining the amount of the Experience Rebate.

(e) Interest on Experience Rebate.

(1) Interest on any Experience Rebate owed to HHSC will be charged beginning 35 days after the due date of the Primary Settlement, as described in **Section 10.08(d)(1)**. Thus, any Experience Rebate due or paid on or after the Primary Settlement will accrue interest starting at 35 days after the due date for the 90-day FSR Report. For example, any Experience Rebate payment(s) made in conjunction with the 334-day FSR, or as a result of audit findings, will accrue interest back to 35 days after the due-date for submission of the 90-day FSR.

The Dental Contractor has the option of preparing an additional FSR based on 120 days of claims run-out (a "120- day FSR"). If a 120-day FSR, and an Experience Rebate payment based on it, are received by HHSC before the interest commencement date above, then such a payment would be counted as part of the Primary Settlement.

(2) If an audit or adjustment determines a downward revision of income after an interest payment has previously been required for the same State Fiscal Year, then HHSC will recalculate the interest and, if necessary, issue a full or partial refund or credit to the Dental Contractor.

(3) Any interest obligations that are incurred pursuant to **Section 10.08** that are not timely paid will be subject to accumulation of interest as well, at the same rate as applicable to the underlying Experience Rebate.

(4) All interest assessed pursuant to **Section 10.08** will continue to accrue until such point as a payment is received by HHSC, at which point interest on the amount received will stop accruing. If a balance remains at that point that is subject to interest, then the balance will continue to accrue interest. If interim payments are made, then any interest that may be due will only be charged on amounts for the time period during which they remained unpaid.

By way of example only, if $100,000 is subject to interest commencing on a given day, and a payment is received for $75,000 45 days after the start of interest, then the $75,000 will be subject to 45 days of interest, and the $25,000 balance, along with any unpaid interest will continue to accrue interest until paid.

The accrual of interest as defined under **Section10.08(e)** will not stop during any period of dispute. If a dispute is resolved in the Dental Contractor's favor, then interest will only be assessed on the revised unpaid amount.

(5) If the Dental Contractor incurs an interest obligation pursuant to **Section 10.08 for an Experience Rebate payment**, HHSC will assess such interest at 12% per annum, compounded daily. If any interest rate stipulated hereunder is found by a court of competent jurisdiction to be outside the range deemed legal and enforceable, then in such specific case the rate hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

(6) Any interest expense incurred pursuant to **Section 10.08** is not an Allowable Expense for reporting purposes on the FSR.

Section 10.09 Federal Disallowance.

If the federal government recoups money from the state for expenses and/or costs that are deemed unallowable by the federal government, the state has the right to, in turn, recoup payments made to the Dental Contractor for these same expenses or costs, even if they had not been previously disallowed by the state and were incurred by the Dental Contractor, and any such expenses or costs would then be deemed unallowable by the state. If the state retroactively recoups money from the Dental Contractor due to a federal disallowance, the state will recoup the entire amount paid to the Dental Contractor for the federally disallowed expenses or costs, not just the federal portion.

Section 10.10 Payment by Members.

(a) The Dental Contractor, Network Providers, and Out-of-Network Providers are prohibited from billing or collecting any amount from a Member for Covered Services, except that

CHIP Network Providers and Out-of-Network Providers may collect copayments authorized in the CHIP State Plan from CHIP Members for Covered Services.

(b) The Dental Contractor must inform Members of costs for non-covered services, and must require its Network Providers to:

(1) inform Members of costs for non-covered services prior to rendering such services; and

(2) obtain a signed Private Pay form from such Members.

Section 10.11 Restriction on Assignment of Fees.

During the Contract Term, Dental Contractor may not, directly or indirectly, assign to any third party any beneficial or legal interest of the Dental Contractor in or to any payments to be made by HHSC pursuant to this Contract. This restriction does not apply to fees paid to Subcontractors.

Section 10.12 Liability for Taxes.

HHSC is not responsible in any way for the payment of any Federal, state or local taxes related to or incurred in connection with the Dental Contractor's performance of this Contract. Dental Contractor must pay and discharge any and all such taxes, including any penalties and interest. In addition, HHSC is exempt from federal excise taxes, and will not pay any personal property taxes or income taxes levied on Dental Contractor or any taxes levied on employee wages.

Section 10.13 Liability for Employment-related Charges and Benefits.

Dental Contractor will perform work under this Contract as an independent contractor and not as agent or representative of HHSC. Dental Contractor is solely and exclusively liable for payment of all employment-related charges incurred in connection with the performance of this Contract, including but not limited to salaries, benefits, employment taxes, workers compensation benefits, unemployment insurance and benefits, and other insurance or fringe benefits for staff.

Section 10.14 No Additional Consideration.

(a) Dental Contractor will not be entitled to nor receive from HHSC any additional consideration, compensation, salary, wages, charges, fees, costs, or any other type of remuneration for Services and Deliverables provided under the Contract, except by properly authorized and executed Contract amendments.

(b) No other charges for tasks, functions, or activities that are incidental or ancillary to the delivery of the Services and Deliverables will be sought from HHSC or any other State agency, nor will the failure of HHSC or any other party to pay for such incidental or ancillary services entitle the Dental Contractor to withhold Services and Deliverables due under the Agreement.

(c) Dental Contractor will not be entitled by virtue of the Contract to consideration in the form of overtime, health insurance benefits, retirement benefits, disability retirement benefits, sick leave, vacation time, paid holidays, or other paid leaves of absence of any type or kind whatsoever.

Section 10.15 Adjustment to Capitation in Consideration of the ACA Section 9010.

The following applies only to Dental Contractors that are covered entities under Section 9010 of the PPACA, and thus required to pay the Health Insurance Providers Fee ("HIP Fee") for United States health risks.

Beginning in calendar year 2014, the PPACA requires the Dental Contractor to pay the HIP Fee no later than September 30th (as applicable to each relevant year, the "HIP Fee Year") with respect to premiums paid to the Dental Contractor in the preceding calendar year (as applicable to each relevant year, the "HIP Data Year"), and continuing similarly in each successive year. In order to satisfy the requirement for actuarial soundness set forth in 42 C.F.R. § 438.4 with respect to amounts paid by HHSC under this Agreement, the parties agree that HHSC will make a retroactive adjustment to capitation to the Dental Contractor for the full amount of the HIP Fee allocable to this Agreement, as follows:

Amount and method of payment: For each HIP Fee Year, HHSC will make an adjustment to capitation to the Dental Contractor for that portion of the HIP Fee that is attributable to the Capitation Payments paid by HHSC to the Dental Contractor for risks in the applicable HIP Data Year under the Agreement, less any applicable exclusions and appropriate credit offsets. This capitation adjustment will be determined by HHSC and will include the following:

(1) The amount of the HIP Fee attributable to this Agreement;

(2) The federal income tax liability, if any, that the Dental Contractor incurs as a result of receiving HHSC's payment for the amount of the HIP Fee attributable to this Agreement; and

(3) Any Texas state premium tax attributable to the capitation adjustment.

The amount of the HIP Fee will not be determinable until after HHSC establishes the regular Capitation Rates for a rate period. HHSC therefore will perform an actuarial calculation to account for the HIP Fee within actuarially sound Capitation Rates each year and apply this Capitation Rate adjustment to the regular Capitation Rates already paid to the Dental Contractor.

The Dental Contractor's federal income tax rate will not be known prior to the end of the tax year. As a result, HHSC will make a tax rate assumption for purposes of developing the capitation adjustment. If the tax rate assumption later proves to be higher than the actual tax rate for one or more Dental Contractors, HHSC may re-determine the capitation adjustment for those Dental Contractors using the lower tax rate and reconcile the capitation amount paid.

Documentation Requirements: HHSC will pay the Dental Contractor after it receives sufficient documentation, as determined by HHSC, detailing the Dental Contractor's Texas

Medicaid and CHIP-specific liability for the HIP Fee. The Dental Contractor will provide documentation that includes the following:

(1) The preliminary and final versions of the IRS Form 8963;

(2) Texas Medicaid/CHIP-specific premiums included in the premiums reported on Form 8963; and

(3) The preliminary and final versions of the Fee statement provided by the IRS.

Payment by HHSC is intended to put the Dental Contractor in the same position as the Dental Contractor would have been had no HIP Fee been imposed upon the Dental Contractor.

This provision will survive the termination of the Agreement.

Article 11. Disclosure, Confidentiality, Privacy, and Security of Information.

Section 11.01 Confidentiality.

(a) The Dental Contractor and all Subcontractors, consultants, or agents must treat all information that is obtained through performance of the Services under the Contract, including information relating to applicants or Dental Members as Confidential Information to the extent that confidential treatment is provided under law and regulations. The Dental Contractor must protect Confidential Information from unauthorized disclosure or public release based on state or federal law or other legal agreement. For purposes of this Contract, the Dental Contractor will treat Agency Sensitive Information as Confidential Information. Although Agency Sensitive Information may not be subject to specific legal, regulatory or other external requirements, it is considered HHS sensitive and is not readily available to the public. Agency Sensitive Information could be subject to disclosure under the Texas Public Information Act, but the Dental Contractor should control disclosure due to sensitivity.

(b) The Dental Contractor is responsible for understanding the degree to which information obtained through performance of the Contract is confidential under State and Federal law, regulations, or administrative rules.

(c) The Dental Contractor and all Subcontractors, consultants, or agents under the Contract must not use any information obtained through performance of the Contract in any manner except as is necessary for the proper discharge of obligations and securing of rights under the Contract.

(d) The Dental Contractor must have a system in effect to protect all records and all other documents deemed confidential under the Contract maintained in connection with the activities under the Contract. Any disclosure or transfer of Confidential Information by the Dental Contractor, including information required by the HHSC, must be in accordance with applicable law. If the Dental Contractor receives a request for information deemed confidential under the Contract, the Dental Contractor must immediately notify HHSC of

such request, and must make reasonable efforts to protect the information from public disclosure.

(e) In addition to the requirements expressly stated in this section, the Dental Contractor must comply with any policy, rule, or reasonable requirement of HHSC that relates to the safeguarding or disclosure of information relating to Dental Members, the Dental Contractor's operations, or the Dental Contractor's performance of the Contract.

(f) In the event of the expiration of the Contract or termination of the Contract for any reason, all Confidential Information disclosed to and all copies thereof made by the Dental Contractor must be returned to HHSC or, at HHSC's option, erased or destroyed. The Dental Contractor must provide HHSC certificates evidencing such erasure or destruction.

(g) The obligations in this section shall not restrict any disclosure by the Dental Contractor pursuant to any applicable law, or by order of any court or government agency, provided that the Dental Contractor must give prompt notice to HHSC of such order.

(h) With the exception of confidential Dental Member information, information provided under the Contract by one Party (the "Furnishing Party") to another Party (the "Receiving Party") will not be considered Confidential Information if such data was:

(1) Already known to the Receiving Party without restrictions at the time of its disclosure by the Furnishing Party;

(2) Independently developed by the Receiving Party without reference to the Furnishing Party's Confidential Information;

(3) Rightfully obtained by the Receiving Party without restriction from a third party after its disclosure to a third party by the Furnishing Party;

(4) Publicly available other than through the fault or negligence of the Receiving Party; or

(5) Lawfully released without restriction to anyone.

Section 11.02 Disclosure of HHSC's Confidential Information.

(a) The Dental Contractor must report to HHSC any and all unauthorized disclosures or uses of HHSC's Confidential Information of which it or its Subcontractor(s), consultant(s), or agent(s) is aware or has knowledge in accordance with Section 11.08 of the Contract. The Dental Contractor acknowledges that any publication or disclosure of HHSC's Confidential Information to others may cause immediate and irreparable harm to HHSC and may constitute a violation of State or federal laws. If the Dental Contractor, its Subcontractor(s), consultant(s), or agent(s) should publish or disclose such Confidential Information to others without authorization, HHSC will immediately be entitled to injunctive relief or any other remedies to which it is entitled under law or equity. HHSC will have the right to recover from the Dental Contractor all damages and liabilities caused by or arising from the Dental Contractor's, its Subcontractors', consultants', or agents' failure to protect HHSC's Confidential Information. The Dental Contractor must defend, with counsel approved by

HHSC, indemnify and hold harmless HHSC from all damages, costs, liabilities, and expenses, including reasonable attorneys' fees and costs, caused by or arising from the Dental Contractor's or its Subcontractors', consultants' or agents' failure to protect HHSC's Confidential Information. HHSC will not unreasonably withhold approval of counsel selected by the Dental Contractor.

(b) The Dental Contractor must require its Subcontractors, consultants, and agents to comply with the terms of this provision.

Section 11.03 Member Records.

(a) HHSC may require the transfer of Dental Member Records, upon written notice to the Dental Contractor, to another entity, as consistent with federal and state laws and applicable releases. The Dental Contractor must comply with the requirements of state and federal laws regarding the transfer of Dental Member Records.

(b) The term "Dental Member Record" for this section means only those administrative, enrollment, case management, and other such records maintained by the Dental Contractor and is not intended to include patient records maintained by participating Providers.

Section 11.04 Requests for Public Information.

(a) HHSC will promptly notify the Dental Contractor of a request for disclosure of information filed in accordance with the Texas Public Information Act, Tex. Gov't. Code Chapter 552 of the, that consists of the Dental Contractor's confidential information, including information or data to which the Dental Contractor has a proprietary or commercial interest. HHSC will deliver a copy of the request for Public Information to the Dental Contractor.

(b) With respect to any information that is the subject of a request for disclosure, the Dental Contractor must demonstrate to the Texas Office of Attorney General the specific reasons why the requested information is confidential or otherwise excepted from required public disclosure under law. The Dental Contractor must provide HHSC with copies of all such communications.

(c) To the extent authorized under the Texas Public Information Act, HHSC agrees to safeguard from disclosure information received from the Dental Contractor that the Dental Contractor believes to be confidential information. The Dental Contractor must clearly mark such information as confidential information or provide written notice to HHSC that it considers the information confidential.

(d) The requirements of Subchapter J, Chapter 552, Government Code, may apply to this contract and the Dental Contractor agrees that this Contract can be terminated if the Dental Contractor knowingly or intentionally fails to comply with a requirement of that subchapter.

Section 11.05 Privileged Work Product.

(a) The Dental Contractor acknowledges that HHSC asserts that privileged work product may be prepared in anticipation of litigation and that the Dental Contractor is performing the Services with respect to privileged work product as an agent of HHSC, and that all matters

related thereto are protected from disclosure by the Texas Rules of Civil Procedure, Texas Rules of Evidence, Federal Rules of Civil Procedure, or Federal Rules of Evidence.

(b) HHSC will notify the Dental Contractor of any privileged work product to which the Dental Contractor has or may have access. After the Dental Contractor is notified or otherwise becomes aware that such documents, data, database, or communications are privileged work product, only the Dental Contractor personnel, for whom such access is necessary for the purposes of providing the Services, may have access to privileged work product.

(c) If the Dental Contractor receives notice of any judicial or other proceeding seeking to obtain access to HHSC's privileged work product, the Dental Contractor must:

(1) Immediately notify HHSC; and

(2) Use all reasonable efforts to resist providing such access.

(d) If the Dental Contractor resists disclosure of HHSC's privileged work product in accordance with this Section, HHSC will, to the extent authorized under Civil Practices and Remedies Code or other applicable State law, have the right and duty to:

(1) Represent the Dental Contractor in such resistance;

(2) To retain counsel to represent the Dental Contractor; or

(3) To reimburse the Dental Contractor for reasonable attorneys' fees and expenses incurred in resisting such access.

(e) If a court of competent jurisdiction orders the Dental Contractor to produce documents, disclose data, or otherwise Breach the confidentiality obligations imposed in the Contract, or otherwise with respect to maintaining the confidentiality, proprietary nature, and secrecy of privileged work product, the Dental Contractor will not be liable for Breach of such obligation.

Section 11.06 Unauthorized Acts.

Each Party agrees to:

(1) Notify the other Party promptly of any unauthorized possession, use, or knowledge, or attempt thereof, by any person or entity that may become known to it, of any HHSC Confidential Information or any information identified by the Dental Contractor as confidential or proprietary;

(2) Promptly furnish to the other Party full details of the unauthorized possession, use, or knowledge, or attempt thereof, and use reasonable efforts to assist the other Party in investigating or preventing the reoccurrence of any unauthorized possession, use, or knowledge, or attempt thereof, of Confidential Information;

(3) Cooperate with the other Party in any litigation and investigation against third Parties deemed necessary by such Party to protect its proprietary rights; and

(4) Promptly make reasonable efforts to prevent a reoccurrence of any such unauthorized possession, use, or knowledge such information.

Section 11.07 Legal Action.

Neither party may commence any legal action or proceeding in respect to any unauthorized possession, use, or knowledge, or attempt thereof by any person or entity of HHSC's Confidential Information or information identified by the Dental Contractor as confidential or proprietary, which action or proceeding identifies the other Party information without such Party's consent.

Section 11.08 Dental Contractor's Incident and Breach Notice, Reporting and Mitigation.

The Dental Contractor's obligation begins at Discovery of any unauthorized disclosure of Confidential Information or any privacy or security incident that may compromise Confidential Information (collectively "Incident") and continues until all effects of the Incident are resolved to HHSC's satisfaction, hereafter referred to as the "Incident Response Period".

For each Incident, the Dental Contractor must perform a risk analysis in accordance with HIPAA requirements to determine the probability of compromise of the Confidential Information.

Section 11.08.1 Notification to HHSC

(a) The Dental Contractor must notify HHSC within the timeframes set forth in subsection (c) below unless HHSC has agreed in writing to an alternate timeframe for notification.

(b) The Dental Contractor must require that its Subcontractors and Providers take the necessary steps to assure that the Dental Contractor can comply with all of the following Incident notice requirements.

(c) Incident Notice:

(1) Initial Notice.

Within 24 hours of Discovery of an Incident that the Dental Contractor's risk analysis has determined has more than a low probability of compromise, or when the Dental Contractor should have reasonably discovered such Incident, the Dental Contractor must preliminarily report on the occurrence of an Incident to the HHSC Privacy Officers via email at: privacy@HHSC.state.tx.us. This initial notice must, at a minimum, contain all information reasonably available to the Dental Contractor about the Incident, confirmation that the Dental Contractor has met any applicable one-hour Breach notification requirement for any Breach of information obtained from a federal system of records in accordance with OMB Memorandum M-17-12, and provide a single point of contact for the Dental Contractors for HHSC communications both during and outside of business hours during the Incident Response Period.

(2) Formal Notice.

No later than three Business Days after Discovery of an Incident that the Dental Contractor's risk analysis has determined has more than a low probability of compromise, or when the Dental Contractor should have reasonably Discovered such Incident, the Dental Contractor must provide written formal notification to HHSC using the Potential Privacy/Security Incident Form which is available on the HHSC website. The formal notification must include all available information about the Incident, and the Dental Contractor's investigation of the Incident.

(3) Annual Notice.

For an Incident that the Dental Contractor's risk analysis has determined has a low probability of compromise or only involves unauthorized disclosure of a single individual's Confidential Information to a single unauthorized recipient, the Dental Contractor must provide notice to HHSC of such Incident no later than 60 Days after the end of the calendar year in which the Incident occurred.

No later than 60 Days after the end of each calendar year, the Dental Contractor must provide the HHS Privacy Office with a comprehensive list of all incidents involving HHSC confidential information that were reported to the US Office for Civil Rights in accordance with the obligations under HIPAA.

Section 11.08.2 Dental Contractor Investigation, Response and Mitigation.

(a) The Dental Contractor must fully investigate and mitigate, to the extent practicable, any Incident. At a minimum, the Dental Contractor must:

(1) Immediately commence a full and complete investigation;

(2) Cooperate fully with HHSC in its response to the Incident;

(3) Complete or participate in an initial risk analysis;

(4) Provide a final risk analysis

(5) Submit proposed corrective actions to HHSC for review and approval;

(6) Commit necessary and appropriate staff and resources to expeditiously respond;

(7) Report to HHSC as required by HHSC and all applicable federal and state laws for Incident response purposes and for purposes of HHSC's compliance with report and notification requirements, to the satisfaction of HHSC;

(8) Fully cooperate with HHSC to respond to inquiries and/or proceedings by federal and state authorities about the Incident;

(9) Fully cooperate with HHSC's efforts to seek appropriate injunctive relief or to otherwise prevent or curtail such Incidents;

(10) Recover, or assure destruction of, any Confidential Information impermissibly disclosed during or as a result of the Incident; and

(11) Provide HHSC with a final report on the Incident explaining the Incident's resolution.

Section 11.08.3 Breach Notification to Individuals and Reporting to Authorities.

(a) In addition to the notices required in Section 11.08.1, the Dental Contractor must provide Breach notification, in accordance with 45 C.F.R. §§ 164.400-414, or as specified by HHSC following an Incident.

(b) The Dental Contractor must assure that the time, manner and content of any Breach notification required by this Section meets all federal and state regulatory requirements. Breach notice letters must be in the Dental Contractor's name and on the Dental Contractor's letterhead and must contain contact information to obtain additional information, including the name and title of the Dental Contractor's representative, an email address and a toll-free telephone number.

(c) The Dental Contractor must provide HHSC with copies of all distributed communications related to the Breach notification.

(d) The Dental Contractor must demonstrate to the satisfaction of HHSC that any Breach notification required by applicable law was timely made. If there are delays outside of the Dental Contractor's control, the Dental Contractor must provide written documentation to HHSC of the reasons for the delay.

Section 11.09 Information Security and Privacy Requirements.

(a) Compliance

The Dental Contractor will comply with all applicable state and federal security and privacy requirements, as well as implement industry best practices, governing the creation, collection, access, use, storage, maintenance, disclosure, safeguarding and destruction of HHS data including Agency Sensitive and Confidential Information.

(b) Protection.

The Dental Contractor will implement, maintain, document, and use appropriate administrative, technical and physical security measures to protect all HHS Information Resources and data, including Agency Sensitive Information and Confidential Information.

(c) Reviews.

The Dental Contractor must comply with security and privacy controls compliance assessments, updates, and monitoring by HHS as required by state and federal law or at HHS' discretion. The security and privacy controls will be based on the National Institute of Standards and Technology (NIST) Special Publication 800-53 from the applicable state and federal requirements. The HHS process is described in the Information Security Risk Assessment and Monitoring Procedures (IS-RAMP) that is published on the HHS Internet website.

(d) Workforce.

The Dental Contractor must ensure that its workforce, including Subcontractors, who are granted specified HHS authorized access to internal HHS Information Resources, comply

with the HHS Acceptable Use Policy (AUP) and sign the Acceptable Use Agreement (AUA) prior to access, in accordance with 1 Tex. Admin. Code Chapter 202.22.

(e) Information Security and Privacy Officials.

The Dental Contractor must designate an Information Security Official and a Privacy Official who will be responsible for managing the security and privacy programs and requirements. The Dental Contractor will provide HHS the names, phone numbers and email addresses of these officials. The Security Official and Privacy Official roles may be performed by the same individual.

(f) Program.

The Dental Contractor must establish an information security and privacy program and maintain information security and privacy policies and standards that are updated at least annually with respect to the management or handling of HHS Information Resources or data. The program will:

(1) Comply with all applicable legal and regulatory requirements for Texas HHS data protection;

(2) Comply with HHS Information Security Office's published or provided policies, standards, and controls (IS-Policy, IS-AUP, AUA, IS-Web and Mobile Minimum Security Standard, IS-RAMP, ISSG/IS-Controls);

(3) Ensure the integrity, availability, and confidentiality by implementing technical, administrative and physical safeguards for HHS Agency Sensitive Information and Confidential Information;

(4) Protect against any anticipated threats or hazards to the security or integrity of such information;

(5) Protect and monitor against unauthorized access to or use of such information that could result in harm to the person that is the subject of such information both logically and physically;

(6) Routinely review, monitor, and remove unnecessary accounts that have access to HHS Agency Sensitive Information or Confidential Information;

(7) Coordinate with HHS to determine the HHS data types accessed, transmitted, stored, or maintained by the system and identify applicable state, federal and regulatory requirements;

(8) Document system accountability with an associated HHS Information Owner and, if provided by the Contractor, Information custodians;

(9) Encrypt the HHS Agency Sensitive Information and Confidential Information on end-user devices, on portable devices, in transit over public networks, and while stored in the cloud;

(10) FIPS 140-2 validated encryption will be used for federal protected data and access to HHS Confidential and Agency Sensitive Information will be controlled and monitored;

(11) Prohibit the use of free Cloud services with HHS Agency Sensitive or Confidential Information;

(12) Prohibit the performance of any work or the maintenance of any information relating or obtained pursuant to this Agreement to occur outside of the United States;

(13) Provide the workforce security and privacy training, conduct appropriate background checks, ensure individual accountability, and implement appropriate sanctions for non-compliance;

(14) Establish a secure method of assigning and selecting passwords, or use of unique identifier technologies, such as biometrics or token devices;

(15) Keep current on security update/patch releases and maintain up-to-date anti-virus/malware protection;

(16) Ensure security will be integrated into all phases including planning, development, and implementation and will include security testing and remediation of security vulnerabilities prior to production especially for online websites, applications and mobile applications;

(17) Establish standards and methods to securely return, destroy or dispose of HHS Agency Sensitive Information or Confidential Information;

(18) Provide documentation of information security and privacy policies/standards to HHS Information Security if requested;

(19) Ensure HHS websites provide the HHS privacy notice;

(20) Develop and implement methods that ensure security for all components, including:

(i) Environmental security;

(ii) Physical site security;

(iii) Computer hardware security;

(iv) Computer software security;

(v) Application security;

(vi) Data access and storage;

(vii) Client/user security;

(viii) Secure processes and procedures;

(ix) Telecommunications and network security; and

(x) General support systems (GSS) security.

Article 12. Remedies and Disputes

Section 12.01 Understanding and Expectations.

The remedies described in this Section are directed to Dental Contractor's timely and responsive performance of the Services and production of Deliverables, and the creation of a flexible and responsive relationship between the Parties. The Dental Contractor is expected to meet or exceed all HHSC objectives and standards, as set forth in the Contract. All areas of responsibility and all Contract requirements will be subject to performance evaluation by HHSC. Performance reviews may be conducted at the discretion of HHSC at any time and may relate to any responsibility or requirement. All responsibilities or requirements not fulfilled may be subject to remedies set forth in the Contract.

Section 12.02 Tailored Remedies.

(a) Understanding of the Parties.

Dental Contractor agrees and understands that HHSC may pursue tailored contractual remedies for noncompliance with the Contract. At any time and at its discretion, HHSC may impose or pursue one or more remedies for each item of noncompliance and will determine remedies on a case-by-case basis. HHSC's pursuit or non-pursuit of a tailored remedy does not constitute a waiver of any other remedy that HHSC may have at law or equity.

(b) Notice and opportunity to cure for non-material breach.

(1) HHSC will notify Dental Contractor in writing of specific areas of Dental Contractor performance that fail to meet performance expectations, standards, or schedules set forth in the Contract, but that, in the determination of HHSC, do not result in a material deficiency or delay in the implementation or operation of the Services.

(2) Dental Contractor will, within five Business Days, or another date approved by HHSC of receipt of written notice of a non-material deficiency, provide HHSC a written response that:

Explains the reasons for the deficiency, the Dental Contractor's plan to address or cure the deficiency, and the date and time by which the deficiency will be cured; or

If Dental Contractor disagrees with HHSC's findings, its reasons for disagreeing with HHSC's findings.

(3) Dental Contractor's proposed cure of a non-material deficiency is subject to the approval of HHSC. Dental Contractor's repeated commission of non-material deficiencies or repeated failure to resolve any such deficiencies may be regarded by HHSC as a material deficiency and entitle HHSC to pursue any other remedy provided in the Contract or any other appropriate remedy HHSC may have at law or equity.

(c) Corrective Action Plan.

(1) At its option, HHSC may require Dental Contractor to submit to HHSC a written Corrective Action Plan to correct or resolve a material breach of the Contract, as determined by HHSC.

(2) The Corrective Action Plan must provide:

A detailed explanation of the reasons for the cited deficiency;

Dental Contractor's assessment or diagnosis of the cause; and

A specific proposal to cure or resolve the deficiency.

(3) The Corrective Action Plan must be submitted by the deadline set forth in HHSC's request for a Corrective Action Plan. The Corrective Action Plan is subject to approval by HHSC, which will not unreasonably be withheld.

(4) HHSC will notify Dental Contractor in writing of HHSC's final disposition of HHSC's concerns. If HHSC accepts Dental Contractor's proposed Corrective Action Plan, HHSC may:

Condition such approval on completion of tasks in the order or priority that HHSC may reasonably prescribe;

Disapprove portions of Dental Contractor's proposed Corrective Action Plan; or

Require additional or different corrective action(s).

Notwithstanding the submission and acceptance of a Corrective Action Plan, Dental Contractor remains responsible for achieving all written performance criteria.

(5) HHSC's acceptance of a Corrective Action Plan under this Section will not:

Excuse Dental Contractor's prior substandard performance;

Relieve Dental Contractor of its duty to comply with performance standards; or

Prohibit HHSC from assessing additional tailored remedies or pursuing other appropriate remedies for continued substandard performance.

(d) Administrative remedies.

(1) At its discretion, HHSC may impose one or more of the following remedies for each item of material noncompliance and will determine the scope and severity of the remedy on a case-by-case basis:

(i) Assess liquidated damages in accordance with "Liquidated Damages Matrix;"

(ii) Conduct accelerated monitoring of the Dental Contractor. Accelerated monitoring includes more frequent or more extensive monitoring by HHSC or its agent;

(iii) Decline to renew or extend the Contract;

(iv) Appoint temporary management under the circumstances described in 42 C.F.R. § 438.706;

(v) Initiate disenrollment of a Member or Members;

(vi) Suspend enrollment of Members;

(vii) Withhold or recoup payment to Dental Contractor;

(viii) Require forfeiture of all or part of the Dental Contractor's bond; or

(ix) Terminate the Contract in accordance with Section 12.03, ("Termination by HHSC").

(2) For purposes of the Contract, an item of material noncompliance means a specific action of Dental Contractor that:

(i) Violates a material provision of the Contract;

(ii) Fails to meet an agreed measure of performance; or

(iii) Represents a failure of Dental Contractor to be reasonably responsive to a reasonable request of HHSC for information, assistance, or support relating to the Services or Deliverables within the timeframe specified by HHSC.

(3) HHSC will provide notice to Dental Contractor of the imposition of an administrative remedy in accordance with this Section, with the exception of accelerated monitoring, which may be unannounced. HHSC may require Dental Contractor to file a written response in accordance with this Section.

(4) The Parties agree that a State or Federal statute, rule, regulation, or Federal guideline will prevail over the provisions of this Section unless the statute, rule, regulation, or guidelines can be read together with this Section to give effect to both.

(e) Damages.

(1) HHSC will be entitled to actual and/or consequential damages resulting from the Dental Contractor's failure to comply with any of the terms of the Contract. In some cases, the actual damage to HHSC or State of Texas as a result of Dental Contractor's failure to meet any aspect of the responsibilities of the Contract and/or to meet specific performance standards set forth in the Contract are difficult or impossible to determine with precise accuracy. Therefore, liquidated damages will be assessed in writing against and paid by the Dental Contractor in accordance with and for failure to meet any aspect of the responsibilities of the Contract and/or to meet the specific performance standards identified by HHSC in Attachment F, "Deliverables/Liquidated Damages Matrix." Liquidated damages will be assessed if HHSC determines such failure is the fault of the Dental Contractor, including the Dental Contractor's Subcontractors and/or consultants, and is not materially caused or contributed to by HHSC or its agents. If at any time, HHSC determines the Dental Contractor has not met any aspect of the responsibilities of the Contract and/or the specific performance standards due to mitigating circumstances,

HHSC reserves the right to waive all or part of the liquidated damages. All such waivers must be in writing, contain the reasons for the waiver, and be signed by the appropriate executive of HHSC.

(2) The liquidated damages prescribed in this Section are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of HHSC's projected financial loss and damage resulting from the Dental Contractor's nonperformance, including financial loss as a result of project delays. Accordingly, in the event Dental Contractor fails to perform in accordance with the Contract, HHSC may assess liquidated damages as provided in this Section.

(3) If Dental Contractor fails to perform any of the Services described in the Contract, HHSC may assess liquidated damages for each occurrence of a liquidated damages event, to the extent consistent with HHSC's tailored approach to remedies and Texas law.

(4) HHSC may elect to collect liquidated damages:

Through direct assessment and demand for payment delivered to Dental Contractor; or

By deduction of amounts assessed as liquidated damages as set-off against payments then due to Dental Contractor or that become due at any time after assessment of the liquidated damages. HHSC will make deductions until the full amount payable by the Dental Contractor is received by HHSC.

(f) Equitable Remedies.

(1) Dental Contractor acknowledges that, if Dental Contractor breaches, or attempts or threatens to breach its material obligation under the Contract, HHSC may be irreparably harmed. In such a circumstance, HHSC may proceed directly to court to pursue equitable remedies.

(2) If a court of competent jurisdiction finds that Dental Contractor breached, or attempted or threatened to breach any such obligations, Dental Contractor agrees that without any additional findings of irreparable injury or other conditions to injunctive relief, it will not oppose the entry of an appropriate order compelling performance by Dental Contractor and restraining it from any further breaches, or attempted or threatened breaches.

(g) Suspension of Contract.

(1) HHSC may suspend performance of all or any part of the Contract if:

(i) HHSC determines that Dental Contractor has committed a material breach of the Contract;

(ii) HHSC has reason to believe that Dental Contractor has committed, assisted in the commission of Fraud, Waste or, Abuse, malfeasance, misfeasance, or nonfeasance by any party concerning the Contract;

(iii) HHSC determines that the Dental Contractor knew, or should have known of Fraud, Waste or, Abuse, malfeasance, or nonfeasance by any party concerning the Contract, and the Dental Contractor failed to take appropriate action; or

(iv) HHSC determines that suspension of the Contract in whole or in part is in the best interests of the State of Texas or the HHSC Programs.

(2) HHSC will notify Dental Contractor in writing of its intention to suspend the Contract in whole or in part. Such notice will:

(i) Be delivered in writing to Dental Contractor;

(ii) Include a concise description of the facts or matter leading to HHSC's decision; and

(iii) Unless HHSC is suspending the contract for convenience, request a Corrective Action Plan from Dental Contractor or describe actions that Dental Contractor may take to avoid the contemplated suspension of the Contract.

Section 12.03 Termination by HHSC.

Prior to completion of the Contract Term, all or a part of this Contract may be terminated for any of the following reasons:

(a) Termination in the best interest of HHSC.

HHSC may terminate the Contract without cause at any time when, in its sole discretion, HHSC determines that termination is in the best interests of the State of Texas. HHSC will provide reasonable advance written notice of the termination, as it deems appropriate under the circumstances. The termination will be effective on the date specified in HHSC's notice of termination.

(b) Termination for cause.

Except as otherwise provided by the U.S. Bankruptcy Code, or any successor law, HHSC may terminate the Contract, in whole or in part, upon the following conditions:

(1) Assignment for the benefit of creditors, appointment of receiver, or inability to pay debts.

HHSC may terminate the Contract at any time if Dental Contractor:

(i) Makes an assignment for the benefit of its creditors;

(ii) Admits in writing its inability to pay its debts generally as they become due; or

(iii) Consents to the appointment of a receiver, trustee, or liquidator of Dental Contractor or of all or any part of its property.

(2) Failure to adhere to laws, rules, ordinances, or orders.

HHSC may terminate the Contract if a court of competent jurisdiction finds Dental Contractor failed to adhere to any laws, ordinances, rules, regulations or orders of any public

authority having jurisdiction and such violation prevents or substantially impairs performance of Dental Contractor's duties under the Contract. HHSC will provide at least 30 Days advance written notice of such termination.

(3) Breach of confidentiality.

HHSC may terminate the Contract at any time if Dental Contractor breaches confidentiality laws with respect to the Services and Deliverables provided under the Contract.

(4) Failure to maintain adequate personnel or resources.

HHSC may terminate the Contract if, after providing notice and an opportunity to correct, HHSC determines that Dental Contractor has failed to supply personnel or resources and such failure results in Dental Contractor's inability to fulfill its duties under the Contract. HHSC will provide at least 30 Days advance written notice of such termination.

(5) Termination for gifts and gratuities.

(i) HHSC may terminate the Contract at any time following the determination by a competent judicial or quasi-judicial authority and Dental Contractor's exhaustion of all legal remedies that Dental Contractor, its employees, agents or representatives have either offered or given anything of value to an officer or employee of HHSC or the State of Texas in violation of state law.

(ii) Dental Contractor must include a similar provision in each of its Subcontracts and must enforce this provision against a Subcontractor who has offered or given anything of value to any of the persons or entities described in this Section, whether or not the offer or gift was in Dental Contractor's behalf.

(iii) Termination of a Subcontract by Dental Contractor pursuant to this provision will not be a cause for termination of the Contract unless:

(a) Dental Contractor fails to replace such terminated Subcontractor within a reasonable time; and

(b) Such failure constitutes cause, as described in this subsection 12.03(b).

(iv) For purposes of this Section, a "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment, and charitable contributions. The term does not include contributions to holders of public office or candidates for public office that are paid and reported in accordance with State or Federal law.

(6) Termination for non-appropriation of funds.

Notwithstanding any other provision of the Contract, if funds for the continued fulfillment of the Contract by HHSC are at any time not forthcoming or are insufficient, through failure of any entity to appropriate funds or otherwise, then HHSC will have the right to terminate the Contract at no additional cost and with no penalty whatsoever by giving prior written notice documenting

the lack of funding. HHSC will provide at least 30 Days advance written notice of such termination. HHSC will use reasonable efforts to ensure appropriated funds are available.

(7) Judgment and execution.

(i) HHSC may terminate the Contract at any time if judgment for the payment of money in excess of $500,000.00 that is not covered by insurance, is rendered by any court or governmental body against Dental Contractor, and Dental Contractor does not:

(a) Discharge the judgment or provide for its discharge in accordance with the terms of the judgment;

(b) Procure a stay of execution of the judgment within 30 days from the date of entry thereof; or

(c) Perfect an appeal of such judgment and cause the execution of such judgment to be stayed during the appeal, providing such financial reserves as may be required under generally accepted accounting principles.

(ii) If a writ or warrant of attachment or any similar process is issued by any court against all or any material portion of the property of Dental Contractor, and such writ or warrant of attachment or any similar process is not released or bonded within 30days after its entry, HHSC may terminate the Contract in accordance with this Section.

(8) Termination for Dental Contractor's material breach of the Contract. HHSC will have the right to terminate the Contract in whole or in part if HHSC determines, at its sole discretion, that Dental Contractor has materially breached the Contract

(9) Termination for Criminal Conviction.

HHSC will have the right to terminate the Contract in whole or in part, or require the replacement of a Material Subcontractor, if the Dental Contractor or a Material Subcontractor is convicted of a criminal offense in a state or federal court:

(i) Related to the delivery of an item or service;

(ii) Related to the neglect or abuse of patients in connection with the delivery of an item or service;

(iii) Consisting of a felony related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct, or

(iv) Resulting in a penalty or fine in the amount of $500,000 or more in a state or federal administrative proceeding.

(c) Pre-termination Process

The following process will apply when HHSC terminates the Contract for any reason set forth in Section 12.03(b), "Termination for Cause," other than Subpart 6, "Termination for Non-appropriation of Funds."

In accordance with 42 C.F.R. § 438.710, before terminating the Contract, HHSC will provide the Dental Contractor with 30 Days advance written notice of its intent to terminate. The pre-termination notice will include the following information: the reason for the termination; the proposed effective date of the termination; and the time and place of the pre-termination hearing. During the pre-termination hearing, the Dental Contractor may present written information explaining why HHSC should not terminate the Contract. After the pre-termination hearing, the State Medicaid Director will provide the Dental Contractor with a written notice of HHSC's final decision affirming or reversing the proposed termination of the Contract and the effective date of termination if applicable.

HHSC's final decision to terminate the Contract is binding and is not subject to review by the State Office of Administrative Hearings under Chapter 2260, Texas Government Code.

The pre-termination process described herein will not limit or otherwise reduce the Dental Contractor's rights and the Parties' responsibilities under Section 12.13, "Dispute Resolution."

Section 12.04 Termination by Dental Contractor.

(a) Failure to pay.

Dental Contractor may terminate the Contract if HHSC fails to pay the Dental Contractor undisputed charges when due as required under the Contract. Retaining premium, recoupment, sanctions, or penalties that are allowed under the Contract or that result from the Dental Contractor's failure to perform or the Dental Contractor's default under the terms of the Contract is not cause for termination. Termination for failure to pay does not release HHSC from the obligation to pay undisputed charges for services provided prior to the termination date.

If HHSC fails to pay undisputed charges when due, then the Dental Contractor may submit a notice of intent to terminate for failure to pay in accordance with the requirements of Section 12.04(e). If HHSC pays all undisputed amounts then due within 30 Days after receiving the notice of intent to terminate, the Dental Contractor cannot proceed with termination of the Contract under this Section.

(b) Change to HHSC Uniform Managed Care Manual.

Dental Contractor may terminate this agreement if the Parties are unable to resolve a dispute concerning a material and substantive change to the HHSC UMCM, a change that materially and substantively alters the Dental Contractor's ability to fulfill its obligations under the Contract. Dental Contractor must submit a notice of intent to terminate due to a material and substantive change in the HHSC UMCM no later than 30 days after the effective date of the policy change. HHSC will not enforce the policy change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(c) Change to Premium Rate.

If HHSC proposes an initial Capitation Rate or a modification to the Premium Rate that is unacceptable to the Dental Contractor, the Dental Contractor may terminate the Contract. Dental Contractor must submit a written notice of intent to terminate due to a change in the Premium Rate no later than 30 Days after HHSC's notice of the proposed change. HHSC will not enforce the rate change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(d) Expiration of Contract.

If Dental Contractor rejects, or intends to reject, an amendment extending the term of the Contract, Dental Contractor is subject to the requirements of Section 12.04(e).

(e) Notice of intent to terminate or to allow the Contract to expire.

If the Dental Contractor intends to terminate the Contract pursuant to this Section, or intends to allow the Contract to expire, Dental Contractor must give HHSC at least 90 Days written notice of intent to terminate, or intent to allow the Contract to expire. The termination date will be calculated as the last day of the month following 90 Days from the date the notice of intent is received by HHSC.

In the event the Dental Contractor fails to comply with this notice requirement, the Contract shall be extended under the same terms, conditions, and rates, for the period of time necessary to satisfy this notice requirement.

Section 12.05 Termination by Mutual Agreement.

The Contract may be terminated by mutual written agreement of the Parties.

Section 12.06 Effective Date of Termination

Except as otherwise provided in the Contract, termination will be effective as of the date specified in the notice of termination. The Turnover Phase obligations of Dental Contractor will continue to apply after the effective date of the Contract termination.

Section 12.07 Extension of Termination Effective Date.

The Parties may extend the effective date of termination one or more times by mutual written agreement.

Section 12.08 Payment and Other Provisions at Contract Termination.

(a) In the event of termination pursuant to this Article, HHSC will pay the Premium Payment for Services and Deliverables rendered through the effective date of termination. All pertinent provisions of the Contract will form the basis of settlement.

(b) Dental Contractor must provide HHSC all reasonable access to records, facilities, and documentation as is required to efficiently and expeditiously close out the Services and Deliverables provided under the Contract.

(c) Dental Contractor must prepare a Turnover Plan, which is acceptable to and approved by HHSC. The Turnover Plan will be implemented during the time period between receipt of notice and the termination date.

Section 12.09 Modification of Contract in the Event of Remedies.

HHSC may propose a modification of this Contract in response to the imposition of a remedy under this Article. Any modifications under this Section must be reasonable, limited to the matters causing the exercise of a remedy, in writing, and executed in accordance with Article 8. Dental Contractor must negotiate such proposed modifications in good faith.

Section 12.10 Turnover Assistance.

Upon receipt of notice of termination of the Contract by HHSC or by the Dental Contractor, Dental Contractor will provide any Turnover assistance reasonably necessary to enable HHSC to effectively close out the Contract and move the work to another vendor or to perform the work itself.

During the Turnover Phase, Dental Contractor must continue performing under the Contract, including rendering all Contracted services, until such time HHSC determines that the Dental Contractor has completed all requirements in accordance with the Turnover Plan.

Section 12.11 Rights upon Termination or Expiration of Contract.

In the event that the Contract is terminated for any reason, or upon its expiration, HHSC will, at HHSC's discretion, retain ownership of any and all associated work products, Deliverables or documentation in whatever form that they exist.

Section 12.12 Dental Contractor Responsibility for Associated Costs.

If HHSC terminates the Contract for Cause, the Dental Contractor will be responsible to HHSC for all reasonable costs incurred by HHSC, the State of Texas, or any of its administrative agencies to replace the Dental Contractor. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation that is reasonably attributable to Dental Contractor's failure to perform any Service in accordance with the terms of the Contract.

Section 12.13 Dispute Resolution.

(a) General Contract of the Parties.

The Parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the Parties employ all reasonable and informal means to resolve any dispute under the Contract. The Parties express their mutual commitment to using all reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this Section.

(b) Duty to negotiate in good faith.

Any dispute that in the judgment of any Party to the Contract may materially or substantially affect the performance of any Party will be reduced to writing and delivered to the other Party. The Parties shall then negotiate in good faith and use every reasonable effort to resolve such dispute and the Parties must not resort to any formal proceedings unless they have reasonably determined that a negotiated resolution is not possible. The resolution of any dispute disposed of by Contract between the Parties shall be reduced to writing and delivered to all Parties within 10 Business Days.

(c) Claims for breach of Contract.

(1) General requirement. Dental Contractor's claim for breach of the Contract will be resolved in accordance with the dispute resolution process established by HHSC in accordance with Chapter 2260, Texas Government Code.

(2) Negotiation of claims. The Parties expressly agree that the Dental Contractor's claim for breach of this Contract that the Parties cannot resolve in the ordinary course of business or through the use of all reasonable and informal means will be submitted to the negotiation process provided in Chapter 2260, Subchapter B, Texas Government Code.

To initiate the process, Dental Contractor must submit written notice to HHSC that specifically states that Dental Contractor invokes the provisions of Chapter 2260, Subchapter B, Texas Government Code. The notice must comply with the requirements of Title 1 Chapter 392, Subchapter B of the Texas Administrative Code.

The Parties expressly agree that the Dental Contractor's compliance with Chapter 2260, Subchapter B, Texas Government Code, will be a condition precedent to the filing of a contested case proceeding under Chapter 2260, Subchapter C, of the Texas Government Code.

(3) Contested case proceedings. The contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be Dental Contractor's sole and exclusive process for seeking a remedy for any and all alleged breaches of contract by HHSC, if the Parties are unable to resolve their disputes under subsection(c)(2) of this section.

The Parties expressly agree that compliance with the contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be a condition precedent to seeking consent to sue from the Texas Legislature under Chapter 107, Civil Practices & Remedies Code. Neither the execution of this Contract by HHSC nor any other conduct of any representative of HHSC relating to this Contract must be considered a waiver of HHSC's sovereign immunity to suit.

(4) HHSC rules. The submission, processing, and resolution of Dental Contractor's claim is governed by the rules adopted by HHSC pursuant to Chapter 2260, Texas Government Code, found Title 1 Chapter 392, Subchapter B of the Texas Administrative Code.

(5) Dental Contractor's duty to perform. Neither the occurrence of an event constituting an alleged breach of contract nor the pending status of any claim for breach

of contract is grounds for the suspension of performance, in whole or in part, by Dental Contractor of any duty or obligation with respect to the performance of the Contract. Any changes to the Contract as a result of a dispute resolution will be implemented in accordance with Article 8 ("Amendments and Modifications").

Section 12.14 Liability of Dental Contractor.

(a) Dental Contractor bears all risk of loss or damage due to:

(1) Defects in products, Services or Deliverables;

(2) Unfitness or obsolescence of products, Services or Deliverables; or

(3) The negligence or intentional misconduct of Dental Contractor or its employees, agents, Subcontractors, or representatives.

(b) Dental Contractor must, at the Dental Contractor's own expense, defend with counsel approved by HHSC, indemnify, and hold harmless HHSC and State employees, officers, directors, contractors, and agents from and against any losses, liabilities, damages, penalties, costs, fees, including, without limitation, reasonable attorneys' fees, and expenses from any claim or action for property damage, bodily injury or death, to the extent caused by or arising from the negligence or intentional misconduct of the Dental Contractor and its employees, officers, agents, or Subcontractors. HHSC will not unreasonably withhold approval of counsel selected by Dental Contractor.

(c) Dental Contractor will not be liable to HHSC for any loss, damages, or liabilities attributable to or arising from the failure of HHSC or any state agency to perform a service or activity in connection with this Contract.

Article 13. Assurances and Certifications

Section 13.01 Proposal Certifications.

Dental Contractor acknowledges its continuing obligation to comply with the requirements of the certifications contained in its Proposal and will immediately notify HHSC of any changes in circumstances affecting the certifications.

Section 13.02 Conflicts of Interest.

(a) Representation.

Dental Contractor agrees to comply with applicable state and federal laws, including 41 U.S.C. § 423, rules, and regulations regarding conflicts of interest in the performance of its duties under this Contract. Dental Contractor warrants that it has no interest and will not acquire any direct or indirect interest that would conflict in any manner or degree with its performance under this Contract.

(b) General duty regarding conflicts of interest.

Dental Contractor will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain. Dental Contractor will operate with complete independence and objectivity without actual, potential, or apparent conflict of interest with respect to the activities conducted under this Contract.

Section 13.03 Organizational Conflicts of Interest.

(a) Definition.

An organizational conflict of interest is a set of facts or circumstances, a relationship, or other situation under which the Dental Contractor or a Subcontractor has past, present, or currently planned personal or financial activities or interests that either directly or indirectly:

(1) Impairs or diminishes the Dental Contractor's or Subcontractor's ability to render impartial or objective assistance or advice to HHSC; or

(2) Provides the Dental Contractor or Subcontractor an unfair competitive advantage in future HHSC procurements, excluding the award of this Contract.

(b) Warranty.

Except as otherwise disclosed and approved by HHSC prior to the Effective Date of the Contract, Dental Contractor warrants that, as of the Effective Date and to the best of its knowledge and belief, there are no relevant facts or circumstances that could give rise to an organizational conflict of interest affecting this Contract. Dental Contractor affirms that it has neither given, nor intends to give, at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant, or any employee, or representative of same, at any time during the procurement process, or in connection with the procurement process, except as allowed under relevant state and federal law.

(c) Continuing duty to disclose.

(1) Dental Contractor agrees that, if after the Effective Date, Dental Contractor discovers or is made aware of an organizational conflict of interest, Dental Contractor will immediately and fully disclose such interest in writing to the HHSC project manager. In addition, Dental Contractor must promptly disclose any relationship that might be perceived or represented as a conflict after its discovery by Dental Contractor or by HHSC as a potential conflict. HHSC reserves the right to make a final determination regarding the existence of conflicts of interest, and Dental Contractor agrees to abide by HHSC's decision.

(2) The disclosure will include a description of the actions that Dental Contractor has taken or proposes to take to avoid or mitigate such conflicts.

(d) Remedy.

If HHSC determines that an organizational conflict of interest exists, HHSC may, at its discretion, terminate the Contract pursuant to Subsection 12.03(b)(9). If HHSC determines that

Dental Contractor was aware of an organizational conflict of interest before the award of this Contract and did not disclose the conflict to the contracting officer, such nondisclosure will be considered a material breach of the Contract. Furthermore, such breach may be submitted to the Office of the Attorney General, Texas Ethics Commission, or appropriate State or Federal law enforcement officials for further action.

(e) Flow down obligation.

Dental Contractor must include the provisions of this Section in all Subcontracts for work to be performed similar to the service provided by Dental Contractor, and the terms "Contract," "Dental Contractor," and "project manager" modified appropriately to preserve the State's rights.

Section 13.04 HHSC Personnel Recruitment Prohibition.

Dental Contractor has not retained or promised to retain any person or company or utilized or promised to utilize a consultant that participated in HHSC's development of specific criteria of the RFP or who participated in the selection of the Dental Contractor for this Contract.

Unless authorized in writing by HHSC, Dental Contractor will not recruit or employ any HHSC personnel who have worked on projects relating to the subject matter of this Contract, or who have had any influence on decisions affecting the subject matter of this Contract, for two years following the completion of this Contract.

Section 13.05 Anti-kickback Provision.

Dental Contractor certifies that it will comply with the Anti-Kickback Act of 1986, 41 U.S.C. §§ 51-58 and Federal Acquisition Regulation 52.203-7, to the extent applicable.

Section 13.06 Debt or Back Taxes Owed to State of Texas.

In accordance with Section 403.055 of the Texas Government Code, Dental Contractor agrees that any payments due to Dental Contractor under the Contract will be first applied toward any debt or back taxes Dental Contractor owes the State of Texas. Dental Contractor further agrees that payments will be so applied until such debts and back taxes are paid in full.

Section 13.07 Outstanding Debts and Judgments.

Dental Contractor certifies that it is not presently indebted to the State of Texas, and that Dental Contractor is not subject to an outstanding judgment in a suit by State of Texas against Dental Contractor for collection of the balance. For purposes of this Section, an indebtedness is any sum of money that is past due and owed to the State of Texas and is not currently under dispute. A false statement regarding Dental Contractor's status will be treated as a material breach of this Contract and may be grounds for termination at the option of HHSC.

Article 14. Representations and Warranties

Section 14.01 Authorization.

(a) The execution, delivery and performance of this Contract has been duly authorized by Dental Contractor and no additional approval, authorization or consent of any governmental or

regulatory agency is required to be obtained in order for Dental Contractor to enter into this Contract and perform its obligations under this Contract.

(b) Dental Contractor has obtained, or will obtain by the deadlines set forth in this Contract, all licenses, certifications, permits, and authorizations necessary to perform the Services under this Contract and currently is in good standing with all regulatory agencies that regulate any or all aspects of Dental Contractor's performance of this Contract. Dental Contractor will maintain all required certifications, licenses, permits, and authorizations during the term of this Contract.

Section 14.02 Ability to Perform.

Dental Contractor warrants that it has the financial resources to fund the capital expenditures required under the Contract without advances by HHSC or assignment of any payments by HHSC to a financing source.

Section 14.03 Minimum Net Worth.

The Dental Contractor has and will maintain throughout the life of this Contract, minimum net worth that complies with standards adopted by TDI. Minimum net worth means the excess total admitted assets over total liabilities, excluding liability for subordinated debt issued in compliance with Chapter 843 of the Texas Insurance Code.

Section 14.04 Insurer Solvency.

(a) The Dental Contractor must be and remain in full compliance with all applicable state and federal solvency requirements, including those set forth in 42 C.F.R. § 438.116, for basic-service indemnity insurance providers or DMOs, including but not limited to, all reserve requirements, net worth standards, debt-to-equity ratios, or other debt limitations. Provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI. In the event the Dental Contractor fails to maintain such compliance, HHSC, without limiting any other rights it may have by law or under the Contract, may terminate the Contract.

(b) If the Dental Contractor becomes aware of any impending changes to its financial or business structure that could adversely impact its compliance with the requirements of the Contract or its ability to pay its debts as they come due, the Dental Contractor must notify HHSC immediately in writing.

(c) The Dental Contractor must have a plan and take appropriate measures to ensure adequate provision against the risk of insolvency as required by TDI. Such provision must be adequate to provide for the following in the event of insolvency:

(1) Payments to unaffiliated dental providers and affiliated dental providers whose Contracts do not contain Member "hold harmless" clauses acceptable to the TDI;

(2) Continuation of Medically Necessary Covered Dental Services for the duration of the Contract Term for which a premium has been paid for a Member;

(3) Provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI and the Contract.

Should TDI determine that there is an immediate risk of insolvency or the Dental Contractor is unable to provide Medically Necessary Covered Dental Services to its Members, HHSC, without limiting any other rights it may have by law, or under the Contract, may terminate the Contract.

Section 14.05 Workmanship and Performance.

(a) All Services and Deliverables provided under this Contract will be provided in a manner consistent with the standards of quality and integrity as outlined in the Contract.

(b) All Services and Deliverables must meet or exceed the required levels of performance specified in or pursuant to this Contract.

(c) Dental Contractor will perform the Services and provide the Deliverables in a workmanlike manner, in accordance with best practices and high professional standards used in well-managed operations performing services similar to the Services described in this Contract.

Section 14.06 Warranty of Deliverables.

Dental Contractor warrants that Deliverables developed and delivered under this Contract will meet in all material respects the specifications as described in the Contract during the period following its acceptance by HHSC, through the term of the Contract, including any subsequently negotiated by Dental Contractor and HHSC. Dental Contractor will promptly repair or replace any such Deliverables not in compliance with this warranty at no charge to HHSC.

Section 14.07 Compliance with Contract.

Dental Contractor will not take any action substantially or materially inconsistent with any of the terms and conditions set forth in this Contract without the express written approval of HHSC.

Section 14.08 Technology Access.

All technological solutions offered by the Dental Contractor must comply with the requirements of Texas Government Code § 531.0162. This includes providing technological solutions that meet federal accessibility standards for persons with disabilities, as applicable.

Section 14.09 Electronic & Information Resources Accessibility Standards.

(a) Applicability.

The following Electronic and Information Resources (EIR) requirements apply to the Contract because the Dental Contractor performs services that include EIR that: (i) HHSC employees are required or permitted to access; or (ii) members of the public are required or permitted to access. This Section does not apply to incidental uses of EIR in the performance of a Contract, unless the Parties agree that the EIR will become property of the State or will be used by the HHSC's clients or recipients after completion of the Contract. Nothing in this section is

intended to prescribe the use of particular designs or technologies or to prevent the use of alternative technologies, provided they result in substantially equivalent or greater access to and use of a Product.

(b) Definitions.

For purposes of this Section:

Accessibility Standards means the Electronic and Information Resources Accessibility Standards and the Web Site Accessibility Standards/Specifications.

Electronic and Information Resources means information resources, including information resources technologies, and any equipment or interconnected system of equipment that is used in the creation, conversion, duplication, or delivery of data or information. The term includes, but is not limited to, telephones and other telecommunications products, information kiosks, transaction machines, Internet websites, multimedia resources, and office equipment, including copy machines and fax machines.

Electronic and Information Resources Accessibility Standards means the accessibility standards for electronic and information resources contained in 1 Tex. Admin. Code Chapter 213.

Web Site Accessibility Standards/ Specifications means standards contained in 1 Tex. Admin. Code Chapter 206.

Product means information resources technology that is, or is related to, EIR.

(c) Accessibility Requirements.

Under Texas Government Code Chapter 2054, Subchapter M, and implementing rules of the Texas Department of Information Resources, HHSC must procure Products that comply with the Accessibility Standards when such Products are available in the commercial marketplace or when such Products are developed in response to a procurement solicitation. Accordingly, Dental Contractor must provide electronic and information resources and associated Product documentation and technical support that comply with the Accessibility Standards.

(d) Evaluation, Testing, and Monitoring.

(1) HHSC may review, test, evaluate and monitor Dental Contractor's Products and associated documentation and technical support for compliance with the Accessibility Standards. Review, testing, evaluation and monitoring may be conducted before and after the award of a contract. Testing and monitoring may include user acceptance testing.

Neither the review, testing, including acceptance testing, evaluation or monitoring of any Product, nor the absence of such review, testing, evaluation or monitoring, will result in a waiver of the State's right to contest the Dental Contractor's assertion of compliance with the Accessibility Standards.

(2) Dental Contractor agrees to cooperate fully and provide HHSC and its representatives' timely access to Products, records, and other items and information needed to conduct such review, evaluation, testing and monitoring.

(e) Representations and Warranties.

(1) Dental Contractor represents and warrants that: (i) as of the Effective Date of the Contract, the Products and associated documentation and technical support comply with the Accessibility Standards as they exist at the time of entering the Contract, unless and to the extent the Parties otherwise expressly agree in writing; and (ii) if the Products will be in the custody of the state or an HHS Agency's client or recipient after the Contract expiration or termination, the Products will continue to comply with such Accessibility Standards after the expiration or termination of the Contract Term, unless HHSC and/or its clients or recipients, as applicable, use the Products in a manner that renders it noncompliant.

(2) In the event Dental Contractor should have known, becomes aware, or is notified that the Product and associated documentation and technical support do not comply with the Accessibility Standards, Dental Contractor represents and warrants that it will, in a timely manner and at no cost to HHSC, perform all necessary steps to satisfy the Accessibility Standards, including but not limited to remediation, replacement, and upgrading of the Product, or providing a suitable substitute.

(3) Dental Contractor acknowledges and agrees that these representations and warranties are essential inducements on which HHSC relies in awarding this Contract.

(4) Dental Contractor's representations and warranties under this subsection will HHSC the termination or expiration of the Contract and will remain in full force and effect throughout the useful life of the Product.

(f) Remedies.

(1) Pursuant to Texas Government Code Sec. 2054.465, neither Dental Contractor nor any other person has cause of action against HHSC for a claim of a failure to comply with Texas Government Code Chapter 2054, Subchapter M, and rules of the Department of Information Resources.

(2) In the event of a breach of Dental Contractor's representations and warranties, Dental Contractor will be liable for direct, consequential, indirect, special, or liquidated damages and any other remedies to which HHSC may be entitled under this Contract and other applicable law. This remedy is cumulative of any and all other remedies to which HHSC may be entitled under this Contract and other applicable law.

Article 15. Intellectual Property

Section 15.01 Infringement and Misappropriation.

(a) Dental Contractor warrants that all Deliverables provided by Dental Contractor will not infringe or misappropriate any right of, and will be free of any claim of, any third person or entity based on copyright, patent, trade secret, or other intellectual property rights.

(b) Dental Contractor will, at its expense, defend with counsel approved by HHSC, indemnify, and hold harmless HHSC, its employees, officers, directors, contractors, and agents from and against any losses, liabilities, damages, penalties, costs, and fees from any claim or action against HHSC that is based on a claim of breach of the warranty set forth in the preceding paragraph. HHSC will promptly notify Dental Contractor in writing of the claim, provide Dental Contractor a copy of all information received by HHSC with respect to the claim, and cooperate with Dental Contractor in defending or settling the claim. HHSC will not unreasonably withhold, delay or condition approval of counsel selected by the Dental Contractor.

(c) In case the Deliverables, or any one or part thereof, is in such action held to constitute an infringement or misappropriation, or the use thereof is enjoined or restricted or if a proceeding appears to Dental Contractor to be likely to be brought, Dental Contractor will, at its own expense, either:

(1) Procure for HHSC the right to continue using the Deliverables; or

(2) Modify or replace the Deliverables to comply with the Specifications and to not violate any intellectual property rights.

If neither of the alternatives set forth in (1) or (2) above are available to the Dental Contractor on commercially reasonable terms, Dental Contractor may require that HHSC return the allegedly infringing Deliverable(s) in which case Dental Contractor will refund all amounts paid for all such Deliverables.

Section 15.02 Exceptions.

Dental Contractor is not responsible for any claimed breaches of the warranties set forth in Section 14.06 to the extent caused by:

(a) Modifications made to the item in question by anyone other than Dental Contractor or its Subcontractors, or modifications made by HHSC or its contractors working at Dental Contractor's direction or in accordance with the specifications; or

(b) The combination, operation, or use of the item with other items if Dental Contractor did not supply or approve for use with the item; or

(c) HHSC's failure to use any new or corrected versions of the item made available by Dental Contractor.

Section 15.03 Ownership and Licenses

(a) Definitions.

For purposes of this Section 15.03, the following terms have the meanings set forth below:

Custom Software means any software developed by the Dental Contractor: for HHSC; in connection with the Contract; and with funds received from HHSC. The term does not include Dental Contractor Proprietary Software or Third Party Software.

Dental Contractor Proprietary Software means software: (i) developed by the Dental Contractor prior to the Effective Date of the Contract, or (ii) software developed by the Dental Contractor after the Effective Date of the Contract that is not developed: for HHSC; in connection with the Contract; and with funds received from HHSC.

Third Party Software means software that is: developed for general commercial use; available to the public; or not developed for HHSC. Third Party Software includes without limitation: commercial off-the-shelf software; operating system software; and application software, tools, and utilities.

(b) Deliverables.

The Parties agree that any Deliverable, including without limitation the Custom Software, will be the exclusive property of HHSC.

(c) Ownership rights

(1) HHSC will own all right, title, and interest in and to its Confidential Information and the Deliverables provided by the Dental Contractor, including without limitation the Custom Software and associated documentation. For purposes of this Section 15.03, the Deliverables will not include Dental Contractor Proprietary Software or Third Party Software. Dental Contractor will take all actions necessary and transfer ownership of the Deliverables to HHSC, including, without limitation, the Custom Software and associated documentation prior to Contract termination.

(2) Dental Contractor will furnish such Deliverables, upon request of HHSC, in accordance with applicable State law. All Deliverables, in whole and in part, will be deemed works made for hire of HHSC for all purposes of copyright law, and copyright will belong solely to HHSC. To the extent that any such Deliverable does not qualify as a work for hire under applicable law, and to the extent that the Deliverable includes materials subject to copyright, patent, trade secret, or other proprietary right protection, Dental Contractor agrees to assign, and hereby assigns, all right, title, and interest in and to Deliverables, including without limitation all copyrights, inventions, patents, trade secrets, and other proprietary rights therein, including renewals thereof, to HHSC.

(3) Dental Contractor will, at the expense of HHSC, assist HHSC or its nominees to obtain copyrights, trademarks, or patents for all such Deliverables in the United States and any other countries. Dental Contractor agrees to execute all papers and to give all facts known to it necessary to secure United States or foreign country copyrights and

patents, and to transfer or cause to transfer to HHSC all the right, title, and interest in and to such Deliverables. Dental Contractor also agrees not to assert any moral rights under applicable copyright law with regard to such Deliverables.

(d) License Rights.

HHSC will have a royalty-free and non-exclusive license to access the Dental Contractor Proprietary Software and associated documentation during the term of the Contract. HHSC will also have ownership and unlimited rights to use, disclose, duplicate, or publish all information and data developed, derived, documented, or furnished by Dental Contractor under or resulting from the Contract. Such data will include all results, technical information, and materials developed for or obtained by HHSC from Dental Contractor in the performance of the Services hereunder, including but not limited to all reports, surveys, plans, charts, recordings, video or sound, pictures, drawings, analyses, graphic representations, computer printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the Services performed as a result of the Contract.

(e) Proprietary Notices.

Dental Contractor will reproduce and include HHSC's copyright and other proprietary notices and product identifications provided by Dental Contractor on such copies, in whole or in part, or on any form of the Deliverables.

(f) State and Federal Governments.

In accordance with 45 C.F.R. § 95.617, all appropriate State and Federal agencies will have a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, translate, or otherwise use, and to authorize others to use for Federal Government purposes all materials, the Custom Software and modifications thereof, and associated documentation designed, developed, or installed with federal financial participation under the Contract, including but not limited to those materials covered by copyright, all software source and object code, instructions, files, and documentation.

Article 16. Liability

Section 16.01 Property Damage.

(a) Dental Contractor will protect HHSC's real and personal property from damage arising from Dental Contractor's, its agent's, employees' and Subcontractors' performance of the Contract, and Dental Contractor will be responsible for any loss, destruction, or damage to HHSC's property that results from or is caused by Dental Contractor's, its agents', employees' or Subcontractors' negligent or wrongful acts or omissions. Upon the loss of, destruction of, or damage to any property of HHSC, Dental Contractor will notify the HHSC Project Manager thereof and subject to direction from the Project Manager or her or his designee, will take all reasonable steps to protect that property from further damage.

(b) Dental Contractor agrees to observe and encourage its employees and agents to observe safety measures and proper operating procedures at HHSC sites at all times.

(c) Dental Contractor will distribute a policy statement to all of its employees and agents that directs the employee or agent to promptly report to HHSC or to Dental Contractor any special defect or unsafe condition encountered while on HHSC premises. Dental Contractor will promptly report to HHSC any special defect or an unsafe condition it encounters or otherwise learns about.

Section 16.02 Risk of Loss.

During the period Deliverables are in transit and in possession of Dental Contractor, its carriers or HHSC prior to being accepted by HHSC, Dental Contractor will bear the risk of loss or damage thereto, unless such loss or damage is caused by the negligence or intentional misconduct of HHSC. After HHSC accepts a Deliverable, the risk of loss or damage to the Deliverable will be borne by HHSC, except loss or damage attributable to the negligence or intentional misconduct of Dental Contractor's agents, employees or Subcontractors.

Section 16.03 Limitation of HHSC's Liability

HHSC WILL NOT BE LIABLE FOR ANY INCIDENTAL, INDIRECT, SPECIAL, OR CONSEQUENTIAL DAMAGES UNDER CONTRACT, TORT INCLUDING NEGLIGENCE, OR OTHER LEGAL THEORY. THIS WILL APPLY REGARDLESS OF THE CAUSE OF ACTION AND EVEN IF HHSC HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

HHSC'S LIABILITY TO THE DENTAL CONTRACTOR UNDER THE CONTRACT WILL NOT EXCEED THE TOTAL CHARGES TO BE PAID BY HHSC TO THE DENTAL CONTRACTOR UNDER THE CONTRACT

Article 17. Insurance and Bonding

Section 17.01 Insurance Coverage.

(a) Statutory and General Coverage.

Dental Contractor will maintain, at Dental Contractor's own expense, during the Term of the Contract and until final acceptance of all Services and Deliverables, the following insurance coverage. Dental Contractor will provide HHSC with proof of the following insurance coverage on or before the Contract Effective Date:

(1) Business Automobile Liability Insurance for all owned, non-owned, and hired vehicles, for bodily injury and property damage;

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

(3) If Dental Contractor's current Comprehensive General Liability insurance coverage does not meet the above stated requirements, Dental Contractor will obtain

Umbrella Liability insurance to compensate for the difference in the coverage amounts. If Umbrella Liability insurance is provided it must follow the form of the primary coverage.

(b) Professional Liability Coverage.

(c) Dental Contractor must maintain at its own expense, or cause its Network Providers to maintain, during the Term of the Contract and until final acceptance of all Services and Deliverables, the following insurance coverage:

(1) Professional Liability Insurance for each Network Provider of $100,000.00 per occurrence and $300,000.00 in the aggregate. Dental Contractor must provide proof of such coverage upon request to HHSC.

(2) An Excess Professional Liability (Errors and Omissions) Insurance Policy for the greater of $3,000,000.00 or an amount, rounded to the nearest $100,000.00 that represents the number of Dental Members enrolled in the Dental Contractor in the first month of the applicable Contract Year multiplied by $150.00, not to exceed $10,000,000.00. Dental Contractor will provide HHSC with proof of this insurance coverage on or before the Contract Effective Date.

(d) General Requirements for All Insurance Coverage.

(1) Except as provided herein, all exceptions to the Contract's insurance requirements must be approved in writing by HHSC.

The Dental Contractor is prohibited from requiring a Network Provider to obtain the insurance coverage described in Section 17.01 if the Dental Provider or Network Provider qualifies as a state governmental unit or municipality under the Texas Tort Claims Act, and is required to comply with, and subject to, the provisions of the Texas Tort Claims Act.

(2) Dental Contractor or the Network Provider is responsible for any and all deductibles stated in the policies.

(3) Insurance coverage will be issued by insurance companies authorized by applicable law to conduct business in the State of Texas, and

(4) Insurance coverage must name HHSC as an additional insured, with the exception of Professional Liability insurance maintained by Providers. Insurance coverage must name HHSC as a loss payee, with the exception of Professional Liability insurance maintained by Providers and Business Automobile Liability insurance.

(5) Insurance coverage kept by the Dental Contractor must be maintained in full force at all times during the Term of the Contract, and until HHSC's final acceptance of all Services and Deliverables. Failure to maintain such insurance coverage will constitute a material breach of this contract.

(6) With the exception of Professional Liability Insurance maintained by Providers, the insurance policies described in this Section must have an extended reporting period of two years. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, the Contract Effective Date.

(7) With the exception of Professional Liability Insurance maintained by Providers, the insurance policies described in this Section must provide that prior written notice to be given to HHSC at least 30 Days before coverage is reduced below minimum HHSC contractual requirements, canceled, or non-renewed. Dental Contractor must submit a new coverage binder to HHSC to ensure no break in coverage. Each policy must include the following provision: "It is a condition of this policy that the company must furnish written notice to HHSC's designated contact at least 30 Days in advance of any reduction in cancellation, or non-renewal of this policy."

(8) The Parties expressly understand and agree that any insurance coverages and limits furnished by Dental Contractor will in no way expand or limit Dental Contractor's liabilities and responsibilities specified within the Contract documents or by applicable law.

(9) Dental Contractor expressly understands and agrees that any insurance maintained by HHSC will apply in excess of and not contribute to insurance provided by Dental Contractor under this contract.

(10) If Dental Contractor or its Providers, desire additional coverage, higher limits of liability, or other modifications for its own protection, Dental Contractor or its Providers will be responsible for the acquisition and cost of such additional protection. Such additional protection will not be an Allowable Expense under this Contract.

(11) Dental Contractor will require all insurers to waive their rights of subrogation against HHSC.

(e) Proof of Insurance Coverage.

(1) Except as provided in Section 17.01(d)(2), Dental Contractor must furnish HHSC original Certificates of Insurance evidencing the required insurance coverage on or before the Effective Date of the Contract. If insurance coverage is renewed during the term of the Contract, the Dental Contractor must furnish HHSC renewal certificates of insurance, or such similar evidence within five Business Days of renewal. Dental Contractor will submit evidence of insurance prior to Contract award. The failure of HHSC to obtain such evidence from Dental Contractor before permitting Dental Contractor to commence work will not be deemed to be a waiver by HHSC and Dental Contractor will remain under continuing obligation to maintain and provide proof of the insurance coverage.

(2) The insurance specified above will be carried until all Services and Deliverables required under the terms of the Contract are satisfactorily completed. Failure to carry or keep such insurance in force will constitute a violation of the Contract.

Section 17.02 Performance Bond.

Beginning on the Effective Date of the Contract, and each year thereafter, the Dental Contractor must obtain a performance bond with a one year term. The performance bond must be renewable, and renewal must occur no later than the first day of each subsequent State Fiscal Year. The performance bond must continue to be in effect for one year following the expiration

of the final renewal period or the date the contract terminates. Dental Contractor must obtain and maintain the annual performance bonds in the form prescribed by HHSC and approved by TDI, naming HHSC as Obligee, and securing Dental Contractor's faithful performance of the terms and conditions of this Contract. The annual performance bond(s) must be issued in the amount of $100,000.00. Performance bonds must be issued by a surety licensed by TDI, and specify cash payment as the sole remedy. Dental Contractor must deliver the initial performance bond to HHSC prior to or on the Effective Date of the Contract, and each renewal prior to the first day of the State Fiscal Year. Prior performance bonds received for a specific SFY will be released upon completion of the audit of the 334-Day FSR for the corresponding SFY.

Section 17.03 TDI Fidelity Bond.

The Dental Contractor will secure and maintain throughout the life of the Contract a fidelity bond as required by the Texas Department of Insurance. The Dental Contractor must promptly provide HHSC with copies of the bond and any amendments or renewals thereto.

TEXAS
Health and Human Services

Texas Health & Human Services Commission

Dental Services Scope of Work

DENTAL SERVICES SCOPE OF WORK

2.1 DENTAL PROGRAM SCOPE

The specifics of the Scope of Work (SOW) for the Dental Program are set forth below, and as appropriately referenced, in any Exhibits to **ATTACHMENT E, HHSC SOLICITATION NO. HHS0002879**, which are incorporated by reference into this Contract.

2.2 TRANSITION PHASE SCOPE

This Section presents the SOW for the Transition Phase of the Contract, which includes all activities the Dental Contractor is required to perform between the Effective Date and the Operational Start Date of a Contract resulting from award through procurement or an assignment and assumption due to termination, expiration, merger, or acquisition.

2.2.1 INTRODUCTION

The Transition Phase includes a timeline for Readiness Review, which must be completed to HHSC's satisfaction prior to the Dental Contractor's Operational Start Date. Readiness Review includes but is not limited to the following areas, which are further explained in Section 2:

- Administration of Key Dental Contractor Personnel
- Organizational Readiness Review
- Financial Readiness Review
- System Testing and Transfer of Data
- System Readiness Review
- Demonstration and Assessment of System Readiness
- Operations Readiness
- Assurance of System and Operational Readiness

Upon the identification by the Dental Contractor or HHSC of any deficiencies during or as a result of Readiness Review, Dental Contractor will correct the deficiencies within 10 Days of identification and written notification to the Parties or provide a Corrective Action Plan or risk mitigation plan as directed by HHSC if the deficiency requires more than 10 Days to correct.

HHSC may, at its discretion, postpone the Dental Contractor's Operational Start Date, or assess contractual remedies, including termination of the Contract, if the Dental Contractor fails to timely correct all Readiness Review deficiencies within a reasonable cure period determined by HHSC.

2.2.2 TRANSITION PHASE READINESS REVIEW DURATION

Dental Contractor must meet the Readiness Review requirements established by HHSC no later than 90 Days prior to the Operational Start Date.

2.2.3 TRANSITION PHASE SCHEDULE AND TASKS

The Dental Contractor has overall responsibility for the timely and successful completion of each of the Transition Phase tasks. The Dental Contractor is responsible for clearly specifying and requesting information needed from HHSC, other HHSC contractors, and Providers in a manner that does not delay the schedule or work to be performed. The Dental Contractor agrees to provide all materials and access required to complete the Readiness Review by the dates established by HHSC and if applicable, HHSC's Readiness Review contractor.

2.2.4 TRANSITION PHASE PLANNING

HHSC and the Dental Contractor will work together during the Transition Phase to:

1. Define reporting standards;
2. Establish communication protocols between HHSC and the Dental Contractor;
3. Establish contacts with other HHSC contractors;
4. Establish a schedule for key activities and milestones; and
5. Clarify expectations for the content and format of the Contract Deliverables.

The Dental Contractor must update the Transition Plan provided with its Proposal no later than 30 Days after the Effective Date, then provide monthly implementation progress reports through the sixth month of Dental Contractor Program operations.

In the case of the assignment and assumption of a Contract due to termination, expiration, merger, or acquisition, the incoming or transitioning Dental Contractor must provide a Transition Plan no later than 30 Days after the Dental Contractor notifies HHSC, or upon notification from HHSC of the termination, expiration, merger, or acquisition. The exiting Dental Contractor must comply with the requirements as described in **Section 2.8**,

The Transition Plan must include:

1. Specific staffing patterns by function for all operations, including enrollment, information systems, member services, quality improvement, claims management, case management, and provider and recipient training;
2. Specific time frames for demonstrating preparedness for implementation before the Operational Start Date; and
3. Other elements identified by HHSC.

The Dental Contractor's Transition Plan must include a detailed description of the process it will use to ensure continued authorization of dental services. HHSC will provide a file

identifying the Dental Members to the Dental Contractor for this purpose. The Dental Contractor's Transition Plan must identify a designated Dental Contractor staff member responsible for the facilitation and oversight of this process. These requirements are further described in **Section 2.3.32**.

2.2.5 ADMINISTRATION AND KEY DENTAL CONTRACTOR PERSONNEL

No later than the Effective Date, the Dental Contractor must:

1. Designate and identify Key Personnel that meet the requirements of **ATTACHMENT A HHSC DENTAL CONTRACT TERMS AND CONDITIONS**;
2. Supply HHSC with current résumés of each Key Personnel and the percent of allocated time for each Key Personnel that is dedicated to the Contract;
3. Report on any organizational information that has changed since the Dental Contractor's Proposal, such as updated job descriptions and organizational charts, including Management Information System (MIS) job descriptions and an MIS staff organizational chart, if applicable; and
4. Provide the organizational chart and oversight criteria for each Material Subcontractors, including the percentage of time each Material Subcontractor dedicate to the Dental Contractor.

During the Transition Phase, the Dental Contractor must notify HHSC no later than five Days following a change in the Key Personnel or Material Subcontractors.

In the case of Contract termination or expiration, the Dental Contractor must provide HHSC with the Key Dental Contractor Personnel who will facilitate ongoing activities and requirements described in the Turnover Plan. In the case of merger or acquisition, the Dental Contractor must provide HHSC with the Key Dental Contractor Personnel who will facilitate ongoing activities and requirements described in the Transition Plan. The Dental Contractor will also provide HHSC with the Material Subcontractor's functions and responsibilities as identified in **Chapter 5 of the UMCM**.

2.2.6 ORGANIZATIONAL AND FINANCIAL READINESS REVIEW

During the Readiness Review, the Dental Contractor must update the organizational and financial information submitted in its Proposal. **Section 7** of **ATTACHMENT E, HHSC SOLICITATION NO. HHS0002879,** contains a list of financial statements, corporate background and experience information, and Material Subcontractor information that the Dental Contractor must update for Readiness Review.

During the Readiness Review, HHSC may request from the Dental Contractor certain operating procedures and updates to documentation to support the provision of Services. The Dental Contractor must provide assurance of the Dental Contractor's understanding of its responsibilities and the Dental Contractor's capability to assume the functions required

under the Contract, based in part on the Dental Contractor's assurances of operational readiness, information contained in its Proposal, and in Transition Phase documentation submitted by the Dental Contractor.

At HHSC's election, the Dental Contractor is required to provide a Corrective Action Plan (CAP) in response to any Readiness Review deficiency no later than 10 Days after the discovery of any such deficiency by HHSC or the Dental Contractor. If the Dental Contractor documents to HHSC's satisfaction that the deficiency has been corrected within 10 Days of such deficiency notification, a CAP may not be required.

2.2.6.1 Responsibilities in the Event of a Federal Emergency Management Agency or Governor-Declared Disaster, or Other Emergencies

In the event of a Federal Emergency Management Agency (FEMA) or State of Texas Governor-declared disaster, or other emergencies that are internal, man-made, or natural, the Dental Contractor must ensure the care of Members in compliance with the Dental Contractor's continuity of Member care emergency response plan (COMCER plan), particularly the care of Members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if Covered Services are disrupted or interrupted. Requirements for the COMCER plan and other disaster-related requirements are described in **Section 16.1.13 of the UMCM.**

The Dental Contractor must have a COMCER plan based on a risk assessment using an "all hazards" approach to respond. An "all hazards" approach focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal emergencies, man-made emergency, or natural disasters. As part of the plan, the Dental Contractor must describe the method to ensure that Members are able to see Out-of-Network providers if Members have a permanent address in FEMA or State of Texas Governor-declared disaster areas, or areas in which internal, man-made, or natural disasters have occurred, and are unable to access Covered Services from Network Providers.

The Dental Contractor must also describe the method it will use to ensure that prior authorizations are extended and transferred without burden to new Providers if directed by HHSC, and the method by which the Dental Contractor will identify the location of Members who have been displaced. Annually, the Dental Contractor must conduct exercises carrying out the plan's provisions, evaluate its performance and make necessary updates.

Additionally, the Dental Contractor must maintain a continuity of operations business plan which includes a collection of resources, actions, procedures, and information that is developed, tested, and held in readiness for use to continue operations in the event of a

major disruption of operations due to a FEMA or State of Texas Governor-declared disaster, or other emergencies that are internal, man-made, or natural.

The continuity of operations business plan must address emergency financial needs, essential functions for Member services, critical personnel, and how to return to normal operations as quickly as possible.

During a FEMA or State of Texas Governor-declared disaster, or other emergency that is internal, man-made, or natural, the Dental Contractor is required to report to HHSC daily or at an interval determined by HHSC, when requested, on the status of Members and issues regarding Member access to Covered Services.

When directed by HHSC, by authority of waivers available through the CHIP State Plan, the Dental Contractor must be able to require Network Providers to waive all CHIP cost-sharing requirements for children of families living in FEMA or State of Texas Governor-declared disaster areas or areas in which internal, man-made, or natural disasters have occurred, at the time of the disaster event.

The Dental Contractor claims system must have the capability to waive edits or allow override of edits by at least ZIP code and county for specific date ranges. The Dental Contractor claims system must have the capability to waive edits or allow override of edits by at least ZIP code and county for specific date ranges. The Dental Contractor must have a COMCER plan based on a risk assessment using an "all hazards" approach to respond. An "all hazards" approach focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal emergencies, man-made emergency, or natural disasters. As part of the plan, the Dental Contractor must describe the method to ensure that Members are able to see Out-of-Network providers if Members have a permanent address in FEMA or State of Texas Governor-declared disaster areas, or areas in which internal, man-made, or natural disasters have occurred, and are unable to access Covered Services from Network Providers.

2.2.6.2 EMPLOYEE BONUS AND/OR INCENTIVE PAYMENT PLAN

If the Dental Contractor intends to include Employee Bonus or Incentive Payments as allowable administrative expenses, the Dental Contractor must furnish a written Employee Bonus and/or Incentive Payments Plan to HHSC. The written plan must include a description of the Dental Contractor's criteria for establishing bonus and/or incentive payments, the methodology to calculate bonus and/or incentive payments, and the timing of bonus and/or incentive payments. The Bonus and/or Incentive Payment Plan and description must be submitted during the Transition Phase, no later than 30 days after the Effective Date of the Contract. If the Dental Contractor substantively revises the Employee

Bonus and/or Incentive Payment Plan during the Operations Phase, the Dental Contractor must submit the revised plan to HHSC at least 30 days in advance of its effective date.

HHSC reserves the right to disallow all or part of a plan that it deems inappropriate. Any such payments are subject to audit and must conform with the **Chapter 6.1 of the UMCM**.

2.2.6.3 SYSTEM TESTING AND TRANSFER OF DATA

The Dental Contractor must have hardware, software, network, and communications systems with the capability and capacity to handle and operate a MIS and all subsystems identified in **Section 2.3.29** within the continental United States.

During this Readiness Review task, the Dental Contractor must accept into its system all necessary data files and information available from HHSC or its contractors. The Dental Contractor must install and test all hardware, software, and telecommunications required to support the Contract. The Dental Contractor must define and test modifications to the Dental Contractor's systems required to support the business functions of the Contract.

The Dental Contractor must produce data extracts and receive all electronic data transfers and transmissions. The Dental Contractor must demonstrate the ability to produce a dental services 837D encounter file during the Readiness Review.

If any errors or deficiencies are evident, the Dental Contractor must implement HHSC-approved resolution procedures to address problems identified. The Dental Contractor must provide HHSC, or a designated vendor, with test data files for systems and interface testing for all external interfaces, this includes testing of the required telephone lines for Providers and Dental Members and any necessary connections to the HHSC Enrollment Broker (EB). The EB will provide test Enrollment Files to new Dental Contractor that do not have previous HHSC Enrollment Files. The Dental Contractor must demonstrate its system capabilities and adherence to the resulting Contract specifications during Readiness Review.

2.2.6.3.1 SYSTEM READINESS REVIEW

During the system Readiness Review, the Dental Contractor must assure HHSC that systems services will not be disrupted or interrupted during the Operations Phase of the Contract. The Dental Contractor must coordinate with HHSC and its contractors to ensure the business and systems continuity for the processing of all dental claims and data as required under the Contract.

The Dental Contractor must submit to HHSC descriptions of interface and data and process flow for each key business process described in **Section 2.3.29** for system-wide functions. The extent to which the claim processing is automated, as required in **Section 2.3.29.4**, will be assessed.

If the Dental Contractor is a current State of Texas vendor, all existing and unresolved projects and systems issues related to hardware, software, claims processing, network, and communications systems must be cured no later than 90 Days prior to the Effective Date of the Contract. Uncured issues present after the Effective Date of the Contract will cause the Dental Contractor to fail Readiness Review.

The Dental Contractor must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. The Dental Contractor must develop and submit for HHSC review and approval the following information no later than 120 Days prior to the Operational Start Date:

1. Joint Interface Plan;
2. Security Plan;
3. Disaster Recovery Plan;
4. Business Continuity Plan;
5. Risk Management Plan; and
6. Systems Quality Assurance Plan.

2.2.6.3.1.1 DEMONSTRATION AND ASSESSMENT OF SYSTEM READINESS

The Dental Contractor must provide documentation on systems and facility security and provide evidence or demonstrate that it is compliant with HIPAA. The Dental Contractor must provide HHSC with a summary of all recent external audit reports, including findings and corrective actions, relating to the Dental Contractor's proposed systems, including any Statement on Standards for Attestation Engagements No. 16 audits that have been conducted in the past three years. The Dental Contractor must promptly make additional information on the detail of such system audits available to HHSC upon request.

In addition, HHSC will provide to the Dental Contractor a test plan that will outline the activities that need to be performed by the Dental Contractor during Readiness Review, and the Dental Contractor must demonstrate system readiness. The Dental Contractor must execute system readiness test cycles to include all external data interfaces, including those with the Dental Contractor's Material Subcontractors.

HHSC may independently test whether the Dental Contractor's MIS has the capacity to administer the requirements of this Contract. This Readiness Review of a Dental Contractor's MIS may include, but is not limited to, a desk review or an onsite review. HHSC may request from the Dental Contractor additional documentation to support the provision of Medically Necessary Covered Dental Services. Based in part on the Dental Contractor's demonstration of systems readiness, information contained in its Proposal, additional documentation submitted by the Dental Contractor, and any review conducted by HHSC or its contractors, HHSC will assess the Dental Contractor's understanding of its responsibilities and the Dental Contractor's capability to assume the MIS functions required under the Contract.

2.2.6.4 OPERATIONS READINESS

The Dental Contractor must clearly define and document the policies and procedures that will be followed to support day-to-day business activities related to the provision of Medically Necessary Covered Dental Services, including coordination with Subcontractors. The Dental Contractor must clearly document all policies and procedures to produce the Contract Deliverables. The Dental Contractor will be responsible for developing and documenting its approach to quality assurance. HHSC will conduct operation Readiness Reviews during the time period between the Contract Effective Date and the Operational Date, as well as biannually to ensure the Dental Contractors are in compliance with the Contract.

The Dental Contractor must reimburse HHSC for all travel costs incurred by HHSC for onsite Readiness Reviews. For purposes of this section, "travel costs" include HHSC approved airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC in connection with the onsite reviews. Reimbursement by the Dental Contractor will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the Dental Contractor. The Dental Contractor may not require a Social Security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement. During operations Readiness Review, the Dental Contractor must perform the following activities and submit Deliverables on a schedule specified by HHSC:

1. Develop, or revise existing operations procedures and associated documentation to support the Dental Contractor's proposed approach to conducting operations activities in compliance with the SOW. If the Dental Contractor is an incumbent HHSC Dental Contractor, a Dental Contractor currently providing Texas Medicaid and CHIP dental services, such revisions must reflect the guidance and direction given to the Dental Contractor by HHSC to date, provided such is applicable to the SOW;
2. Submit a comprehensive plan for Network adequacy that includes a list of all contracted and credentialed Providers in a format approved by HHSC. The list must include the Provider types identified in Tex. Gov't Code § 533.005(a)(21)(B)(i), (ii), and (iv). The plan must include a description of additional contracting and credentialing activities scheduled to be completed before the Operational Start Date;
3. Implement a Dental Member services staff training curriculum and a Provider training curriculum, and provide documentation demonstrating compliance with training requirements, such as enrollment or attendance rosters dated and signed by each attendee or other written evidence of the training. Training must meet the requirements of 1 Tex. Admin. Code § 353.105, and include privacy, Member advocacy, Internal Dental Contractor Member Appeal process, HHSC State Fair Hearing process, Medically Necessary Covered Dental Services, Value-added

Services (VAS), medical necessity, Dental Member harm identification, issue escalation, prohibitions related to restraint, and community resource navigation;

4. Prepare a coordination plan documenting how the Dental Contractor will coordinate its business activities with those activities performed by HHSC or its contractors, and if any, Material Subcontractors. The coordination plan must include identification of coordinated activities and protocols for the Transition Phase;
5. Submit to HHSC the draft Dental Member handbook, draft Provider manual, draft Provider directory, and draft Dental Member identification card for HHSC's review and approval. The materials must meet the requirements specified in **Section 2.3.2** and include the Critical Elements defined in the **UMCM.** The Dental Contractor must submit a final Dental Member handbook and Provider directory incorporating changes required by HHSC prior to the Operational Start Date;
6. Submit to HHSC the Dental Contractor's proposed Dental Member Complaint and Internal Dental Contractor Appeal processes;
7. Provide sufficient copies of the final Provider directory to HHSC in sufficient time to meet the enrollment schedule;
8. Demonstrate toll-free telephone systems and reporting capabilities for the Dental Member services hotline and the Provider hotline;
9. Submit a written Fraud, Waste, and Abuse (FWA) compliance plan to HHSC for approval no later than 30 Days after the Contract's Effective Date. **Section 2.3.31.1** provides the requirements of the plan.
10. Ensure that, if this function is subcontracted to another entity, the Subcontractor also meets all the requirements in this section and the FWA requirements stated in **Section 2.3.31.1.** Submit model Provider Contracts to HHSC for review during Readiness Review. HHSC may reject or require changes to any model Provider Contract that does not comply with HHSC requirements for these Provider Contracts;
11. Fully inform all Providers about the claim submission process and claim data requirements at least 30 Days prior to the Operational Start Date and as a provision within the Dental Contractor's Provider Contract and the Provider manual described in subsection 5 above;
12. Develop and implement a network access assurance program to continually improve Network access and quality. Under this program, the Dental Contractor must provide enhanced payments to qualified Providers. During Readiness Review, the Dental Contractor must submit a written description of its proposed network access assurance program to HHSC, and must receive HHSC's written approval before implementing the program;
13. Develop a privacy notice, commonly referred to as Notice of Privacy Practice (NOPP), as required by HIPAA, including 45 C.F.R. § 164.520. The Dental Contractor must provide HHSC with a copy of its privacy notice during Readiness Review for HHSC approval;

14. Submit a Cultural Competency plan to HHSC for approval. The plan must align with the federal and state standards as described in **Chapter 11 of the UMCM**. The Cultural Competency plan must detail how the Dental Contractor implements each component of the related federal and state standards for such plans. The Dental Contractor must describe how its implementation of these standards impact implementation of the principal standard, which is to "Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."

Note to Dental Contractors. The above services and Chapter reference in Number 14 may not have been incorporated into the UMCM at the time this Contract was awarded. In the event they have not been, such services will be as part of the current HHSC UMCM change process. The Contract will be amended appropriately at that time.

HHSC may require the Dental Contractor to resubmit one or more of the above items if the Dental Contractor begins providing a new service or benefit, or implements a Major Systems change after the Effective Date.

2.2.6.5 ASSURANCE OF SYSTEM AND OPERATIONAL READINESS

In addition to successfully providing the Deliverables described in **Section 2.2.4**, the Dental Contractor must assure HHSC that all processes, MIS, and staffed functions are ready and able to successfully assume responsibilities for operations prior to the Operational Start Date, including hiring and training of the Key Personnel, Member services staff, Provider services staff, and MIS staff. The Dental Contractor must also assure HHSC that the MIS system and interfaces are in place and functioning properly; communications procedures are in place; Provider manuals have been distributed; and Provider training sessions have occurred according to the HHSC approved schedule.

HHSC may terminate the Contract, postpone the Operational Start Date, or assess other contractual remedies if the Dental Contractor fails to timely correct all Transition Phase deficiencies within a reasonable cure period, as determined by HHSC.

2.2.6.6 MEMBER ENROLLMENT DURING TRANSITION

During the Transition period, HHSC will notify potential and current Dental Members of their option to choose a Dental Contractor for the Operations Phase. HHSC will notify current Dental Members about Dental Contractor options starting six months prior to the Operational Start Date. Beginning three months prior to Operational Start Date, HHSC will provide a prospective member file to each Dental Contractor.

The Dental Contractor must:

1. Load the prospective eligibility file, receive daily updates of the prospective eligibility file, and process eligibility changes sent by HHSC;
2. Create a file that will include all pertinent dental and clinical data associated with Dental Members who transition away from their Dental Contractor; and
3. Coordinate with HHSC to determine the appropriate file layouts and timelines for transfers between the Dental Contractor and HHSC.

The Dental Contractor is required to mitigate risk associated with not being prepared for the Operations Phase in coordination with HHSC, with consideration of the following high-level processes:

1. HHSC will identify key events (Readiness Review milestones) based on a project work plan that each Dental Contractor must achieve by a specified time;
2. To ensure that each Dental Contractor is on track to meet these Readiness Review milestones, HHSC will conduct weekly Readiness Review webinars;
3. If a Dental Contractor consistently fails to meet the established Readiness Review milestones, it will be identified as high risk and targeted for increased technical assistance;
4. HHSC will conduct an abbreviated systems and operations Readiness Review six months prior to the Operational Start Date and will tentatively assess a Dental Contractor as "Go" or "No-Go" based on established and published criterion;
5. The "No-Go" determination will be made only in those instances where a Dental Contractor cannot become fully operational by the Operational Start Date, as determined by HHSC. In that case, the Dental Contractor will not be listed as an option for Dental Members selecting a Dental Contractor during initial Dental Member notification;
6. Upon a Dental Contractor's remediation of the issues identified by HHSC to HHSC's satisfaction, the Dental Contractor status will change to "Go" and become an option;
7. Final Readiness Review will occur 90 Days prior to go live, and if at this point a Dental Contractor is identified as a "No-Go" then Dental Members will be notified that the Dental Contractor is no longer available as an option and another Dental Contractor must be selected. If a Dental Member does not select a Dental Contractor, then HHSC will default a Dental Member into a plan.
8. When the Dental Contractor is able to demonstrate readiness to HHSC, then it will be restored as an option and HHSC will apply the default enrollment criteria specified by HHSC.

2.2.7 Texas Department of Insurance and Centers for Medicare and Medicaid Services Licensure, Certification, or Approval

The Dental Contractor must receive Texas Department of Insurance (TDI) licensure, certification, or approval as a dental maintenance organization or an indemnity insurer in

all counties in the State no later than 60 Days after the Contract's Effective Date. HHSC may terminate the Contract at no additional cost to HHSC and with no penalty for the Dental Contractor's failure to provide HHSC with the required TDI certification or approval.

2.2.8 CONTINUITY OF CARE AND OUT-OF-NETWORK PROVIDERS

During the Transition Phase, HHSC will require current Dental Contractor to provide any new Dental Contractor with files identifying Dental Members with prior authorizations for dental services as instructed by HHSC. The Dental Contractor must describe the process it will use to ensure continuation of these services in its Transition Plan, as noted in **Section 2.2.4**. The Dental Contractor must ensure that Providers are educated about and trained regarding the process for continuing these services prior to the Operational Start Date.

The Dental Contractor must ensure that each Dental Member has access to a second opinion regarding the use of any Covered Service. A Dental Member must be allowed access to a second opinion from a Network Provider or Out-of-Network provider if a Network Provider is not available, at no cost to the Dental Member, in accordance with 42 C.F.R. §438.206(b)(3). The Dental Contractor may use single case agreements with Out-of-Network providers to facilitate a Dental Member's access to a second opinion. The Dental Contractor is not required to include Dental Members seeking a second opinion as part of its "Out-of-Network Utilization Reporting" requirements under **Chapter 5 of the UMCM.**

2.2.9 CONTINUING TRANSITION OBLIGATIONS

The Dental Contractor must work with HHSC, Providers, and Dental Members to promptly identify and resolve problems identified after the Operational Start Date and to communicate to HHSC, Providers, and Dental Members, as applicable, the steps the Dental Contractor is taking to resolve the problems.

2.3 OPERATIONS PHASE SCOPE

This section describes SOW requirements for the Operations Phase of the Contract which begins on the Operational Start Date. HHSC has additional requirements in **ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS** and the **UMCM.** The Respondent is responsible for all requirements set forth in **ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS** and the **UMCM,** which is incorporated by reference into the Contract. HHSC may modify these documents as it deems necessary.

2.3.1 GENERAL SCOPE OF WORK

The Dental Contractor must provide Medically Necessary Covered Dental Services to Dental Members enrolled with the Dental Contractor on or after the Operational Start Date.

The Dental Contractor must comply, to the satisfaction of HHSC, with all Contract requirements and all applicable provisions of state and federal laws, rules, regulations, and all state plan or waiver agreements with CMS.

2.3.2 OPERATIONAL PHASE READINESS, OPERATIONAL, AND TARGETED REVIEWS

HHSC may conduct desk or onsite reviews related as part of its Contract performance. HHSC may also require Contractors to submit detailed policies and procedure that document day-to-day business activities related to Contract requirements for HHSC review and approval.

The Dental Contractor may be subject to additional Readiness Reviews if it makes changes deemed by HHSC to require such Readiness Reviews. Changes made during the Operational Phase that may lead to additional Readiness Reviews include, but are not limited to:

1. Location change;
2. Processing system changes, including changes in Material Subcontractors performing MIS or claims Processing Functions;
3. Carve-ins of new membership; and
4. Carve-ins of new Services.

HHSC will determine whether the proposed changes will require a desk review or an onsite review.

HHSC will determine whether the proposed changes require a desk review and/or an onsite review. The Dental Contractor must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent for onsite reviews conducted as part of Readiness Review or HHSC's normal Contract monitoring efforts. For purposes of this section, "authorized reimbursable travel costs" may include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite reviews. Reimbursement by the Dental Contractor will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the Dental Contractor. The Dental Contractor may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

Unless the Dental Contractor receives HHSC approval for a one-time exception in writing, the Dental Contractor must provide HHSC with secure access rights as an authorized guest user to all Member and Provider access points, including but not limited to its Member and

Provider portals and call center services, for remote monitoring capability. To qualify for an exception to this requirement, the Dental Contractor must demonstrate to HHSC the required functionality for Member and Provider portals via WebEx or onsite reviews. Portal demonstrations must be conducted in the Dental Contractor or the Subcontractor's production environment or an environment that mirrors the production environment functionality.

The Dental Contractor must develop and submit a risk management plan and contingency plan, as required by the UMCM, to ensure risks and issues are effectively monitored and managed as to limit impact to business operations.

The Dental Contractor must document and report resolution of system or service related issues to HHSC, including the length of time from discovery to resolution, severity level, and provide corrective measures and a root cause analysis to prevent future problems from occurring.

For MIS Changes Only: The Dental Contractor must provide HHSC updates to the Dental Contractor's organizational chart and descriptions of MIS responsibilities at least 30 Days prior to the effective date of an MIS change. The Dental Contractor must provide an up-to-date official point of contact to HHSC for MIS issues on an ongoing basis. The Dental Contractor or its designee must be able to demonstrate, upon HHSC's request, sufficient oversight of each Material Subcontractor based on Dental Contractor's assessed risk of Material Subcontractor's performance.

Major Systems Changes are subject to HHSC desk review and onsite review of the Dental Contractor's facilities, as necessary, to test readiness and functionality prior to implementation. Prior to HHSC approval of the Major Systems Change, the Dental Contractor may not implement any changes to its operating systems.

The Dental Contractor must provide HHSC updates to the Dental Contractor's organizational chart relating to MIS and the description of MIS responsibilities at least 30 Days prior to the effective date of the change. The Dental Contractor must provide HHSC official points of contact, on an on-going basis, for MIS issues.

During the Operational Phase, HHSC may conduct any Systems Readiness Reviews described in **Section 2.3.2;** or elsewhere in the Contract to validate the Dental Contractor's ability to meet the MIS requirements. The System Readiness Review may include a desk review or onsite review and must be conducted for the following events:

1. A new Dental Contractor is brought into the Dental Program;
2. An existing Dental Contractor changes location; or
3. An existing Dental Contractor changes its processing system, including changes in Material Subcontractors performing MIS or claims processing functions.

Refer to **Section 2.2** for additional information regarding Readiness Reviews and **Section 4.08(c) of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS** for

information regarding Readiness Reviews of the Dental Contractor's Material Subcontractors.

2.3.3 HHSC PERFORMANCE REVIEW AND EVALUATION

In accordance with **Section 12.01 of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**, HHSC, at its discretion, will review, evaluate and assess the development and implementation of the Dental Contractor's policies and procedures related to the timely and appropriate delivery of Services and Deliverables as required under the Contract. Reviews, evaluations, and assessments may include the following:

1. Dental Contractor's reviews of its own policies and procedures, and ensuing corrective actions taken, including demonstration by the Dental Contractor that the corrective action(s) or intervention(s) included in the Corrective Action Plan (CAP) have been completed or implemented using a method approved or provided by HHSC;
2. Dental Contractor internal policies;
3. Dental Contractor internal procedures;
4. Dental Contractor workflows;
5. Dental Contractor use of prior authorizations;
6. Dental Contractor utilization review process;
7. Assessment of the Dental Contractor service planning package;
8. The potential for underutilization of services; assessments; delivery of services; and
9. Case notes.

Upon notice and at no charge to HHSC, the Dental Contractor and its Subcontractors must cooperate with HHSC and provide any assistance required to complete the review, evaluation, or assessment including prompt and adequate access to related documents, internal systems containing Dental Member information and records, and appropriate staff, as well as, utilization management documentation, case notes, and service locations or facilities that are related to the scope of services provided under the Contract.

HHSC may monitor the Dental Contractor to confirm the Dental Contractor is using prior authorization and Utilization Review processes that ensure appropriate utilization and prevent overutilization or underutilization of services. A Dental Contractor providing dental services must also comply with the terms of **Section 2.3.25**.

2.3.4 MEDICALLY NECESSARY COVERED DENTAL SERVICES

The Dental Contractor is responsible for authorizing, arranging, coordinating, and providing Medically Necessary Covered Dental Services in accordance with the requirements of this Contract. The Dental Contractor must provide Medically Necessary Covered Dental Services to all Dental Members beginning on the Member's date of enrollment regardless of pre-existing conditions, prior diagnosis, receipt of any prior dental health care services, or for any other reason, subject to the HHSC-prescribed benefit

limitations. The Dental Contractor must not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any Dental Member.

The Dental Contractor must not practice discriminatory selection or encourage segregation among the total group of eligible Dental Members by excluding, seeking to exclude, or otherwise discriminating against any group or class of individuals.

1) Dental Contractor is responsible for providing all Medically Necessary Covered Dental Services available to clients of the Fee-for-Service (FFS) program to the Dental Contractor's eligible Medicaid members, in no less than the amount, duration, and scope as is available through FFS, as reflected in the state plan under Title XIX of the Social Security Act Medical Assistance Program and detailed in the Texas Medicaid Provider Procedures Manual (TMPPM) as **ATTACHMENT H, TEXAS MEDICAID PROVIDER PROCEDURES MANUAL**, and as required by 42 C.F.R. subpart B of Part 441 for Members under the age of 21, and in accordance with 42 C.F.R. § 438.210, with the exception of Non-capitated Services explained in **Section 2.5.1.5**. Dental Contractor must provide the services described in the most recent TMPPM and any updates thereto. The Dental Contractor is responsible for educating Dental members about the availability of Non-capitated Services and referring Dental members to and helping coordinate care for Non-capitated Services.

ATTACHMENT G, CHIP MEDICALLY NECESSARY COVERED DENTAL SERVICES, includes a comprehensive list of Medically Necessary Covered Dental Services for CHIP members, including preventive, diagnostic, restorative, endodontic, periodontal, prosthodontic, and oral and maxillofacial surgery.

The Dental Contractor is responsible for paying for or reimbursing for all Medically Necessary Covered Dental Services provided to CHIP members, up to maximum benefit amounts.

Dental Members who receive Medically Necessary Covered Dental Services are not responsible for paying the costs of such services, other than any authorized cost-sharing under CHIP, unless the Dental Member has exhausted his or her applicable maximum benefit limits.

Certain dental services are benefits of CHIP but are excluded from the Covered Dental Services provided by the Dental Contractor. The Dental Contractor is not responsible for coverage of or payment for these "Non-capitated Services," which are described more fully in **Section 2.5.1.5.** The Dental Contractor is responsible for educating CHIP Dental members about the availability of these Non-capitated Services and referring CHIP Dental members to and helping coordinate care for these Non-capitated Services.

Medically Necessary Covered Dental Services for Medicaid and CHIP Dental Members are subject to change due to changes in federal and state law; changes in the Medicaid or

CHIP state plan; changes in Medicaid or CHIP policy; and changes in dental practice, protocols, or technology.

In the development of medical necessity determinations, the Dental Contractor must adopt practice guidelines that:

1. Are based on valid and reliable clinical evidence or a consensus of oral health care professionals in the particular field;
2. Consider the needs of the Dental Contractor's Members;
3. Do not conflict in part or in whole with state or federal policy;
4. Are adopted in consultation with contracting oral health care professionals;
5. Are reviewed and updated periodically as appropriate or as requested by HHSC; and
6. Are shared with Providers in the Dental Contractor Network as a means of transparency.

2.3.5 VALUE-ADDED SERVICES

The Dental Contractor may propose additional services for coverage which are Value-added Services (VAS). VAS may be actual dental services, benefits, or positive incentives that HHSC determines will promote oral health, healthy lifestyles, health literacy, service access, and improved oral health outcomes among Dental Members. If approved by HHSC, VAS may also include transportation. A VAS must not be Medicaid or CHIP benefits covered under the Contract. Best practice approaches to delivering Medically Necessary Covered Dental Services are not considered VAS.

The Dental Contractor must offer VAS to all Dental Members; but may distinguish among an identified group or category of Dental Members. VAS do not need to be consistent between Medicaid and CHIP.

Any VAS that the Dental Contractor elects to provide must be provided at no additional cost to HHSC. The costs of VAS are not reportable as Allowable Costs on the Financial Statistical Report (FSR) for either dental or administrative expenses and are not factored into the rate-setting process. In addition, the Dental Contractor must not pass on the cost of the VAS to Dental Members or Providers. HHSC may collect data on VAS costs in the FSR or elsewhere, for informational purposes.

The Dental Contractor may offer discounts on non-covered benefits to Dental Members as VAS, provided that the Dental Contractor complies with Tex. Ins. Code § 1451.2065. The Dental Contractor must ensure that Providers do not charge Members for any other cost-sharing for a VAS, including copayments or deductibles.

The Dental Contractor must specify the conditions and parameters regarding the delivery of each VAS and must clearly describe any limitations or conditions specific to each VAS in the Dental Member handbook. The Dental Contractor must also include a disclaimer in

its Marketing Materials and Provider directory indicating that restrictions and limitations may apply to VAS.

The Dental Contractor's proposed VAS must be approved by HHSC prior to implementation. The Dental Contractor must use HHSC's template for submitting proposed VAS. See **Chapter 4 of the UMCM**.

Dental Contractor will be given the opportunity to add, enhance, delete, or reduce VAS once per State Fiscal Year (SFY), with changes to be effective September 1. HHSC may allow additional modifications to VAS if Medically Necessary Covered Dental Services are amended by HHSC during a SFY. The Dental Contractor must submit requests to add, enhance, delete, or reduce a VAS to HHSC by April 1 of each SFY to be effective the following September 1.

Once requests are approved, the Dental Contractor must not reduce or delete any VAS until September 1. When the Dental Contractor requests deletion or reduction of a VAS, the Dental Contractor must include information regarding the processes by which the Dental Contractor will notify Dental Members and revise Member Materials and Marketing Materials. See **Chapter 4 of the UMCM**.

A Dental Contractor's request to add a VAS must at least:

1. Define and describe the proposed VAS;
2. Identify the category or group of Dental Members eligible to receive the VAS, if it is a type of service that is not appropriate for all Dental Members;
3. Describe any limitations or restrictions that apply to the VAS;
4. Identify the Providers or entities responsible for providing the VAS;
5. Describe how the Dental Contractor will identify the VAS in its financial statistical report (FSR), as applicable;
6. Propose how and when the Dental Contractor will notify Providers and Dental Members about the availability of such VAS;
7. Describe the process by which a Dental Member may obtain or access the VAS, including any action required by the Dental Member, as appropriate;
8. Include a statement that the Dental Contractor will provide such VAS for at least 12 months following HHSC approval; and
9. Describe how the Dental Contractor will identify the VAS in administrative data (e.g., Encounter Data), and in Encounters, FSRs, and in any other reports to HHSC.

A Dental Contractor must not include a VAS in any material distributed to Dental Members or prospective members until the Dental Contractor obtains HHSC's approval. If a VAS is deleted, the Dental Contractor must notify each Dental Member, at a minimum of 30 Days prior to discontinuing the VAS that the service will no longer be available as a VAS through the Dental Contractor. The Dental Contractor must also revise all materials distributed to prospective members to reflect the change in VAS. These materials are subject to review and approval by HHSC as outlined in **Section 2.3.20.3**.

2.3.6 CASE-BY-CASE SERVICES

The Dental Contractor may offer additional benefits that are outside the capitation rate and scope of Medically Necessary Covered Dental Services to individual Dental Members on a case-by-case basis, based on medical necessity, cost-effectiveness, the wishes of the Dental Member or Dental Member's Legally Authorized Representative (LAR), and the potential for improved dental health status of the Dental Member. In compliance with **Section 9.01** of **ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**, The Dental Contractor does not have to receive HHSC approval for Case-by-case Services and does not have to provide such services to all Dental Contractor Members. Contractor must maintain documentation of authorized case-by-case services that includes the reasons for the approval, at a minimum this documentation must include the reason for providing the service. Case-by-case services authorized by the Dental Contractor are not considered in the rate-setting process, are provided by the Dental Contractor at no cost to HHSC, the Dental Member, or Provider, and must be appropriately reported in the Dental Contractor's FSR.

2.3.7 COORDINATION OF NON-CAPITATED SERVICES

The Dental Contractor is not responsible for coverage or payment of Non-capitated Services, including Emergency Dental Services provided to CHIP members in a Hospital or ambulatory surgical center setting. These Non-capitated Services are part of the medical benefit provided by CHIP. The CHIP medical benefit provides limited emergency dental coverage for dislocated jaw, traumatic damage to teeth, and removal of cysts; treatment of oral abscess of tooth or gum origin; treatment and devices for craniofacial anomalies; and drugs. The CHIP medical benefit also provides coverage for hospital, physician, and related medical services (e.g. anesthesia) associated with dental care in these settings.

Under Medicaid, Emergency Dental Services in a Hospital or ambulatory surgical setting are also Non-capitated Services provided as part of the medical benefit paid by traditional Medicaid FFS or Medicaid medical managed care. Medicaid medical benefits provide for coverage of some dental related services, including but not limited to, dislocated jaw, traumatic damage to teeth and supporting structures, removal of cysts, treatment of oral abscess of tooth or gum origin, treatment and devices for correction of craniofacial anomalies, and drugs. The Medicaid medical benefit also provides for hospital, physician, and related medical services (e.g. anesthesia and facility fees) associated with dental care in these settings.

The Dental Contractor must educate Dental Members regarding the availability of Non-capitated Services and appropriate referrals for Dental Members to obtain or access these services. The Dental Contractor must inform Providers that bills for all Non-capitated Services must be submitted to the appropriate CHIP or Medicaid Dental Contractor s or HHSC's Claims Administrator.

2.3.7.1 NONEMERGENCY MEDICAL TRANSPORTATION SERVICES AND MEDICAID DENTAL SERVICES

Members may use NEMT Services to access Medically Necessary Covered Dental Services if they have no other available means of transportation. A Member's managed care organization is responsible for arranging and coordinating NEMT Services. The Dental Contractor must inform all Members of the availability of NEMT Services and advise them to contact their managed care organizations to request the services. Once contacted by a Member, the managed care organization may need supporting documentation from the Dental Contractor to approve the requested NEMT Services. The Dental Contractor must be responsive to these requests from the managed care organization and in a timely manner that does not delay the Member's ability to access Medically Necessary Covered Dental Services.

2.3.8 ACCESS TO CARE

All Medically Necessary Covered Dental Services must be available to Dental Members on a timely basis, in accordance with appropriate dental guidelines, and consistent with generally accepted practice parameters, and the requirements in the Contract. The Dental Contractor must ensure that all Dental Members have access to a choice of Providers for all Medically Necessary Covered Dental Services. If the Dental Contractor is unable to meet this standard, the Dental Contractor must request an exception from HHSC.

The Dental Contractor must comply with the applicable access requirements established by TDI under 28 Tex. Admin. Code § 3.9208 and § 11.1607 for all Dental Contractor operating in Texas, except as otherwise required by the Contract. Where conflicts exist between TDI access requirements and the Contract, the shortest mileage and timeframe requirements will apply.

Providers must retain the authority to control the number of Dental Members they accept into their practice. The Dental Contractor cannot require a Provider to maintain an Open or closed panel.

The Dental Contractor must ensure that Providers offer office hours to Dental Members that are at least equal to those offered to members of the Dental Contractor's commercial lines of business, or to Fee-for-Service participants. The Dental Contractor must ensure all Providers' locations are accessible to Dental Members.

A Dental Contractor must provide the Medically Necessary Covered Dental Services outlined in Attachment G, "Medicaid Medically Necessary Covered Services". If the Medically Necessary Covered Dental Services are not available through Network Providers, the Dental Contractor must, upon the request of a Provider or Dental Member, the Dental Contractor must provide a referral to an Out-of-Network (OON) provider if

Medically Necessary Covered Dental Services are not available through the Provider, within the timeframes noted in **Section 2.3.8.1**. The Dental Contractor must fully reimburse the OON provider in accordance with the OON methodology for Medicaid as defined by HHSC, and for CHIP, at the usual and customary rate defined by TDI in 28 Tex. Admin. Code § 11.506. A Medicaid or CHIP Dental Contractor is not responsible for payment for unauthorized non-emergency services provided to a Member by Out-of-Network Providers, except when that provider is an Indian Health Care Provider (IHCP) enrolled as a Federally Qualified Health Center (FQHC), as provided in **Section 2.3.33**

The Dental Contractor must not require the Dental Member to pay for any Medically Necessary Covered Dental Services by Providers except HHSC-specified copayments for CHIP Dental Members, where applicable.

2.3.8.1 APPOINTMENT ACCESSIBILITY

Through its Network composition and management, the Dental Contractor must ensure that the following standards for appointment accessibility are met. The standards are measured from the date of presentation or request, whichever occurs first:

1. Urgent care, including urgent specialty care, must be provided within 24 hours.
2. Therapeutic and diagnostic care must be provided within 14 Days.
3. Main Dentists must make referrals for specialty care on a timely basis, based on the urgency of the Dental Member's oral health condition, but no later than 30 Days.
4. Preventive dental must be provided within 14 Days. Services should be offered to CHIP members in accordance with the American Academy of Pediatric Dentistry (AAPD) periodicity schedule, and to Medicaid members who are 6 months through 20 years of age, with dental checkups occurring at 6-month (180-day) intervals, and thereafter, in accordance with the AAPD periodicity schedule.
5. Non-urgent specialty care must be provided within 60 Days of authorization.

2.3.8.2 ACCESS TO NETWORK PROVIDERS

The Dental Contractor's Network must have dental Providers in sufficient numbers, and with sufficient capacity, to provide timely access in accordance with the appointment accessibility standards in **Section 2.3.8.1**, "Appointment Accessibility" and in **Chapter 5.28.1, Access to Network Providers Performance Standards and Specifications of the UMCM**.

Counties will be designated as Metro, Micro, or Rural and as defined in **ATTACHMENT N, Access Standards Map**. The county designation is based on population and density parameters. Dental Members' residences in eligibility files with HHSC will be used to assess distance and travel times. The Dental Contractor must ensure that access is consistent with 1 Tex. Admin. Code § 353.411.

HHSC will track Dental Contractor performance. HHSC will use the Dental Contractor Provider Files to run geo-mapping reports which will measure provider choice, distance and travel time from the Dental Member to the Provider. HHSC will compile the reports based on each Dental Contractor's Network. HHSC will share identified deficiencies with the Dental Contractor.

2.3.8.3 DENTIST ACCESS

2.3.8.3.1 MAIN DENTISTS

The Dental Contractor's Network must comply with the accessibility standards set forth in 1 Tex. Admin. Code § 353.411 and in **Chapter 5.28.1 Access to Network Providers Performance Standards and Specifications UMCM**. At a minimum the Dental Contractor must ensure that Members have access to a Main Dentist with an Open Panel.

2.3.8.3.2 SPECIALISTS

The Dental Contractor must ensure that Dental Members have access to a Pediatric dentist, Orthodontist, endodontist, periodontist, and oral surgeon. Dental Contractors must make best efforts to include orthodontists who provide cleft/craniofacial services in their Networks.

2.3.8.4 EXCEPTION PROCESS

HHSC will consider requests for exceptions to the access standards for all provider types under limited circumstances (e.g. if no appropriate provider types are located within the distance standard). Each exception request must be supported by information and documentation specified by HHSC Managed Care Compliance and Operations Network Adequacy. Exceptions may be granted on a case-by-case basis for an area that does not meet the performance standards as outlined in **Chapter 5, "Access to Network Providers Performance Standards and Specifications." of the UMCM.** Exceptions may be granted only for a specific amount of time at HHSC's discretion. The Dental Contractor must establish, through applicable supporting documentation, a normal pattern for securing Health Care Services or that the Dental Contractor is providing care of a higher skill level or specialty that the level available within the Service Area.

2.3.8.5 MONITORING ACCESS

The Dental Contractor must verify that Medically Necessary Covered Dental Services furnished by Network Providers are available and accessible to Members in compliance with the standards described in Sections **2.3.8.1,** "Appointment Accessibility," and Section **2.3.8.2**, "Access to Network Providers."

The Dental Contractor must design, develop, and implement a Provider Directory verification survey to verify that the provider information maintained by the Dental Contractor is correct and in alignment with the provider information maintained by the HHSC Administrative Services Contractor.

The survey must be conducted annually each fiscal year. At a minimum, survey must include verification of provider directory critical elements in accordance with **Chapter 5 of the UMCM.**

The Dental Contractors may conduct the survey through its online Provider Portal, telephone calls, onsite visits, email, or other method that collects and verifies information. The Dental Contractor must conduct a statistically valid random sample (95 percent confidence level with a margin of error +/- 5% percent) of Network Main Dentists and specialists. The Dental Contractor must collect, analyze, and submit survey results and supporting documentation as specified in **Chapter 5 of the UMCM**.

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

2.3.9 MAIN DENTISTS

The Dental Contractor must develop a Network of Main Dentists consisting of general dentists, pediatric dentists, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs), that will provide preventive care and refer Dental Members to specialty care as needed.

The Dental Contractor must require Main Dentists to provide Dental Members with diagnostic and preventive services in accordance with the AAPD recommendations - see http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf. The Dental Contractor must make best efforts to ensure that Main Dentists follow these dental periodicity requirements. These best efforts include, but are not limited to, Provider education, Provider profiling, monitoring, and feedback activities.

The Dental Contractor must require Main Dentists to assess the dental needs of Dental Members for referral to specialty care providers and provide referrals as needed. The Dental Contractor must ensure that Main Dentists assess Members' needs for referrals and make such referrals. The Dental Contractor must have provisions in place that ensure referrals to specialists are processed within 72 hours after receiving the referral from the Provider. The Dental Contractor must require Main Dentists to coordinate the Dental Members' care with specialty care providers after each referral. The Dental Contractor must address specialty care in its Provider education activities, and review Provider referral patterns.

The Dental Contractor must assist the Dental Member in selecting a Main Dentist within 30 Days of enrollment with the Dental Contractor. If the Member has not selected a Main Dentist within 30 Days of enrollment, the Dental Contractor must assign the Member to a Main Dentist. This automated assignment is done using an automated algorithm approved by HHSC that considers:

1. The Dental Member's established history with a Main Dentist, as demonstrated by Encounter history with the Provider in the preceding year, if available;
2. The geographic proximity of the Dental Member's home address to the Main Dentist;
3. Whether the Provider serves as the Main Dentist to other children in the Dental Member's household who are enrolled in Medicaid or CHIP;
4. Limitations on default assignment, such as restrictions on age and capacity by the Main Dentist; and
5. Other criteria as approved by HHSC.

The Dental Contractor must allow Main Dentists to request a Dental Member to be reassigned to another Main Dentists for any of the following reasons:

1. The Dental Member is not included in the Main Dentist's scope of practice;
2. The Dental Member is noncompliant with dental advice;
3. The Dental Member consistently displays unacceptable office decorum; or
4. The Dental Member's and Main Dentist's relationship is not mutually agreeable.

Through its Provider Contracts, the Dental Contractor must require that Dental Members have 24 hours a day, 7 days a week access to Main Dentists. Through its Provider Contracts, the Dental Contractor must require such access with the following acceptable and unacceptable telephone coverage for Dental Members to contact Main Dentists after normal business hours. Normal business hours are at the discretion of each individual Main Dentist.

Acceptable coverage after normal business hours includes all of the following:

1. The office telephone is answered after normal business hours by an answering service, which meets the language requirements of each of the Prevalent Languages and can contact the Main Dentist or another designated dental Provider in emergency situations. The answering service, Main Dentist, or his or her designee must be able to provide the Dental Member instructions on accessing Emergency Dental Services. For calls regarding non-emergent conditions received by an answering service, the Main Dentist or his or her designee must respond within four hours after normal business operations resume;
2. The office telephone is answered after normal business hours by a recording in the language of each of the Prevalent Languages, directing the Member to call another number to reach the Main Dentist or another dental Provider designated by the Main Dentist. Someone must be available to answer the designated Provider's telephone. Another recording is not acceptable; and,

3. The office telephone is transferred after normal business hours to another location where someone will answer the telephone and be able to contact the Main Dentist or another dental Provider, who can return the call within four hours.

Unacceptable after normal business hours coverage:

1. The office telephone is only answered during office hours;
2. The office telephone is answered after normal business hours by a recording that tells Members to leave a message;
3. The office telephone is answered after normal business hours by a recording that directs Members to go to an Emergency room for any services needed; and
4. Returning calls received after normal business hours more than four hours after normal business hours resume.

The Dental Contractor is encouraged to include in its Network Providers who offer dental care services during evening and weekend hours.

2.3.9.3 MAIN DENTIST NOTIFICATIONS

The Dental Contractor must furnish each Main Dentist with a current list of enrolled Dental Members assigned to that Provider no later than five Business Days after the Dental Contractor receives the Enrollment File from the EB each month. The Dental Contractor may offer and provide such enrollment information in alternative formats when such format is acceptable to the Main Dentist.

2.3.9.4 INDIAN HEALTH CARE PROVIDERS

The Dental Contractor must demonstrate a sufficient number of Indian Health Care Providers (IHCP) are participating in its Provider Network to ensure that Indian Members who are eligible to receive services have timely access to services available from a Network IHCP. The Dental Contractor must allow an Indian Member to designate a Network IHCP as a Main Dental Home Provider, as long as that provider has capacity to provide the services. The Dental Contractor must allow an Indian Member to receive Covered Services from an Out-of-Network (OON) IHCP from whom the Indian Member is otherwise eligible to receive such services.

If the Dental Contractor cannot ensure timely access to Covered Services because of few or no Network IHCPs, the Dental Contractor will be considered as compliant with this Contract in accordance with 42 C.F.R. §438.14(b)(1), and §457.1209 if Indian Members are allowed to access IHCPs out-of-state or if the circumstance is deemed good cause for disenrollment from managed care in accordance with 42 C.F.R.§438.56(c) and §457.1212. The Dental Contractor must permit an OON IHCP to refer an Indian Member to a Network Provider.

The Dental Contractor must pay for Covered Services provided by an IHCP to an Indian Member, regardless of whether the IHCP is a Network Provider. The Dental Contractor must (1) pay the IHCP an agreed to negotiated rate, or (2) in the absence of a negotiated rate, pay a rate not less than the level and amount that would be paid to a Network Provider that is not an IHCP; and (3) make payment to all IHCPs in its Network in a timely manner as required for payments to practitioners in individual or group practices under 42 C.F.R. §447.45 and §447.46.

If an IHCP is not enrolled in Medicaid as an FQHC and regardless of whether an IHCP is a Network Provider, the IHCP must be paid the applicable encounter rate published annually in the Federal Register by the Indian Health Service, or, in the absence of a published encounter rate, the amount the IHCP would be paid if services were provided under the State Plan in Medicaid FFS. If a n IHCP is enrolled in Medicaid as an FQHC, the IHCP must be reimbursed as described in Section 8.1.15.

2.3.9.5 PROVIDER NETWORK

The Dental Contractor must maintain a Network with Open Panels sufficient to provide all Dental Members with access to the full range of Medically Necessary Covered Dental Services required under the Contract. The Dental Contractor must ensure its Providers and Subcontractors meet all state and federal eligibility criteria, reporting requirements, and any other applicable rules or regulations, as amended, which relate to the Contract.

The Network must be responsive to the linguistic, cultural, and other unique needs of any minority, or physically, intellectually, or cognitively disabled individuals, or other special population served by the Dental Contractor, including the capacity to communicate with Dental Members in languages other than English, when necessary, as well as, with those who are blind, deaf-blind, deaf, or hearing impaired.

The Dental Contractor's initial base of Providers may consist primarily of Providers currently participating in Medicaid or CHIP. The Dental Contractor must also recruit other Providers, particularly in Medically Underserved Areas. The Dental Contractor must seek qualified Providers currently serving Dental Members to participate in its Network. Dental Contractor utilizing OON providers to render services to their Dental Members must not exceed the utilization standards established in 1 Tex. Admin. Code § 353.4.

In addition, if applicable, the Dental Contractor's Network must include a sufficient number of Indian Health Care Providers to ensure that eligible Dental Members enrolled with the Dental Contractor have timely access to services.

HHSC may modify this requirement for Medicaid Dental Contractors that demonstrate good cause for noncompliance, as set forth in 1 Tex. Admin. Code § 353.4(e)(3).

A Provider must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D.

Dental Contractor is prohibited from employing, contracting with, or entering into a Provider agreement with Providers whose license is expired or cancelled who are excluded, suspended, or terminated from participation in the Texas Medicaid and CHIP programs.

2.3.10 PROVIDER CONTRACT REQUIREMENTS

The Dental Contractor must enter into written Provider Contracts with properly credentialed Providers. The Dental Contractor's contract with Providers must be in writing, must be in compliance with applicable federal and state laws and regulations, and must include the minimum requirements specified in **Chapter 8 of the UMCM**. The Dental Contractor must give each Provider a copy of its executed contract within 45 Days of execution.

If licensure or certification is required to provide a Covered Dental Service, the Provider Contract must ensure that a Provider is licensed or certified in the State of Texas, except as provided in **Section 2.3.17**. The Provider Contract must ensure that all Providers comply with all state and federal laws governing the provision of Medically Necessary Covered Dental Services. The Dental Contractor must not contract with Providers who are under sanction or exclusion from Medicaid or CHIP.

The Dental Contractor is prohibited from requiring a Provider or Provider group to enter into an exclusive contracting arrangement with the Dental Contractor as a condition for participation in its Network.

2.3.11 FIRST DENTAL HOME SERVICES FOR MEDICAID MEMBERS

The First Dental Home is a package of dental services aimed at improving the oral health of children 6-35 months of age. Its purpose is to provide simple, consistent messages that promote the importance of oral health to parents and caregivers of very young children and to keep children free from oral disease. The First Dental Home visit can be initiated as early as 6 months of age and must include, but is not limited to, the following:

1. Comprehensive oral examination;
2. Oral hygiene instruction with primary caregiver;
3. Dental prophylaxis, if appropriate;
4. Topical fluoride varnish application when teeth are present;
5. Caries risk assessment; and
6. Dental anticipatory guidance.

To provide First Dental Home services, Providers must have the appropriate certification from HHSC Texas Health Steps. The Dental Contractor must ensure Providers of First Dental Home Services apply for the First Dental Home certification through Texas Health Steps after completing the continuing education course. Training for certification to provide First Dental Home services is available as a free continuing education course on the Texas Health Steps website at www.txhealthsteps.com. Dental Contractor is

responsible for verifying that Providers who submit claims for First Dental Home services have the appropriate certification from HHSC Texas Health Steps. The Dental Contractor must consult the MASTER Provider File issued weekly by Claims Administrator or check in the Online Provider Lookup (OPL) to confirm.

2.3.12 PROVIDER CREDENTIALING AND RE-CREDENTIALING

Dental Contractor must utilize the Texas Association of Health Plans' (TAHP) contracted Credentialing Verification Organization (CVO) as part of its credentialing and recredentialing process regardless of membership in the TAHP. The CVO is responsible for receiving completed applications, attestations, and primary source verification documents. The Dental Contractor retains the sole responsibility for credentialing the Provider.

At least once every three years, the Dental Contractor must review and approve the credentials of all participating Providers. The Dental Contractor may subcontract with another entity to which it delegates credentialing activities, if the delegated credentialing is maintained in accordance with the National Committee for Quality Assurance delegated credentialing requirements and HHSC defined requirements.

At a minimum, the scope and structure of a Dental Contractor's credentialing and re-credentialing processes must be consistent with recognized Dental Contractor industry standards and relevant state and federal regulations including 28 Tex. Admin. Code §§ 11.1402(c) and 11.1902, relating to provider credentialing and notice. For the Medicaid Program, Dental Contractor must also comply with 42 C.F.R. §§ 438.12 and 438.214. The re-credentialing process must take into consideration Provider performance data including Member Complaints and Appeals, quality of care, and Utilization Management.

The Dental Contractor must complete the credentialing process for a new provider, and its claims system must be able to recognize the provider as a Provider no later than 90 Days after receipt of a complete application.

If an application does not include required information, the Dental Contractor must notify the Provider in writing of all missing information no later than 5 Business Days after receipt. If the provider responds with the missing information within 10 Days of receipt of the written notice, the Dental Contractor must complete the process within 90 Days from receipt of the original application. If the provider responds with the missing information after more than 10 Days of receipt of the written notice, the Dental Contractor has 90 Days to complete the credentialing process from the date of receipt of the completed application.

The Dental Contractor must not discriminate for the participation, reimbursement, or indemnification of any provider 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. If the Dental Contractor declines to include individual or groups of providers in its Network, it must give the affected providers written notice of the reasons for its decision.

The Dental Contractor may not require providers to participate in the Dental Contractor's other lines of business in order to participate in the Dental Program. Credentialing documentation must be submitted to HHSC upon request.

2.3.12.3 EXPEDITED CREDENTIALING PROCESS

The Dental Contractor must establish and implement an expedited credentialing process, as required by Tex. Gov't Code § 533.0064, that allows applicant providers to provide services to Members on a provisional basis for the following provider types:

1. Dentists; and
2. Dental specialists, including dentists and physicians providing dental specialty care.

The Dental Contractor must allow providers to qualify for expedited credentialing if the provider:

1. Is a member of an established dental care provider group that has a current contract in place with a Dental Contractor;
2. Is a Medicaid enrolled provider;
3. Agrees to comply with the terms of the contract between the Dental Contractor and the dental care provider group, and
4. Timely submits all documentation and information required by the Dental Contractor, as necessary, for the Dental Contractor to begin the credentialing process.

Additionally, if a provider qualifies for expedited credentialing, the Dental Contractor's claims system must be able to process claims from the provider as if the provider was a Network Provider no later than 30 Days after receipt of a complete application, even if the Dental Contractor has not yet completed the credentialing process.

2.3.12.4 BOARD CERTIFICATION STATUS

The Dental Contractor must maintain a policy with respect to pediatric dentists and specialty providers that encourages participation of board-eligible and board-certified Providers in the Network. The Dental Contractor must make information on the percentage of board-eligible and board-certified pediatric dentists, and specialty Providers by specialty in the Network available to HHSC upon request.

2.3.13 PROVIDER RELATIONS INCLUDING MANUAL, MATERIALS, AND TRAINING

The Dental Contractor must maintain a provider relations presence in Texas. If the provider relations presence is a named provider relations specialist, upon a change of that specialist, the Dental Contractor must notify impacted Providers within ten Days of the change. Notification must be in writing, either through email, or in the Provider portal. The

notification must include the new provider relations specialist's name, phone number, and email address.

The Dental Contractor must designate a dedicated provider relations email address or telephone number for Provider relations issues requiring additional follow up or escalation. The Dental Contractor must provide an email response or returned phone call to the Provider within three Business Days to all inquiries received; an auto-generated or pre-recorded response acknowledging the inquiry does not meet this requirement.

2.3.13.3 PROVIDER MANUAL

The Dental Contractor must prepare and issue a Provider manual to all existing Providers. For newly contracted Providers, the Dental Contractor must issue copies of the Provider manual within five Business Days from inclusion of the Provider into the Network. The Provider manual must contain the critical elements defined in **Chapter 3 of the UMCM**. The Dental Contractor must update the Provider manual in accordance with any changes made to the critical elements in **Chapter 3 of the UMCM** and provide the updated manual to Providers within 30 Days of such changes.

HHSC must review and approve any substantive revisions to the Provider Manual before the Dental Contractor publishes or distributes it to Providers.

2.3.13.4 PROVIDER MATERIALS

Provider Materials must comply with state and federal laws, rules and regulations, governing the Dental Program. **Chapters 4 and 8 of the UMCM** set forth material and submission requirements. HHSC may require discontinuation or correction of any Provider Materials, including those previously approved by HHSC.

2.3.13.5 PROVIDER TRAINING

The Dental Contractor must provide training to all Providers and their staff regarding the requirements of the Contract and any requirements related to meeting the special needs of the population of the Dental Program. The Dental Contractor's training must be completed within 30 Days of the date the Provider completes contracting and credentialing. The Dental Contractor must maintain and make available upon request the attendance rosters, dated and signed by each attendee, or other written evidence of training of each Provider and his or her staff.

The Dental Contractor must establish ongoing Provider training that includes the following issues:

1. Medically Necessary Covered Dental Services and the Provider's responsibilities for providing and coordinating these services;

   a. Special emphasis must be placed on areas that vary from commercial coverage rules, prior authorization (PA) processes, and claims processing expectations, and
   b. The processes for making referrals and coordination with Non-capitated Services.
2. Relevant requirements of the Contract;
3. The Dental Contractor's quality assurance and performance improvement (QAPI) program and the Provider's role in such a program;
4. The Dental Contractor's policies and procedures regarding referrals by Main Dentists, especially regarding Network and OON referrals;
5. Member cost-sharing obligations, for CHIP members only, limitations on Medically Necessary Covered Dental Services, VAS, and prohibitions on balance-billing Dental Members for Medically Necessary Covered Dental Services;
6. Cultural Competency training based on federal and state requirements;
7. Texas Health Steps (THSteps) dental benefits and the necessity of documentation of services qualifying for reimbursement;
8. NEMT Services available to Dental Members and how Members may request NEMT Services to access Medically Necessary Covered Dental Services;
9. The importance of updating contact information to ensure accurate Provider directories and the online Provider lookup;
10. Information about the Dental Contractor's process for acceleration of THSteps dental services for Farmworker Child(ren) enrolled in Medicaid;
11. Missed appointment referrals and assistance provided by the Texas Health Steps Outreach and Informing Unit for Medicaid members;
12. HHSC policies related to Dental Contractor retaliation against providers;
13. Dental Contractor and HHSC Complaint and Appeal processes;
14. Claims processing and policies specific to the Dental Contractor including:
    a. Claims procedures as described in **Chapter 2 of the UMCM**;
    b. Recoupments; and
    c. Dental Member rights and responsibilities, primary coverage requirements and under what circumstances a Dental Member may be responsible for some fees; and
15. Education about responsibility to report FWA, including how and where to make reports.
16. For general and pediatric dentists, First Dental Home certification requirements, including the training and application processes.

When developing Provider training materials, the Dental Contractor must consult with major stakeholders, such as trade associations and provider groups.

2.3.14 PROVIDER HOTLINE

The Dental Contractor must operate a toll-free telephone line for Provider inquiries during normal business hours which are, for the purposes of this section, from 8 a.m. to 5 p.m. local time throughout the state, Monday through Friday, excluding State-approved holidays. The State-approved holiday schedule is updated annually and can be found on the Texas State Auditor's Office website under Holiday Schedule. The Provider hotline must be staffed with personnel who are knowledgeable about the Dental Program, Medically Necessary Covered Dental Services, and Non-capitated Services.

The Dental Contractor must ensure that, during non-business hours, the Provider hotline is answered by an automated system with the capability to provide callers with operating hours information and instructions on how to verify enrollment for a Dental Member with an urgent condition.

The Dental Contractor must ensure the Provider hotline has an automated response option in which the dental Providers may enter a child's unique Dental Member ID number and receive the following information:

1. Verification of a child's membership in Medicaid or CHIP;
2. The child's eligibility for the current month; and
3. The status of a child's dental benefit, and if the child is in CHIP, any amounts drawn against HHSC's specified annual CHIP benefit cap.

This information must also be available through a fax-back capability.

The Dental Contractor must ensure the Provider hotline staff has the ability to:

1. Search for enrollment information by a variety of fields;
2. Confirm the year-to-date status of a child's CHIP dental benefit, including any amounts that have been drawn against the dental benefit cap;
3. Accurately answer questions about the dental claims process and confirm the status of a pending claim; and
4. Accurately answer questions about enrollment as a dental Provider and facilitate the enrollment process.

The Dental Contractor must ensure that the Provider hotline meets each of the following minimum performance requirements:

1. No more than 7 percent of the calls are abandoned; and
2. No more than 2 minutes average hold time.

The Dental Contractor must conduct ongoing call quality assurance to ensure these standards are met. The Provider hotline may serve multiple Programs if the hotline staff is knowledgeable about each Program. The Dental Contractor may include the Dental Program in its existing Member Services hotline, if the hotline staff is knowledgeable about the Dental Program, as well as, the Dental Contractor's other contracted dental services.

The Dental Contractor must monitor its performance regarding Provider hotline standards and submit performance reports summarizing call center performance for the hotline as indicated in **Chapter 5 of the UMCM**. If the Dental Contractor's hotline serves multiple managed care programs, the Dental Contractor must have the capability to report call center performance for each program, including reporting the Medicaid and CHIP call center performance separately.

If HHSC determines that it is necessary to conduct onsite monitoring of the Dental Contractor's hotline functions, the Dental Contractor must reimburse HHSC for all travel costs incurred by HHSC relating to such monitoring. For purposes of this section, "travel costs" may include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC in connection with the onsite monitoring. Reimbursement by the Dental Contractor will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the Dental Contractor. The Dental Contractor must not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

2.3.15 PROVIDER REIMBURSEMENT

The Dental Contractor must pay for all Medically Necessary Covered Dental Services provided to Dental Members. The Provider Contract must include a complete description of the payment methodology or amount, as described in **Chapter 8 of the UMCM**. The Dental Contractor must define in its Provider Contract if it is using the Texas Medicaid Fee Schedule or another source for reimbursement purposes.

The Provider Contracts must require Providers to comply with the requirements of Tex. Gov't Code § 531.024161, regarding reimbursement of claims based on orders or referrals by supervising providers.

The Dental Contractor must ensure claims payment is timely and accurate as described in **Section 2.3.29.4** and **Chapter 2 of the UMCM**. The Dental Contractor must require tax identification numbers from all participating providers. The Dental Contractor is required to do back-up withholding from all payments to Providers who fail to give tax identification numbers or who give incorrect numbers.

Provider payments must comply with all applicable state and federal laws, rules, and regulations, including the following sections of the Patient Protection and Affordable Care Act:

1. 42 U.S.C. § 1396a(a)(80), "Prohibition on Payments to Institutions or Entities Located Outside of the United States"; and
2. 42 U.S.C. § 1396b-1, "Payment Adjustment for Health Care-Acquired Conditions."

The Dental Contractor must comply with registration requirements in Tex. Ins. Code § 1458.051 and with reimbursement and fee schedule requirements in Tex. Ins. Code §§ 1451.451 and 1458.101–102.

As required by Tex. Gov't Code § 533.005(a)(25), the Dental Contractor must not implement significant, non-negotiated, across-the-board Provider reimbursement rate reductions unless:

1. It receives HHSC's prior approval; or
2. The reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by HHSC.

For purposes of this requirement, an across-the-board rate reduction is a reduction that applies to all similarly-situated providers or types of providers. The Dental Contractor must submit a written request for an across-the-board rate reduction to the State Medicaid Director and provide a copy to HHSC Managed Care Compliance & Operations division, if the reduction is not based on a change in the Medicaid fee schedule or cost containment initiative implemented by HHSC.

The Dental Contractor must submit the request at least 90 Days prior to the planned effective date of the reduction. If HHSC does not issue a written statement of disapproval within 45 Days of receipt, then the Dental Contractor may move forward with the reduction on the planned effective date. Further, the Dental Contractor must give Providers at least 30 Days' written notice of changes to the Dental Contractor's fee schedule, excluding changes derived from changes to the Medicaid fee schedule, before implementing the change. If the Dental Contractor fee schedule is derived from the Medicaid fee schedule, the Dental Contractor must implement fee schedule changes no later than 30 Days after the Medicaid fee schedule change, and any retroactive claim adjustments must be completed within 60 Days after HHSC retroactively adjusts the Medicaid fee schedule.

2.3.15.1 PROVIDER PREVENTABLE CONDITIONS

"Provider-preventable condition" has the same meaning as "provider-preventable condition" provided in 42 C.F.R. 447.26 and includes the following events: the wrong surgical or other invasive procedure performed on a Dental Member; surgical or other invasive procedure performed on the wrong tooth; or surgical or other invasive procedure performed on the wrong patient. For purposes of this term, most dental procedures, other than preventative procedures, will be considered "invasive."

The Dental Contractor must not pay for Provider-preventable conditions. The Dental Contractor must ensure its Provider Contracts contain language requiring Providers to report to the Dental Contractor the following events: the wrong surgical or other invasive procedure performed on a Dental Member; surgical or other invasive procedure performed on the wrong tooth; or surgical or other invasive procedure performed on the wrong patient. The Dental Contractor must also submit quarterly reports of Provider-preventable conditions to the HHSC health plan monitoring team and the HHSC Dental Director.

This section is effective September 1, 2020.

2.3.15.2 PROVIDER OVERPAYMENTS

The Dental Contractor must have a mechanism in place through which Providers report overpayments. The Dental Contractor must inform Providers of this mechanism. The mechanism must allow Providers to include a reason for the overpayment. The Dental Contractor must ensure that the Provider submit overpayments within 60 Days from identification. For purposes of this section, "identification" refers to when the person has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment.

2.3.16 TERMINATION OF DENTAL CONTRACTOR PROVIDER CONTRACTS

The Dental Contractor must notify HHSC five Days prior to Dental Contractor termination of the following Dental Contractor Provider Contracts:

1. A Main Dentist contract that impacts more than one percent of its Members; or
2. Any Provider contract that impacts more than five percent of its Network for a provider type by Dental Reporting Region and Dental Contractor program.

Additionally, the Dental Contractor must give written notice of termination of a Provider to each Dental Member who receives his or her primary dental care, or who is seen on a regular basis by, the Provider as follows:

1. For a Provider disenrolled from Medicaid by HHSC, the Dental Contractor must provide notice to affected Dental Members within five Days following disenrollment;
2. For involuntary terminations of a Provider (terminations initiated by the Dental Contractor), the Dental Contractor must provide notice to the Dental Member of the termination of the Provider once the Dental Contractor has made a final decision to terminate the Provider, but in no event later than 15 Days after the Dental Contractor issues notice of termination to the Provider;
3. For voluntary terminations of a Provider (terminations initiated by the Provider), the Dental Contractor, to the extent practicable, must provide notice to the Dental Member of the termination of the Provider, but in no event less than at least 30 Days before the effective date of the termination.

In the event that the Provider sends untimely notice of termination to the Dental Contractor making it impossible for the Dental Contractor to send Dental Members notice within the required timeframe, the Dental Contractor must provide notice as soon as practical, but no more than 15 Days after the Dental Contractor receives notification to terminate from the Provider.

The Dental Contractor must send notice of termination of a Provider to:

1. All Dental Members in a Main Dentist's panel; and

2. All Dental Members who have had one visit within the past three months, or two or more visits with the Provider in the past 12 months.

2.3.17 OUT-OF-STATE PROVIDERS

The Dental Contractor may enroll out-of-state providers in its Network, in accordance with 1 Tex. Admin. Code § 352.17. To participate in Medicaid, the provider must be enrolled with HHSC as a Medicaid provider. The Dental Contractor may enroll out-of-state diagnostic laboratories in its Medicaid and CHIP Networks under the circumstances described in Texas Government Code § 531.066.

2.3.18 PROVIDER ADVISORY GROUPS

The Dental Contractor must establish and conduct quarterly meetings with Providers. The Dental Contractor must maintain a record of provider advisory group meetings, including agendas and minutes, for the time period established in **Section 9.01 of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**.

2.3.19 PROVIDER PROTECTION PLAN

In accordance with the requirements of Tex. Gov't Code § 533.0055, the requirements of HHSC's provider protection plan are listed below, and the Dental Contractor must comply with the following:

1. Provide responses to authorization requests within three Business Days of routine requests;
2. Provide for timely and accurate claims adjudication and proper claims payment in accordance with **Chapter 2 of the UMCM**;
3. Include Provider training and education on the requirements for claims submission and appeals, including the Dental Contractor's policies and procedures. See also **Section 2.3.13**;
4. Ensure Member access to care, in accordance with **Section 2.3.8**;
5. Ensure prompt credentialing, as required by **Section 2.3.12**;
6. Ensure compliance with state and federal standards regarding PAs, as described in **Sections 2.3.24** and **Section 2.3.25**;
7. Provide 30 Days notice to Providers before implementing changes to policies and procedures affecting the PA process. However, in the case of suspected FWA by a single Provider, the Dental Contractor may implement changes to policies and procedures affecting the PA process without the required notice period;
8. Include other measures developed by HHSC or a provider protection plan workgroup, or measures developed by the Dental Contractor and approved by HHSC; and

9. The Dental Contractor must participate in HHSC's provider protection plan work group, which will develop recommendations and proposed timelines for other components of the provider protection plan.

2.3.20 MEMBER SERVICES

The Dental Contractor must maintain a Member services department with a sufficient number of staff to assist Dental Members and Dental Members' family members, guardians, or LAR in obtaining Medically Necessary Covered Dental Services for Dental Members including meeting Member services hotline requirements and Linguistic Access capabilities. The Dental Contractor must maintain employment standards and requirements for Member services department staff.

2.3.20.3 MEMBER MATERIALS

The Dental Contractor must design, print, and distribute Dental Member identification (ID) cards and a Dental Member handbook to Dental Members. Within five Business Days following the receipt of an Enrollment File from the EB, the Dental Contractor must mail a Dental Member ID card and a Dental Member handbook to the Case Head or Account Name for each new Dental Member. When the Case Head or Account Name is associated with two or more new Dental Members, the Dental Contractor is only required to send one Dental Member handbook. The Dental Contractor is responsible for mailing materials only to those Dental Members for whom valid address data are contained in the Enrollment File.

All Member Materials must be at or below a 6th grade reading level as measured by the appropriate score on the Flesch-Kincaid Readability Test. Member Materials must be written and distributed in English, Spanish, and Prevalent Languages identified by HHSC. HHSC will provide the Dental Contractor with reasonable notice when a non-English language is spoken by ten percent of the managed care eligible population. All Member Materials must be available in a format accessible to the visually impaired, which may include large print, Braille, compact disc, or other electronic format. Member Materials must comply with the requirements set forth in the **UMCM**, including required critical elements and marketing policies and procedures.

Written materials must also be made available in alternative formats upon request of the Dental Member at no cost. Written materials must include taglines in the Prevalent Languages in the Dental Reporting Region, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone numbers of the Dental Contractor's Member service unit. Large print means printed in a font size no smaller than 18 point. All written materials for Dental Members and potential members must use a font size no smaller than 12 point. All written materials for potential members and Dental Members must also include a large print tagline and information on how to request Auxiliary Aids

and Services, including the provision of materials in alternative formats. Auxiliary Aids and Services must be made available upon request of the Dental Member at no cost.

The Dental Contractor's Member Materials and other communications cannot contain discretionary clauses, as described in Section 1271.057(b) of the Texas Insurance Code.

The Dental Contractor must submit Member Materials to HHSC for approval prior to publication or distribution, including revisions to previously approved Member Materials. If HHSC has not responded to the Dental Contractor's request for review within 15 Business Days, the Dental Contractor may use the submitted materials provided the Dental Contractor first notifies HHSC of its intended use. HHSC may, at any time, require discontinuation, revision, or correction of any Member Materials, including those previously approved by HHSC.

2.3.20.4 Member Identification Cards

All Dental Member ID cards must include all the critical elements identified in **Chapter 3 of the UMCM**. The Dental Contractor must reissue the Dental Member ID card within seven Days at no charge for any reason that results in a change to the information disclosed on the Dental Member ID card.

2.3.20.5 Member Handbook

The Member handbook must meet the Member Materials requirements specified by **Section 2.3.20.3** above and must include critical elements in **Chapter 3 of the UMCM**.

The Dental Contractor must produce and distribute a revised Dental Member handbook, or an insert informing Dental Members of changes to Medically Necessary Covered Dental Services upon HHSC notification and at least 30 Days prior to the effective date of such change in Medically Necessary Covered Dental Services. In addition to modifying the Member Materials for new Dental Members, the Dental Contractor must notify all existing Dental Members of changes to the Medically Necessary Covered Dental Services. If HHSC notifies the Dental Contractor that the change in Covered Services is significant, the Dental Contractor must notify existing Members through a written notice, such as a mailed letter or electronic mail, within the same timeframe or within a timeframe approved by HHSC. If multiple members reside within a single household, the Dental Contractor shall send only one written notice pursuant to this section. If HHSC notifies the Dental Contractor that the change in Medically Necessary Covered Dental Services is not significant, the Dental Contractor must notify existing Dental Members through any method of communication within the same timeframe or within a timeframe approved by HHSC.

2.3.20.6 Provider Directory

The Dental Contractor must have a process in place to compare the information in the

master provider file provided by the HHSC Administrative Services Contractor with the Dental Contractor's Provider directory. When the Dental Contractors identifies a discrepancy, the Dental Contractor must assist the Provider through the process of updating inaccurate information with the HHSC Administrative Services Contractor. Dental Contractors must contact Providers monthly until the information on the master provider file reflects the Dental Contractor Provider Verification survey in Section **2.3.8.5** or other data sources provided to the Dental Contractors by HHSC or identified by the Dental Contractor. The Dental Contractor must include in its Provider Contract that the Provider will update its information with the HHSC Administrative Services Contractor in a timely fashion or immediately upon request by the Dental Contractor.

The Dental Contractor must develop separate Provider Directories for the Medicaid and CHIP Programs. Provider Directories must be available in hard copy, and the directories must be submitted to the HHSC Administrative Services Contractor. The Provider Directory for each Dental Contractor Program, including substantive revisions, must be approved by HHSC before publication and distribution. Substantive revisions are revisions to the information required by **Chapter 3 of the UMCM** (with the exception of information contained in actual the Provider listings and indices) and any additional information that the Dental Contractor adds to the directory at its discretion.

For each Program, HHSC may divide the State into more than one area for the purpose of publishing the Provider Directories. HHSC will establish weight limits for the Provider Directories, which may vary by area. HHSC will require Dental Contractors that exceed the weight limits to compensate HHSC for postage fees in excess of the weight limits.

As described in Section 7, "Transition Phase Requirements," during the Readiness Review, the Dental Contractor must develop and submit to HHSC the draft Provider Directory templates for approval and must submit the final Provider Directories incorporating changes required by HHSC prior to the Operational Start Date. Such draft and final Provider Directories must be submitted according to the Readiness Review deadlines established by HHSC.

The Provider Directory must comply with HHSC's marketing policies and procedures, as set forth in Chapter **4 of the UMCM**.

The Provider Directories for each Program must, at a minimum, meet the Member Materials requirements specified by Section **2.3.20.1** above and must include the required elements identified in **Chapter 3 of the UMCM**. The Provider Directory must include only Network Providers credentialed by the Dental Contractor in accordance with Section **2.3.23.2.5**, "Provider Credentialing and Re-credentialing." If the Dental Contractor contracts with limited Provider Networks, the Provider Directory must comply with the

requirements of 28 Tex. Admin. Code §11.1600(b)(11), relating to the disclosure and notice of limited Provider Networks.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3, requires the State to submit oral health provider data on a quarterly basis to the CMS' contractor, currently the Health Resources and Services Administration (HRSA). HRSA uploads the data to the Insure Kids Now (IKN) website and persons enrolled in Medicaid and CHIP may access this information using a provider lookup tool. The intent of this CHIPRA provision is to provide persons enrolled in Medicaid and CHIP access to oral health provider information across the nation. To align with the intent of this oral health provision in CHIPRA, the Dental Contractor must provide HHSC with an electronic version of an updated Provider Directory on a quarterly basis and to Members upon request.

2.3.20.6.1 HARD COPY PROVIDER DIRECTORY

The hard copy Provider directory must contain the required information included in **Chapter 3 of the UMCM**.

The Dental Contractor must update hardbound copies of the Provider Directory in accordance with 42 C.F.R. § 438.10 or as directed by HHSC. The Dental Contractor must make such updates available to existing Members upon request.

The Dental Contractor must develop separate Provider Directories for Medicaid and CHIP. The Dental Contractor must send the most recent Provider directory, including any updates, to Dental Members upon request in accordance with Texas Gov't Code § 533.0063. The Dental Contractor must, at least annually, offer the Provider Directory to Dental Members in writing or by verbal offer through its Dental Member outreach efforts and education materials.

2.3.20.6.2 ONLINE PROVIDER DIRECTORY

The Dental Contractor must have an online Provider directory to provide an electronic Provider look-up search of its Provider Network. The Dental Contractor must have procedures for systematically updating the Provider Network database that must include predictable scheduled algorithms. The online Provider directory must be updated at least on a weekly basis to reflect its most current Network.

The online Provider directory must contain the required information included in **Chapter 3 of the UMCM**.

The Dental Contractor must maintain a mobile optimized site for the online Provider directory that meets the requirements pertaining to the Dental Contractor's website as described in **Section 2.3.21**. The site must minimize download and wait time and must not use tools or techniques that require significant memory, disk resources, or special intervention. HHSC, where cost effective to HHSC and less burdensome to the Dental

Members, requires the development of mobile device applications in addition to the use of tools that take advantage of efficient data access methods, reduce server load, and consume less bandwidth.

Upon request, the Dental Contractor must send Dental Members, via email, an electronic version of the Provider directory for the mailing region in which they reside. The Dental Contractor must inform Dental Members that the Provider directory is available in paper form, without charge, upon the Dental Member's request, and provide it within five Business Days of the request. **Exhibit "M"** to **ATTACHMENT E, HHSC SOLICITATION NO. HHS0002879, Dental Reporting Regions Map**, contains the map detailing the mailing regions referenced above.

2.3.20.7 MEMBER SERVICES HOTLINE

The Dental Contractor must operate a toll-free hotline that Dental Members can call 24 hours a day, seven days a week (Member services hotline). The Member services hotline must be staffed with personnel designated solely to the Texas Dental Program. This staff must be properly trained, competent, and knowledgeable about the Dental Program and Medically Necessary Covered Dental Services including Non-capitated Services.

The Member services hotline must have staff available during normal business hours, which for the purposes of this section are Business Days between the hours of 8:00 a.m. to 5:00 p.m. local time excluding State-approved holidays.

The Dental Contractor must ensure that during non-business hours, the Member services hotline is answered by an automated system with the capability to provide callers with operating hours and instructions on what to do in case of emergency. All recordings must be in English, Spanish, and other Prevalent Languages. A voice mailbox must be available during non-business hours for callers to leave messages. The Dental Contractor's Member services hotline staff must return Dental Members' calls received by the automated system on the next working day during normal business hours. If the Member services hotline does not have a voice-activated menu system, the Dental Contractor must have a menu system that will accommodate Dental Members who cannot access the system through other physical means.

The Dental Contractor must ensure that its Member services hotline staff treat all callers with dignity and respect the callers' need for privacy. All of the Dental Contractor's Member services hotline staff must be:

1. Able to answer non-clinical questions pertaining to the role of the Main Dental Home, such as referrals or the process for receiving authorization for procedures or services;
2. Able to give information about Providers in a particular area;
3. Knowledgeable about FWA and the requirements to report any conduct that if substantiated may constitute FWA in the Dental Program;

4. Trained regarding the federal and state Cultural Competency standards;
5. Trained to assist a Dental Member or a Dental Member's authorized representative, guardian, or LAR with scheduling an appointment with a Provider during the Provider's hours of operation and within the Dental Member's availability, in accordance with **Section 2.3.8.2**. Member services hotline staff must offer Dental Members the opportunity to participate in a facilitated three-way call between the Member or the Member's authorized representative, guardian, or LAR and a Provider's office to schedule an appointment. If a Dental Member does not want to participate in a three-way call, the Dental Contractor must document refusal and offer a list of Providers;
6. Knowledgeable about the Dental Program and Medically Necessary Covered Dental Services limitations, including limitations on procedures and annual CHIP benefit cap, and any VAS and oral health education initiatives as described in **Section 2.3.20.8** offered by the Dental Contractor;
7. For CHIP Members, be able to confirm the year-to-date status of the member's dental benefit, including any amounts that have been drawn against the annual benefit cap for a specific member, and be able to give correct cost-sharing information relating to premiums, co-pays, or deductibles, as applicable; See **Chapter 6 of the UMCM**.
8. Able to answer non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services; and
9. Able to answer non-clinical questions pertaining to accessing Non-capitated Services.

Hotline services must meet Cultural Competency requirements and must appropriately handle calls from callers who speak Prevalent Languages, including Spanish, as well as calls from individuals who are deaf or hard-of-hearing. To meet these requirements, the Dental Contractor must employ bilingual Spanish-speaking Member services representatives and must secure the services of other contractors as necessary. The Dental Contractor must provide such oral interpretation services to all hotline callers free of charge.

The Dental Contractor must process all incoming Dental Member telephone inquiries in a timely and responsive manner. The Dental Contractor must not impose maximum call duration limits and must allow calls to be of sufficient length to ensure adequate information is provided to the Dental Member. The Dental Contractor must ensure that the hotline meets the following minimum performance requirements for the Dental Program:

1. At least 80 percent of toll-free line calls must be answered within 30 seconds measured from the time the call is placed in queue after selecting an option.
2. No more than 7 percent of the calls are abandoned; and
3. No more than 2 minutes average hold time.

The Dental Contractor must conduct ongoing quality assurance monitoring to ensure these standards are met. The Dental Contractor may include the Dental Program in its existing

Member services hotline, if the hotline staff is knowledgeable about the Dental Program, as well as the Dental Contractor's other contracted dental services.

The Dental Contractor must submit performance reports summarizing its call center performance for its Member services hotline as indicated in **Chapter 5 of the UMCM**. If the Dental Contractor's Hotline serves multiple managed care programs, the Dental Contractor must have the capability to report call center performance by program, as well as reporting Medicaid and CHIP call center performance separately.

If HHSC determines that it is necessary to conduct onsite monitoring of the Dental Contractor's hotline functions, the Dental Contractor must reimburse HHSC for all travel costs incurred by HHSC relating to such monitoring. For purposes of this section, "travel costs" may include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC in connection with the onsite monitoring. Reimbursement by the Dental Contractor will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the Dental Contractor. The Dental Contractor may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

2.3.20.8 MEMBER EDUCATION

The Dental Contractor must develop and implement health education initiatives that educate Dental Members, their authorized representative, LAR, or guardian, as appropriate, about:

1. How the Dental Program operates, including the role of the Main Dental Home;
2. Medically Necessary Covered Dental Services, CHIP member cost-sharing obligations and limitations, and any VAS offered by the Dental Contractor;
3. The value of dental exams and preventive care; and
4. How to obtain Medically Necessary Covered Dental Services.

The Dental Contractor must provide a range of oral health promotion and wellness information and activities for Dental Members in formats that meet the needs of all Dental Members. The Dental Contractor must propose, implement, and assess innovative Dental Member education strategies for wellness care, as well as general health promotion and prevention. The Dental Contractor must conduct wellness promotion programs to improve the oral health status of its Dental Members. The Dental Contractor may cooperatively conduct oral health education classes for all enrolled Dental Members with one or more Dental Contractors also contracting with HHSC. The Dental Contractor must work with its Providers to integrate health education, wellness, and prevention training into the care of each Dental Member.

In accordance with Tex. Health & Safety Code § 48.052(c), Dental Contractor may employ or contract with certified Community Health Workers or "promotors" to conduct outreach and Dental Member education activities.

2.3.20.9 CULTURAL COMPETENCY PLAN

The Dental Contractor must have a comprehensive written Cultural Competency plan ("CC plan") describing how the Dental Contractor will ensure culturally competent services and provide Linguistic Access and Disability-related Access. The CC plan must be developed in adherence to the federal and state Cultural Competency standards. The CC plan must adhere to the following:

1. Title VI of the Civil Rights Act guidelines and the provision of Auxiliary Aids and Services, in compliance with the Americans with Disabilities Act;
2. Title III, Department of Justice Regulation 28 C.F.R. § 36.303, 42 C.F.R. § 438.206 (c)(2); and
3. 1 Tex. Admin. Code § 353.411.
4. **Chapter 16 of the UMCM**

The CC plan must describe how the individuals and systems within the Dental Contractor's organization will effectively provide services to Dental Members, caregivers, and Providers of all cultures, races, ethnic backgrounds, languages, communications needs, disabilities, and religions, as well as those with disabilities, in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each. Additionally, it must describe how the Dental Contractor will implement each component of the federal and state standards.

During the Operations Phase, the Dental Contractor must submit modifications and amendments to its CC plan to HHSC no later than 30 Days prior to implementation. Its CC plan must also be made available to the Dental Contractor's Providers. HHSC may require the Dental Contractor to update its CC plan to incorporate new or amended requirements based on HHSC guidance. In that event, the Dental Contractor has 60 Days to submit its updated CC plan to HHSC.

2.3.20.10 COMPETENT INTERPRETER SERVICES

The Dental Contractor must arrange and pay for Competent Interpreter services, including written, spoken, and sign language interpretation, for Dental Members to ensure effective communication regarding treatment, medical and dental history, or health condition. The Dental Contractor must maintain policies and procedures outlining the manner in which Dental Members and their Providers can access Competent Interpreter services including written, spoken, and sign language interpretation, when the Dental Member is in his or her Provider's office.

2.3.20.11 MEMBER SERVICE EMAIL ADDRESS

The Dental Contractor must have a secure email address through which a Dental Member may contact the Dental Contractor to receive assistance with identifying Providers and scheduling an appointment for the Dental Member or accessing services. The Dental

Contractor must, within one Business Day, acknowledge the Dental Member's request with an email response informing the Dental Member that by communicating via email the Dental Member consents to receive information through the same means. Member services staff must provide the Dental Member the requested information within three Business Days following the receipt of the email.

2.3.20.12 MEMBER ELIGIBILITY

The Dental Contractor must, if possible, provide eligibility renewal assistance as allowed by federal law and CMS policy guidance for Members whose eligibility is about to expire.

2.3.21 DENTAL CONTRACTOR WEBSITE

The Dental Contractor must develop and maintain, consistent with HHSC standards, Tex. Ins. Code § 843.2015, and all other applicable state laws, a website to provide general information about:

1. The Dental Contractor's Dental Program;
2. The Dental Contractor's Network, including an online Provider directory as outlined in **Chapter 3 of the UMCM**;
3. The Dental Contractor's Member and Provider services hotline numbers; and
4. The Dental Contractor's Complaints and Appeals process.

The Dental Contractor's website must meet the requirements of **Chapter 3 of the UMCM** and comply with state and federal accessibility standards, guidelines, policies, and procedures for all work products, including, but not limited to, 29 U.S.C. § 794; 1 Tex. Admin. Code. Chapter 206, Subchapter B; 1 Tex. Admin. Code. Chapter 213, Subchapter B; and Texas Health and Human Services Electronic and Information Resources Accessibility Standards.

The website must contain a link to financial literacy information on the Office of Consumer Credit Commissioner's webpage. The Dental Contractor must also maintain a mobile optimized site for mobile device use. The Dental Contractor may develop a page within its existing website to meet the requirements of this section.

The Dental Contractor must minimize download and wait time and not use tools or techniques that require significant memory, disk resources, or special user interventions. HHSC may require discontinuation, revision, or correction of any Member Materials posted on the Dental Contractor's website, including those previously approved by HHSC.

2.3.21.3 MEMBER PORTAL

The Dental Contractor must provide a Dental Member portal ("DM portal") that supports functionality to provide administrative functions and available health information to Dental Members. For the purposes of the Contract, a DM portal must bring information, which a

Dental Member is entitled to access, together from diverse sources in a uniform way. The Dental Contractor may require Dental Members to affirmatively opt-in to participate in its DM portal. The Dental Contractor must provide Dental Members who opt-in with unique log-in credentials. The Dental Contractor must ensure that its DM portal is mobile compatible and has download and printing capabilities. The DM portal's functionality must include the following requirements:

1. **Administrative Functions** - Dental Members must be able to:
    a. Verify eligibility;
    b. View Dental Member demographic information;
    c. Change his or her Main Dentist; and
    d. Request and print Dental Member ID cards.
2. **Health Information** - Dental Members must be able to view:
    a. His or her history and assessment;
    b. Referral history;
    c. PA requests, approvals, and denials
    d. Copies of any Notices of Action sent to the Dental Member in the last 12 months; and
    e. A dental health summary including dentist visits.

In addition, the Dental Contractor must provide HHSC secure access rights as an authorized or guest user to all Dental Member access points, including but not limited to, its DM portal and call monitoring system, for remote monitoring capability.

2.3.21.4 PROVIDER PORTAL

The Dental Contractor must provide a Provider portal that supports functionality to reduce administrative burden on Providers at no cost to the Providers as described in **Chapter 3 of the UMCM**.

The Provider portal should support both online and Batch Processing as applicable to the information being exchanged. To facilitate the exchange of clinical data and other relevant documentation, the Provider portal must provide a secure exchange of information between the Provider and Dental Contractor, including, as applicable, a Subcontractor of the Dental Contractor.

2.3.22 MARKETING AND PROHIBITED PRACTICES

The Dental Contractor and its Subcontractors must comply with all applicable federal and state laws and regulations regarding marketing, gifts, and other inducements. The Dental Contractor and its Subcontractors must adhere to the Marketing policies and procedures as set forth in the Contract, including **Chapter 4 of the UMCM**. HHSC must approve all Marketing Materials before use or distribution. All Marketing Materials must comply with all state and federal marketing requirements, including State insurance laws and TDI regulations regarding marketing.

2.3.23 QUALITY IMPROVEMENT AND PERFORMANCE EVALUATION

The Dental Contractor must provide for the delivery of quality care with the primary goal of improving the dental health status of Dental Members. The Dental Contractor must work in collaboration with Providers to actively improve the quality of care provided to Dental Members, consistent with the Quality Improvement goals, and all other requirements of the Contract. The Dental Contractor must provide mechanisms for Dental Members and Providers to offer input into the Dental Contractor's Quality Improvement activities.

2.3.23.1 PERFORMANCE MEASURES

The Dental Contractor must provide to HHSC all information necessary to analyze the Dental Contractor's provision of quality care to Dental Members using measures to be determined by HHSC.

2.3.23.2 QUALITY ASSURANCE AND PERFORMANCE MANAGEMENT

This section provides quality assurance and performance requirements of the Dental Contractor.

2.3.23.2.1 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM OVERVIEW

The Dental Contractor must develop, maintain, and operate a quality assurance and performance improvement (QAPI) program consistent with the Contract and TDI requirements, including 28 Tex. Admin. Code §§ 11.1901 and 11.1902. The Dental Contractor must also meet the requirements of 42 C.F.R. § 438.330.

The Dental Contractor must have on file with HHSC an approved plan describing its QAPI program, including how the Dental Contractor will accomplish the activities required by this section. The Dental Contractor must annually submit a QAPI program Annual Summary in a format and timeframe specified by HHSC. The Dental Contractor must keep participating Providers and other providers informed about the QAPI program and related activities. The Dental Contractor must include a requirement securing cooperation with the QAPI in its Provider Contracts.

The Dental Contractor must be accredited by URAC, as required by Tex. Gov't Code § 533.0031. The Dental Contractor must provide HHSC and its EQRO a copy of its most recent accreditation review in accordance with 42 C.F.R. § 438.332. HHSC may use information from an accreditation organization in its oversight processes.

The Dental Contractor must approach all clinical and non-clinical aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement /Total Quality Management and must:

1. Evaluate Provider's performance using objective quality indicators;
2. Foster data-driven decision-making;
3. Solicit Dental Member and Provider input on performance and QAPI activities;
4. Support continuous ongoing measurement of clinical and non-clinical effectiveness and Dental Member satisfaction;
5. Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and
6. Support re-measurement of effectiveness and Dental Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

2.3.23.2.2 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM STRUCTURE

The Dental Contractor must maintain a well-defined QAPI structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. The Dental Contractor must designate a senior executive responsible for the QAPI program, and the Dental Director must have substantial involvement in QAPI program activities. The Dental Contractor must ensure that the QAPI program structure:

1. Is organization-wide, with clear lines of accountability within the organization;
2. Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including dentists, other clinicians, and non-clinicians;
3. Includes annual objectives or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and
4. Evaluates the effectiveness of clinical and non-clinical initiatives.

2.3.23.2.3 CLINICAL INDICATORS

The Dental Contractor must collect clinical indicator data. The Dental Contractor must use such clinical indicator data in the development, assessment, and modification of its QAPI program.

2.3.23.2.4 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM SUBCONTRACTING

If the Dental Contractor subcontracts any of the essential functions or reporting requirements contained within the QAPI program to another entity, the Dental Contractor must maintain detailed files documenting the work of the Subcontractors. The file must be available for review by HHSC upon request.

2.3.23.2.5 PROVIDER CREDENTIALING AND PROFILING

In accordance with **Section 2.3.12**, the Dental Contractor must review and approve the credentials of all participating licensed Providers in the Dental Contractor's Network. Through the QAPI process, the Dental Contractor must report annually to HHSC the results of any credentialing activities conducted during the reporting year. The Dental Contractor must use the QAPI form found in **Chapter 5 of the UMCM**.

The Dental Contractor must conduct Provider profiling activities at least annually. As part of its QAPI program, the Dental Contractor must describe the methodology it uses to identify which and how many Providers to profile and to identify measures to use for profiling such Providers. Provider profiling activities must include, but not be limited to:

1. Developing Provider-specific reports that include a multi-dimensional assessment of a Provider's performance using clinical, administrative, and Dental Member satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population;
2. Establishing Provider, group, statewide, or regional Benchmarks for areas profiled, where applicable; and
3. Providing feedback to individual Providers regarding the results of his or her performance and the overall performance of the Network.

If the Dental Contractor wishes to move to a preferred Provider arrangement, the Dental Contractor must profile all Providers of the service for a period of no less than 12 months. The results of the Provider profiles must be used to determine the Provider or Providers selected for a preferred Provider arrangement. If the Dental Contractor enters into a preferred Provider arrangement for a service or supply, the Dental Contractor must notify Dental Members using that service or supply of the arrangement in writing and offer Dental Members the opportunity to opt out of using the preferred Provider and use another Provider. The Dental Contractor must provide clear written instructions on how a Dental Member may opt out of using the preferred Provider. The Dental Contractor's Preferred provider arrangements must be in accordance with requirements in the **UMCM**.

2.3.23.3 NETWORK MANAGEMENT

The Dental Contractor must:

1. Use the results of its Provider profiling activities to identify areas of improvement for individual Providers, or groups of Providers;
2. Establish Provider-specific quality improvement goals for priority areas in which a Provider or Providers do not meet established Dental Contractor standards or improvement goals;
3. Develop and implement incentives, which may include financial and non-financial incentives, to motivate Providers to improve performance on profiled measures; and

4. At least annually, measure and report to HHSC on the Network and individual Providers' progress, or lack of progress, towards such improvement goals.

2.3.23.4 PROVIDER INCENTIVE PLANS

If the Dental Contractor implements a Provider incentive plan under 42 C.F.R. § 438.6(h), the plan must comply with all applicable law, including 42 C.F.R. §§ 422.208 and 422.210. The Dental Contractor must not make payments under a Provider incentive plan if the payments are designed to induce Providers to reduce or limit Medically Necessary Covered Dental Services to Dental Members.

If the Provider incentive plan places a Provider or Provider group at a substantial financial risk for services not provided by the Provider or Provider group, the Dental Contractor must ensure adequate stop-loss protection and conduct and submit annual Dental Member surveys no later than five Business Days after the Dental Contractor finalizes the survey results. Refer to 42 C.F.R. § 422.208 for information concerning "substantial financial risk" and "stop-loss protection".

The Dental Contractor must make information regarding Provider incentive plans available to Dental Members upon request, in accordance with **UMCM** requirements. The Dental Contractor must provide the following information to the requesting Dental Member:

1. Whether the Dental Member's Provider or other Providers are participating in the Dental Contractor's Provider incentive plan;
2. Whether the Dental Contractor uses a Provider incentive plan that affects the use of referral services;
3. The type of incentive arrangement; and
4. Whether stop-loss protection is provided.

No later than five Business Days prior to implementing or modifying a Provider incentive plan, the Dental Contractor must provide the following information to HHSC:

1. Whether the Provider incentive plan covers services that are not furnished by a Provider or Provider group.

The Dental Contractor is only required to report on items 2-4 below if the Provider incentive plan covers services that are not furnished by a Provider or Provider group;

2. The type of incentive arrangement (e.g., withhold, bonus, capitation);
3. The percent of withhold or bonus, if applicable;
4. The panel size, and if Dental Members are pooled, the HHSC approved method used; and
5. If the Provider or Provider group is at substantial financial risk, the Dental Contractor must report proof that the Provider or group has adequate stop-loss protection, including the amount and type of stop-loss protection.

2.3.23.5 DENTAL CONTRACTOR ALTERNATIVE PAYMENT MODELS WITH PROVIDERS

HHSC requires the Dental Contractor to transition Provider payment methodologies from volume-based payment (VBP) approaches, i.e. Fee-for-Service, to value-based alternative payment models (APM), increasing year-over-year percentages of provider payments linked, to measures of quality or efficiency, or maintaining every year the percentage achieved the year before. The APMs should be designed to improve oral health outcomes for Dental Members, empower Dental Members and improve experience of care, lower healthcare cost trends and reward high-performing Providers.

The Dental Contractor must demonstrate satisfactory progress towards advancing APM initiatives within an APM performance framework. Dental Contractors will earn credit by meeting or making minimum progress on benchmarks in the APM performance framework components listed below. Specifications and benchmarks of the APM performance framework are detailed in **Chapter 8 of the UMCM**.

APM Performance Framework Components:

1. **Achieve a minimum Overall APM Ratio and a Risk-Based APM Ratio**. The ratios are expressions of APM-based provider payments relative to total provider payments. The calculations and yearly benchmarks for the APM targets ratios, are delineated **Chapter 8 of the UMCM**.

2. Implement APMs that promote improvements in priority areas and quality measures specified by HHSC in Chapter 8 of the UMCM. Examples of HHSC priority areas include prevention and follow-up from emergency dental care treatment.

3. Implement processes to support and incentivize Providers. The Dental Contractor must engage and support Providers' efforts to implement value-based care models and reward high-performing Providers, as defined by the Dental Contractor. The Dental Contractor must:

a. Share data and performance reports with Providers on a regular basis and provide or make available the data Providers need to coordinate care in an APM. Dental Contractors must provide evidence of these reports and processes upon request by HHSC.

b. Dedicate enough resources for Provider outreach and negotiation, assistance with data or report interpretation, and other activities to support Provider's improvement.

c. To the extent possible Dental Contractors should collaborate on development of standardized formats for the Provider performance reports and data exchanged with Providers and align quality measures. Dental Contractors are encouraged to sponsor or support collaborative learning opportunities for Providers in a Service Area.

HHSC may request evidence of these reports and processes from the Dental Contractors

4. Submit to HHSC its inventories of APMs with Providers by August 1st of each year. The report will be completed using the data collection tool in **Chapter 8 of the UMCM**, Alternative Payment Models Data Collection Tool (DCT). The DCT will capture APM activity for the previous year and will be used to calculate the APM ratios and determine whether the Dental Contractor has achieved minimum progress on the components of the APM performance framework. Some requirements in the DCT will vary by program. Provider types include, but are not limited to, dentists and specialty dentists. Upon request by HHSC, the Dental Contractor must submit to HHSC underlying data for the information reported on the data collection tool (e.g., names of providers, NPIs, TPIs). HHSC will post on its website basic information from reported APMs.

5. Evaluate the impact of APMs on utilization, quality and cost, as well as return on investment (ROI).

a. The Dental Contractor must evaluate the impact of their APMs. Upon request, the Dental Contractor must report on methodologies used for APM evaluations along with results and findings related to the APM's impact on utilization, quality, costs, provider satisfaction, or ROI.

b. The Dental Contractors will report to HHSC, annually, the net financial impact to Providers of APMs, including the sum of incentive payments, shared savings, and payment reductions. The financial impact to Providers must be reported in the DCT for each APM and Medicaid program.

c. The Dental Contractor is encouraged to develop and continually update a strategic plan for advancing value-based care and APMs to advance quality and efficiency.

If the Dental Contractor DCT does not adhere to HHSC requirements or is not submitted by the required deadline, or if the Dental Contractor does not demonstrate minimum required progress within the APM performance framework, the Dental Contractor shall be required to submit a corrective action plan and may be subject to additional contractual remedies, including liquidated damages.

2.3.23.6 COLLABORATION WITH THE EXTERNAL QUALITY REVIEW ORGANIZATION

The Dental Contractor must collaborate with HHSC's External Quality Review Organization (EQRO) to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. The Dental Contractor must supply claims data to the EQRO, or another vendor identified by HHSC, in a format identified by HHSC in consultation with Dental Contractor. The Dental Contractor must supply the EQRO, or another vendor identified by HHSC, dental records for focused clinical reviews conducted by the EQRO, or another contractor. The Dental Contractor must work collaboratively with HHSC and

the EQRO, or another vendor identified by HHSC to annually measure HHSC-selected Healthcare Effectiveness Data and Information Set (HEDIS) measures that require chart reviews. Dental Contractor must conduct chart reviews for HEDIS hybrid measures and submit results to the EQRO in a format and timeline specified by HHSC. Dental Contractor is responsible for all costs associated with these reviews.

The Dental Contractor must comply with any requests for data from the EQRO, including but not limited to, data required for these activities:

1. Performing dental record review;
2. Performing encounter data validation for data certification purposes; and
3. Calculating measure results using encounter and enrollment data.

2.3.23.7 Performance Improvement Projects

Performance Improvement Projects (PIPs) must be designed, conducted, and reported in a methodologically sound manner in accordance with **Chapter 10 of the UMCM**. The Dental Contractor must complete the PIP templates in accordance with **Chapter 10 of the UMCM**. Each Dental Contractor must also complete progress reports as outlined in the **Chapter 10 of the UMCM**.

2.3.23.8 Dental Contractor Quality Rating System

42 C.F.R. §§ 438.334 and 457.1240 and Tex. Gov't Code § 536.051 require HHSC to adopt an annual quality rating system for Dental Contractors. HHSC may prominently display the results on HHSC's website or a website maintained by HHSC's contractor. Additionally, HHSC may provide the results to Dental Members through other methods at HHSC's election.

If the Dental Contractor requests the recalculation or any other modifications to the quality measure data or member-level results, HHSC may charge the Dental Contractor any costs related to preparing this data for the Dental Contractor.

2.3.23.9 Non-Pharmacy Preferred Provider Arrangement

A preferred provider arrangement is a contracted agreement between the Dental Contractor and one or more Providers. After the effective date of the agreement, services specified in the agreement will be delivered to Members by the Provider(s) in the preferred provider arrangement.

If a Dental Contractor enters into a preferred provider arrangement, the Dental Contractors must notify Members of the arrangement in writing at least 60 Days in advance of effective date of the arrangement. The Dental Contractor must also develop and implement a process whereby Members have the choice to opt out of using the preferred provider arrangement and use another Network Provider. The Dental Contractor must provide clear written

instructions on how a Member may opt out of using the preferred provider arrangement. The Dental Contractor must manage its opt out process, including the receipt and review of all Member requests and may not delegate any process steps to its Providers. For preferred provider arrangements in effect prior to September 1, 2021. Dental Contractors must provide notification to impacted Members that gives clear written instructions on how the Member may opt out of using the preferred provider arrangement. Furthermore, the Dental Contractor may not change a Member's Provider without notifying the member of the change and giving clear written instructions on how the Member may opt out of using the Provider.

When implementing a preferred provider arrangement, the Dental Contractor must notify the Providers through its internet website, at minimum every time such an arrangement is implemented. The Dental Contractor must coordinate with other Network Providers of the Covered Service during the transition to ensure Continuity of Care.

The Dental Contractors must provide to HHSC health plan manager all the Member and provider notices pertaining to the new preferred provider arrangement at least 90 Days before initiating any such arrangement. The Dental Contractor must ensure notices comply with **Chapter 4 of the UMCM**.

To be counted as an APM, per Section 2.3.23.5, a preferred provider arrangement must be based on a provider's performance on metrics of quality or value and meet the requirements set forth in 2.3.23.5.

2.3.24 UTILIZATION MANAGEMENT

The Dental Contractor's Utilization Management (UM) program must be consistent with the Texas Dental Practice Act's requirements, Texas State Board of Dental Examiners rules, and national guidelines from the American Dental Association (ADA) and the AAPD.

The Dental Contractor must have a written UM program description, which includes:

1. Procedures to evaluate the need for Medically Necessary Covered Dental Services;
2. For CHIP members who have exhausted their annual benefit limits, a procedure to evaluate PA requests for additional services necessary to return the member to normal, pain and infection-free oral functioning (see **ATTACHMENT G, CHIP MEDICALLY NECESSARY COVERED DENTAL SERVICES**);
3. The clinical review criteria used, the information sources, and the process used to review and approve the provision of Medically Necessary Covered Dental Services;
4. The method for periodically reviewing and amending the UM clinical review criteria;
5. The staff position functionally responsible for the day-to-day management of the UM function; and
6. Evidence-based policies and procedures.

The Dental Contractor must make best efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating dentist as appropriate in making UM determinations.

The Dental Contractor must issue coverage determinations, including Adverse Determinations, within three Business Days after receipt of a request for authorization of services. For prior authorization requests received with insufficient or inadequate documentation, Dental Contractors must follow timeframes established by HHSC as set forth in **Chapter 3 of the UMCM**.

The Dental Contractor must have a process in place that allows a Provider to submit a prior authorization or service authorization request for services at least 60 Days prior to the expiration of the current authorization period. If practicable, the Dental Contractor must review the request and issue a determination prior to the expiration of the existing authorization. The Dental Contractor's process must consider if the request contains sufficient clinical information to justify reauthorization of services.

The Dental Contractor's UM program must include written policies and procedures to ensure each of the following:

1. Compliance with Tex. Ins. Code § 4201.456;
2. Consistent application of review criteria that are compatible with Dental Members' needs and situations;
3. Determinations to deny or limit services are made by Texas-licensed dentist under the direction of the Dental Director. Peer-to-peer consultation regarding UM determinations with a dentist of the same specialty must be available upon Provider's request;
4. Appropriate personnel are available to respond to UM inquiries 8:00 a.m. to 5:00 p.m., Monday through Friday, with a telephone system capable of accepting UM inquiries during non-business hours. The Dental Contractor must respond to calls within one Business Day;
5. Confidentiality of clinical information; and
6. Compensation to individuals or entities conducting UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Dental Services as required by 42 C.F.R. § 438.210(e), and quality of services provided is not adversely impacted by financial and reimbursement-related processes and decisions

For preauthorization or concurrent review programs, the Dental Contractor must ensure that a qualified Texas-licensed dentist supervise the preauthorization and concurrent review decisions.

The Dental Contractor UM program must include policies and procedures to:

1. Routinely assess the effectiveness and the efficiency of the UM program;
2. Target areas of suspected inappropriate service utilization;

3. Detect over- or under- utilization, including procedures to address underutilization of essential services such as dental checkups, First Dental Home visits, and sealants;
4. Routinely generate Provider profiles regarding utilization patterns and compliance with UM criteria and policies;
5. Compare Dental Member and Provider utilization with norms for comparable individuals; and
6. Refer suspected cases of Provider or Dental Member FWA to the OIG as required by **Section 2.3.31**.

2.3.25 COMPLIANCE WITH STATE AND FEDERAL PRIOR AUTHORIZATION REQUIREMENTS

The Dental Contractor must adopt PA requirements that comply with state and federal laws governing authorization of dental services. In addition, the Dental Contractor must comply with Tex. Ins. Code § 1217.004. The Dental Contractor must ensure that the provider requesting prior authorization for a service is also the provider who performs the service, with the exception of services provided in a dental school or teaching facility.

2.3.26 SUBMISSION OF SERVICE AUTHORIZATIONS

The Dental Contractor must provide access to a toll-free fax line and Provider portal where Providers may send requests for authorization of services and any supplemental information related to service authorization. The fax line and Provider portal must be available 24 hours per day, seven days a week.

2.3.27 FINANCIAL REQUIREMENTS FOR MEDICALLY NECESSARY COVERED DENTAL SERVICES

The Dental Contractor must pay for or reimburse Providers for all Medically Necessary Covered Dental Services provided to a Dental Member, up to the Dental Member's applicable benefit limits. The Dental Contractor is not liable for costs incurred in connection with dental care rendered prior to the date of the Dental Member's Effective Date of Coverage with that Dental Contractor. When Medicaid provider rates are increased as a result of a legislative appropriation, MCOs must increase provider rates as required by HHSC to the extent allowed by federal laws and regulations. Medicaid and CHIP are the payers of last resort for Covered Services, unless an exception applies under federal law or HHSC policy. If a Dental Member is entitled to coverage for specific services payable under another insurance plan and the Dental Contractor paid for such Medically Necessary Covered Dental Services, the Dental Contractor must obtain reimbursement from the responsible insurance entity, not to exceed 100 percent of the value of any Medically Necessary Covered Dental Services paid by the Dental Contractor. See **Sections 2.5.5** and **2.7.5** for more information.

2.3.28 REPORTING REQUIREMENTS

The following sections provide reporting requirements required of the Dental Contractor.

2.3.28.1 GENERAL REPORTING REQUIREMENTS

The Dental Contractor must provide and must require its Material Subcontractors to provide, at no cost to HHSC, the following:

1. All information required under this Contract, including but not limited to, the reporting requirements or other information related to the performance of its responsibilities hereunder as reasonably requested by the HHSC;
2. Any information in its possession sufficient to permit HHSC to comply with the Federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats, and instructions as specified by HHSC. Where practicable, HHSC may consult with Dental Contractor to establish time frames and formats reasonably acceptable to both parties; and
3. Ad hoc reports as requested by HHSC.

All information must be provided in accordance with the timelines, definitions, formats, and instructions as specified by HHSC. Where practicable, HHSC may consult with the Dental Contractor to establish timeline and formats reasonably acceptable to both Parties.

Any Deliverable or report not listed in **Chapter 5 of the UMCM**, but referenced in this Contract without a specified due date, is due quarterly on the last day of the month following the end of the reporting period. Where the due date states 30 Days, the Dental Contractor is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 Days, the Dental Contractor is to provide the deliverable by the 15th Day of the second month following the end of the reporting period. See **Chapter 5 of the UMCM**.

The Dental Contractor must provide the reports specified in **Chapter 5 of the UMCM**. This chapter includes a list of required reports, and a description of the format, content, file layout, and submission deadlines for each report

Pursuant to CFR §438.606 and UMCM Chapter 5, Data Certification Instructions, the Dental Contractor's chief executive (CEO); and chief financial officers (CFO); or an individual who reports directly to those positions with delegated authority to sign for them so that the CEO or CFO is ultimately responsible for the certification, , must certify that the financial data, Encounter Data, and other data, as specified by CFR §438.604, has been reviewed, and is true and accurate to the best of the certifying person's knowledge. Such certification may not be delegated.

HHSC is constructing a portal for delivery and receipt of Dental Contractor deliverables. The Dental Contractor will be required to participate in the online portal.

2.3.28.1.1 DENTAL CONTRACTOR DELIVERABLES RELATED TO MANAGEMENT INFORMATION SYSTEM REQUIREMENTS

The Dental Contractor must comply with all applicable Joint Interface Plans (JIPs), as modified or amended, and all required file submissions for EB, EQRO, and HHSC's Medicaid Claims Administrator. The JIP must include the Dental Contractor's interfaces required to conduct business under the Contract. The JIP must address the coordination with each of the Dental Contractor's interface partners to ensure the development and maintenance of the interface; and the timely transfer of required data elements between contractors and partners. The JIPs are posted in TXMedCentral under the MCOLAYUT folder. See **Chapter 7 of the UMCM**.

The Dental Contractor must submit plans and checklists related to MIS to HHSC according to the format and schedule identified in **Chapter 5 of the UMCM**. Additionally, if a systems readiness review is triggered by one of the events described in **Section 2.3.29**, the Dental Contractor must submit all of the plans identified in this section in accordance with an HHSC approved timeline.

2.3.28.2 ACCOUNTING AND REPORTING REQUIREMENTS

The Dental Contractor's accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with Federal Acquisition Regulations (FAR), Generally Accepted Accounting Principles (GAAP), and the cost principles contained in the HHSC Cost Principles document in **Chapter 6 of the UMCM**. HHSC will not recognize costs that are unallowable, or that cannot be properly substantiated by the Dental Contractor and verified by HHSC. The Dental Contractor must:

1. Maintain accounting records for the Dental Program and the resulting contract separate and apart from other corporate accounting records;
2. Maintain records for all claims payments, refunds, and adjustment payments to Providers, capitation payments, interest income, and payments for administrative services or functions, and must maintain separate records for dental and administrative fees, charges, and payments;
3. Ensure and provide access to HHSC or its auditors to the detailed records and supporting documentation for all costs incurred by the Dental Contractor. The Dental Contractor must ensure access to its Affiliates' records for any costs billed to or passed to the Dental Contractor with respect to the Dental Program; and
4. Maintain an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts.

The Dental Contractor must reimburse HHSC, if reimbursement is sought from the Dental Contractor, for reasonable costs incurred by HHSC to perform examinations, investigations, audits, or other types of attestations that HHSC determines are necessary to

ensure Dental Contractor's compliance with the Contract. The use and selection of any external parties to conduct examinations, investigations, audits, or other types of attestations are at HHSC's sole discretion.

2.3.28.2.1 GENERAL ACCESS TO ACCOUNTING RECORDS

The Dental Contractor, and any Affiliate Subcontractor, must provide authorized representatives of the State and federal governments full access to all financial and accounting records related to the performance of the Contract. See **ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS** for additional requirements.

The Dental Contractor and any subcontracted Affiliates must:

1. Cooperate with the state and federal governments in their evaluation, inspection, audit, or review of accounting records and any necessary supporting information;
2. Permit authorized representatives of the State and federal governments full access, during normal business hours, to the accounting records that the State and federal governments determine are relevant to the Contract. Such access is guaranteed at all times during the performance and retention period of the Contract, and may include both announced and unannounced inspections, on-site audits, and the review, analysis, and reproduction of reports produced by the Dental Contractor;
3. Make copies, at no cost to HHSC, of any accounting records or supporting documentation relevant to the Contract, including Provider Contracts, available to the State and federal governments within seven Business Days, or as otherwise specified, of receiving a written request for the specified records or information. If such documentation is not made available as requested, the Dental Contractor agrees to reimburse the requesting party for all costs, including, but not limited to, transportation, lodging, and subsistence for all state and federal representatives, or their designees, to carry out the inspection, audit, review, analysis, and reproduction functions at the location(s) of such accounting records; and
4. Pay all additional costs incurred by the State and federal governments that are the result of the Dental Contractor's failure to provide the requested accounting records or financial information within ten Business Days of receiving a written request from the State or federal government. Failure to provide such required documentation and information in a timely manner may be deemed to be a material breach of the Contract's terms.

2.3.28.2.2 FINANCIAL REPORTING REQUIREMENTS

HHSC will require the Dental Contractor to provide separate financial reports for Medicaid and CHIP to support the Contract monitoring as well as state and federal reporting requirements. All financial information and reports submitted by the Dental Contractor become property of HHSC. HHSC may, at its discretion, release such information and reports to the public at any time and without notice to the Dental Contractor. In accordance

with state and federal laws regarding Dental Member confidentiality, HHSC will not release any Dental Member-identifying information contained in such reports.

Any data submitted with respect to the required financial reports or filings that is in portable document format (PDF), or similar file format, must be generated in a text-searchable format. Copies of required filings or reports may not be submitted in non-text-searchable formats, such as JPG or GIF. In certain exceptions, where expressly permitted by HHSC, signature pages may be submitted in a non-text-searchable format.

The Dental Contractor must submit all required financial reports as detailed in **Chapter 5 of the UMCM** and the Contract using the templates in **Chapter 5 of the UMCM**.

Note to Dental Contractors. Not all the above referenced financial reports have been incorporated into the UMCM at the time this Contract was awarded. The development of the report templates is part of the current HHSC UMCM change process, and Dental Contractors will be notified when the templates are published and made part of the Contract.

2.3.29 MANAGEMENT INFORMATION SYSTEM REQUIREMENTS

The Dental Contractor must maintain a Management Information System (MIS) that supports all functions of the Dental Contractor's processes and procedures for the flow and use of Dental Program data. If the Dental Contractor subcontracts an MIS function, the Subcontractor's MIS must comply with the requirements of this section. The Dental Contractor must have hardware, software, and a network and communications system with the capability and capacity to handle and operate all MIS subsystems, with limited manual intervention for routine processing, for the following operational and administrative areas:

1. Enrollment/eligibility subsystem;
2. Provider subsystem;
3. Encounter/claims processing subsystem;
4. Benefit tracking/limitations subsystem;
5. Financial subsystem;
6. Utilization/Quality Improvement subsystem;
7. Reporting subsystem;
8. Interface subsystem; and
9. Third Party Recovery subsystem.

The MIS must enable the Dental Contractor to meet this Contract's requirements, including all applicable state and federal laws, rules, and regulations. The MIS must have the capacity and capability to capture and utilize various data elements required for Dental Contractor administration.

The Dental Contractor must have a system that can be adapted to changes in business practices or policies within the timeframes negotiated by the Parties. The Dental Contractor

is expected to cover the cost of such systems modifications through the Term of the Contract.

The Dental Contractor is required to participate in work groups and regular calls related to MIS convened by HHSC.

The Dental Contractor must provide HHSC prior written notice of a Major Systems Change and implementation no later than 180 Days prior to the planned change or implementation, including any changes relating to Material Subcontractors, in accordance with the requirements of the Contract and **ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**. HHSC may modify or waive the notification requirement contingent upon the nature of the request from the Dental Contractor.

The Dental Contractor must notify HHSC of a Major Systems Change in writing, as well as by email, to HHSC's Managed Care Compliance & Operations division's staff. The notification must detail the following:

1. The aspects of the system that will be changed and date of implementation;
2. How these changes will affect the Provider and Dental Member community, if applicable;
3. The communication channels that will be used to notify these communities, if applicable;
4. A detailed implementation plan and schedule of proposed changes; and
5. A contingency plan in the event of downtime of system(s) or substantial non-performance of the system(s).

Major Systems Change is subject to HHSC desk review and onsite review of the Dental Contractor's facilities as necessary to test readiness and functionality prior to implementation. See **Section 2.3.2.**

2.3.29.1 ENCOUNTER DATA

The Dental Contractor must provide complete and accurate Encounter Data that reflects information received on claims for all Medically Necessary Covered Dental Services, including VAS. Encounter Data must follow the format and data elements as described in the most current version of Health Insurance Portability and Accountability Act (HIPAA)-compliant 837D Companion Guides, and Encounters Submission Guidelines. The Dental Contractor will adhere to the method of transmission, the submission schedule, and any other requirements specified in the **UMCM.** HHSC will use Encounter data to set rates, monitor utilization, conduct system reporting, quality monitoring, FWA activities, and for other programmatic purposes.

Encounter Data quality validation must incorporate assessment standards developed jointly by the Dental Contractor and HHSC. The Dental Contractor must ensure that HHSC receives complete and accurate Encounter Data not later than the 30th day after the last day of the month in which the claim was adjudicated. The Dental Contractor must make

original records and data available for inspection by HHSC for validation purposes upon HHSC request. Encounter Data that do not meet quality standards must be corrected and resubmitted within a time period specified by HHSC.

In addition to providing Encounter Data in the format described above, HHSC may request that the Dental Contractor submit an Encounter Data file to HHSC's EQRO, in the format provided in the **UMCM**.

For reporting Encounters to HHSC, the Dental Contractor must use the procedure codes, diagnosis codes, and other codes as directed by HHSC. Any exceptions will be considered on a code-by-code basis after HHSC receives written notice from the Dental Contractor requesting an exception. The Dental Contractor must also use the Provider numbers as directed by HHSC, in the format provided in the **UMCM** for Encounter submissions.

2.3.29.2 SYSTEM-WIDE FUNCTIONS

The Dental Contractor's MIS system must include key business processing functions or features, which must apply across all subsystems as follows:

1. Process electronic data transmission or media to add, delete, or modify membership records with accurate begin and end dates;
2. Track Medically Necessary Covered Dental Services received by Dental Members through the system, and accurately and fully maintain those Medically Necessary Covered Dental Services as HIPAA compliant Encounter transactions;
3. Transmit or transfer Encounter Data transactions on electronic media in the HIPAA format to the contractor designated by HHSC to receive the Encounter Data;
4. Maintain a history of changes and adjustments and audit trails for current and retroactive data;
5. Maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure;
6. Employ industry standard dental billing taxonomies (procedure codes, diagnosis codes) to describe services delivered and Encounter transactions produced;
7. Accommodate the coordination of benefits;
8. For CHIP members, produce standard explanation of benefits (EOBs);
9. Pay financial transactions to Providers in compliance with federal and state laws, rules, and regulations;
10. Ensure that all financial transactions are auditable according to GAAP guidelines;
11. Ensure that FSRs conform to the FAR and **Chapter 6 of the UMCM**, with respect to segregating costs that are allowable for inclusion in HHSC-designed financial reports;
12. Relate and extract data elements to produce report formats in the **UMCM** or otherwise as required by HHSC;
13. Ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS;

14. Maintain and cross-reference all Dental Member-related information with the most current Main Dentist number;
15. Maintain and cross-reference all Dental Member-related information with current and historical Medicaid or CHIP Provider numbers;
16. Track utilization of benefits within the Program's benefit limit(s); and
17. Report benefit utilization information to other Dental Contractor and HHSC.

2.3.29.3 Electronic Data Interchange and Health Insurance Portability and Accountability Act Compliance

In addition to other requirements in this Contract, the Dental Contractor must comply with HIPAA Electronic Data Interchange (EDI) requirements including the HIPAA-compliant format version. The Dental Contractor must be able to receive, load, and read eligibility files received from HHSC in the 834 HIPAA-compliant format. Eligibility inquiries must be in the 270/271 HIPAA-compliant format. Claim transactions must be in the 837D/835 HIPAA-compliant format.

The Dental Contractor must develop a privacy notice, commonly referred to as Notice of Privacy Practice (NOPP), as required by HIPAA, including 45 C.F.R. § 164.520. The Dental Contractor must provide HHSC with a copy of its NOPP prior to distribution and after any changes are made to the NOPP prior to distribution. The Dental Contractor must provide its new Dental Members with a NOPP, and to all existing Dental Members after making revisions to the NOPP.

The Dental Contractor must offer its Providers and Subcontractors the option of submitting and receiving claims information through an EDI that allows for automated processing and adjudication of claims. EDI processing must be offered as an alternative to the filing of paper claims. The Dental Contractor must use HIPAA-compliant electronic formats.

HHSC may require the Dental Contractor to receive initial electronic claims through an HHSC-contracted vendor. The Dental Contractor must allow Providers to send claims to one location, which will then identify where the claim should be submitted. The Dental Contractor's interface must allow receipt of these electronic submissions. The Dental Contractor must maintain a mechanism to receive claims from an HHSC-contracted vendor in addition to the HHSC claims portal. The Dental Contractor must allow Providers to send claims directly to the Dental Contractor or its Subcontractor.

The Dental Contractor must make an electronic funds transfer payment process for direct deposit available to Providers when processing claims for Medically Necessary Covered Dental Services.

The Dental Contractor may deny a claim submitted by a Provider for failure to file in a timely manner as provided for in **Chapter 2 of the UMCM**.

2.3.29.4 CLAIMS PROCESSING REQUIREMENTS

The Dental Contractor must administer an effective, accurate, and efficient claims payment process in compliance with federal and state laws, rules, and regulations including **Chapter 2 of the UMCM**. The Dental Contractor must process and adjudicate all claims for Medically Necessary Covered Dental Services that are filed within the timeframes specified in **Chapter 2 of the UMCM**. The Dental Contractor and its Subcontractor cannot directly or indirectly charge or hold a Dental Member or Provider responsible for claims adjudication or transaction fees.

The Dental Contractor should employ a fully automated claims processing system to the extent practicable. If not practicable to be fully automated, the Dental Contractor must maintain an automated claims processing system that requires minimal and limited manual intervention for routine claims processing and that registers the date a claim is received by the Dental Contractor, the detail of each claim transaction or action, including date of service, at the time the transaction occurs, and has the capability to report each claim transaction by date and type to include interest payments. The claims system must maintain information at the claim and line detail level. The claims system must maintain adequate audit trails and report accurate claims performance measures to HHSC.

The Dental Contractor's claims system must maintain online and archived files. The Dental Contractor must keep online automated claims payment history for the most current 18 months. The Dental Contractor must retain other financial information and records, including all original claims forms, for the time period established in **Section 9.01 of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**. All claims data must be easily sorted and produced in formats as requested by HHSC.

The Dental Contractor must withhold all or part of payment for any claim submitted by a Provider:

1. Who has been excluded or suspended from the Medicare, Medicaid, or CHIP programs based on a determination of FWA;
2. For whom his or her license has been terminated or suspended;
3. Who is on payment hold under the authority of HHSC;
4. With debts, settlements, or pending payments due to HHSC, the State or federal government;

With the following exceptions, the Dental Contractor must complete all audits of a provider claim no later than 18 months after receipt of a Clean Claim, regardless of whether the provider participates in the Dental Contractor's Network. This limitation does not apply in cases of provider FWA that the Dental Contractor did not discover within the two-year period following receipt of a claim. In addition, the two-year limitation does not apply when the officials or entities identified in **Section 9.02(c) of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**, conclude an examination, audit, or inspection of a provider more than two years after the Dental Contractor received the claim,

or when HHSC has recovered a capitation from the Dental Contractor based on a Dental Member's ineligibility. If an exception to the two-year limitation applies, then the Dental Contractor may recoup related payments from providers, only if approved by HHSC.

A Clean Claim must meet all requirements for accurate and complete data as defined in the appropriate 837 encounter guides as follows:

(1) 837 Dental Implementation Guide; and

(2) 837 Dental Companion Guide;

The Dental Contractor may not require a dentist or dental provider to submit documentation that conflicts with the requirements of 28 Tex. Admin. Code Chapter 21, Subchapters C and T.

If an additional payment is due to a provider as a result of an audit, the Dental Contractor must make the payment no later than 30 Days after it completes the audit. If the audit indicates that the Dental Contractor is due a refund from the provider, the Dental Contractor must send the provider written notice of the basis and specific reasons for the recovery no later than 30 Days after it completes the audit. If the provider disagrees with the Dental Contractor's request, the Dental Contractor must give the provider an opportunity to appeal and may not attempt to recover the payment until the provider has exhausted all appeal rights. If the Dental Contractor recouped and did not allow provider time to appeal, Dental Contractor must repay the provider for funds recouped.

The Dental Contractor must obtain recovery of payment from a liable third party and not from the provider unless the provider received payment from both the Dental Contractor and the liable third party. The Dental Contractor must notify HHSC of a claims processing Major Systems Change in writing no later than 180 Days prior to implementation. The Dental Contractor must provide an implementation plan and schedule of proposed changes. HHSC may require a desk or on-site readiness review of the changes.

The Dental Contractor must inform all Providers about the information required to submit a claim at least 30 Days prior to the Operational Start Date and as a provision within its Provider Contract. The Dental Contractor must make any policies affecting claims adjudication and claims coding and processing guidelines available to Providers for the applicable Provider type. Providers must receive 90 Days written notice prior to the Dental Contractor's implementation of changes to these claims policies and guidelines.

The Provider Contract must specify that program violations arising out of performance of the Provider Contract are subject to administrative enforcement by the HHSC OIG as specified in 1 Tex. Admin. Code Chapter 371, Subchapter G.

2.3.29.5 CLAIMS PROJECT

For purposes of this section, claims project means a project initiated by a Dental Contractor, outside of the Provider Appeal process, after payment or denial of claim(s) for

the purpose of conducting any necessary research on the claim(s) or to adjust the claim(s), if appropriate.

Dental Contractor may initiate a claims project at its own initiative. All claims included in a particular claims project must be finalized within 60 Days of the claims project being opened or within an agreed upon timeframe between the Provider and the Dental Contractor. The Dental Contractor must enter a written agreement with the Provider before the expiration of the initial 60 day period to establish the claims project's agreed upon timeframe. Dental Contractor must maintain the agreement for 18 months from the conclusion of the claims project and make the agreement available to HHSC upon request. Dental Contractor will report monthly to HHSC the start and end date for all claims projects using HHSC's report template.

Claims projects must be included in the quarterly claims report including interest paid. All claims projects must be reported to the HHSC MCCO team on the required standardized report. Any claims project that exceeds 60 Days must receive prior approval for an extension from MCCO.

2.3.29.6 NATIONAL CORRECT CODING INITIATIVE

For all claims filed, the Dental Contractor must comply with the requirements of 42 U.S.C. § 1396b(r)(1)(B)(iv), regarding the National Correct Coding Initiative, including all applicable rules, regulations, and methodologies implemented as a result of this initiative.

2.3.30 ELECTRONIC FUND TRANSFER

Dental Contractor must offer Providers electronic fund transfers (EFT) for claims payment, or other direct deposit operations such as paycheck deposits, as a safe alternative to paper checks for payment of claims. Dental Contractor must make EFT available to Providers whether claims are filed electronically or in hardcopy. Dental Contractor must utilize a financial subsystem that provides the technological capability to process EFT using HIPAA national standards for electronic payment and remittance advice. Dental Contractor must ensure that no less than 85 percent of the dollars processed as claims payments are issued via EFT.

The Dental Contractor not meeting the stated EFT processing standard must develop a plan and corresponding timeline for HHSC approval that improves the payment processing system to a level of maturity to support and achieve the stated performance standard.

2.3.31 FRAUD, WASTE, AND ABUSE

The Dental Contractor is subject to all state and federal laws and regulations relating to Fraud, Waste, and Abuse (FWA) in the Dental Program including Gov't. Code §§ 531.102, 531.113, 531.1131, and 533.012; 1 Tex. Admin. Code §§ 353.501-353.505; 1 Tex. Admin. Code §§ 370.501-370.505; and 1 Tex. Admin. Code Chapter 371 Subchapter G.

The Dental Contractor must cooperate and assist the HHSC Office of Inspector General (OIG) and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected FWA.

The Dental Contractor must submit a written Fraud, Waste, and Abuse compliance plan to HHSC OIG for approval each year per 1 Texas Admin. Code 353.502. The plan must be submitted 90 Days prior to the start of the State Fiscal Year. See Section 7, "Transition Phase Requirements" for requirements regarding timeframes for submitting the original plan.

The Dental Contractor must require all employees who process Medicaid and CHIP claims, including Subcontractors, to attend annual training as provided by HHSC per Tex. Gov't Code § 531.105.

The Dental Contractor must perform pre-payment review for identified providers as directed by OIG. When requested by the HHSC OIG, the Dental Contractor will be required to provide employees to participate in administrative proceedings pursued by the HHSC OIG. Such employees must be knowledgeable about the subject matter on which they are called to testify and must be available for preparatory activities and for formal testimony. The Dental Contractor must provide the employees at no cost to HHSC.

Failure to comply with any requirement of Sections 2.3.31 may subject the Dental Contractor to liquidated damages, as specified in Attachment F, or administrative enforcement pursuant to 1 Tex. Admin. Code Chapter 371 Subchapter G, in addition to any other legal remedy.

2.3.31.1 Fraud, Waste, and Abuse Compliance Plan

The Dental Contractor must submit a written FWA compliance plan to HHSC OIG for approval each year. The plan must be submitted 90 Days prior to the start of the SFY. The compliance plan must address how the Dental Contractor will meet each of the requirements outlined in 42 C.F.R. § 438.608 (a) and 1 Tex. Admin. Code § 353.502.

As part of the FWA compliance plan, the Dental Contractor must:

a. Designate executive and essential personnel to attend mandatory HHSC conducted training in FWA detection, prevention, and reporting. Executive and essential FWA personnel means Dental Contractor staff persons who supervise staff in the following areas:
   - i Data collection;
   - ii Provider credentialing and Network oversight;
   - iii Encounter Data;
   - iv Claims processing;
   - v Utilization Management;
   - vi Complaint or Appeal;
   - vii Quality assurance and marketing;

viii Special investigation unit; and
ix Those who are directly involved in the decision making and administration of the FWA detection program within the Dental Contractor's organization.

Training will be conducted free of charge by the HHSC Office of Inspector General (OIG). The Dental Contractor must schedule, and all designated executive and essential personnel must complete training no later than 90 Days after the Effective Date;

b. Designate an officer or director, who must have additional resources in addition to him or herself, within the Dental Contractor's organization, responsible for carrying out the provisions of the FWA compliance plan;

If a Dental Contractor has not made any changes to its plan from the previous year, it may submit a notice to HHSC OIG in lieu of the compliance plan that:

1. No changes have been made to the previously approved plan and;
2. The plan will remain in place for the upcoming SFY.

HHSC OIG may request an updated plan, regardless of such notice. In addition to the compliance plan, the Dental Contractor must submit supplemental documentation describing how it has met the requirement of the compliance plan for the previous year. The notification must be signed and certified by an officer or director of the Dental Contractor that is responsible for carrying out the FWA compliance plan.

2.3.31.2 Special Investigative Units

In order to facilitate cooperation with OIG, the Dental Contractor must establish and maintain a special investigative unit (SIU), either-in house or by contract with another entity, to investigate possible acts of FWA for all services provided under the Contract, including those that the Dental Contractor subcontracts to outside entities.

The Dental Contractor's SIU does not have to be physically located in Texas but must be adequately staffed and with resources apportioned at the levels and experience sufficient to effectively work Dental Program cases based on objective criteria considering, but not necessarily limited to, the Dental Contractor's total Dental Member population, claims processes, risk exposure, current caseload, and other duties as described in 1 Tex. Admin. Code §§ 353.501-353.505, and 1 Tex. Admin. Code §§ 370.501-370.505..

The Dental Contractor must maintain a full-time SIU manager dedicated solely to the Texas Medicaid and CHIP programs to direct oversight of the SIU and Fraud, Waste, and Abuse activities.

The Dental Contractor SIU must employ or subcontract, at minimum, one full-time investigator, in addition to the SIU manager, who is dedicated solely to the services provided under the Texas Medicaid and CHIP contracts. The investigator must hold credentials such as a certification from the Association of Certified Fraud Examiners, an accreditation from the National Health Care Anti-Fraud Association, or have a minimum of three (3) years Medicaid or CHIP Fraud, Waste, and Abuse investigatory experience.

2.3.31.3 General Requests for and Access to Data, Records, and Other Information

The Dental Contractor and its Subcontractors must allow access to all premises and provide complete, unredacted and accurate originals or copies of all records and information requested free of charge to HHSC OIG, HHSC, CMS, the U.S. Department of Health and Human Services (DHHS), the Federal Bureau of Investigation (FBI), the Office of the Attorney General (OAG), TDI, or other units of the State that have requested the information. The Dental Contractor must provide all copies of records free of charge. See **Attachment A, HHSC Dental Contract Terms and Conditions**, for additional requirements. The Dental Contractor must:

1. Designate one primary and one secondary contact person for all records requests. Each Dental Contractor must also identify a central group email inbox that will receive all HHSC OIG records requests. HHSC OIG records requests will be sent to the designated Dental Contractor contact person(s) in writing by email, fax, mail, or established file exchange process and will provide the specifics of the information being requested;
2. Respond to the appropriate requestor within the timeframe designated in the request. If the Dental Contractor is unable to provide all of the requested information within the designated timeframe to HHSC OIG, the Dental Contractor may request an extension in writing to the requestor no less than two Business Days prior to the due date; and
3. The Dental Contractor's response must include complete, unredacted and accurate data for all data fields, as available. The data must be provided in the order and format requested. If any data field is left blank, an explanation must accompany the response. The Dental Contractor must not add or delete any additional data fields in its response. All requested information must be accompanied by a notarized business records affidavit unless indicated otherwise in the record request
4. The Dental Contractor must retain records in accordance with **Chapter 18 of the UMCM**.
5. The Dental Contractor must respond to requests for interpretations or clarifications of the Dental Contractor's policy and procedures within five Business Days.
6. The Dental Contractor must provide the basis for providing case-by-cases, value-added services, and Comprehensive Care Program (CCP) services provided through Texas Health Steps on an as needed basis.

The most common requests include but are not limited to:

a. 3 Business Days - 1099 and other financial information; urgent claims data requests;
b. 10 Business Days - Claims data
c. 10 Business Days - provider education information

d. 15 Business Days - files associated with an investigation conducted by a Dental Contractor
e. The OIG may request other information as needed, these requests must be submitted within the timeframes specified by the OIG.
f. Requests submitted to the Dental Contractor for interpretations or clarifications of the Dental Contractor policy and procedure- five Business Days Other time-sensitive requests – as needed.

2.3.31.4 CLAIMS DATA SUBMISSION REQUIREMENTS

The Dental Contractor and its Subcontractors must submit Adjudicated claims data per the frequency and scope prescribed by HHSC OIG. This data must include submission of complete, unredacted and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of all paid and denied claims. In the event that the Dental Contractor or its Subcontractors denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the Dental Contractor and its Subcontractors are required to submit all available claims data for such denied claims to HHSC OIG without alteration or omission.

The Dental Contractor and its Subcontractors must submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by HHSC OIG, in order to support comprehensive financial reporting, utilization analysis, and investigative efforts.

The Dental Contractor and its Subcontractors must supply EFT account numbers in the frequency and scope required by HHSC OIG for all Medicaid or CHIP providers who have elected to receive payments via EFT.

2.3.31.5 PAYMENT HOLDS AND SETTLEMENTS

42 C.F.R. § 455.23 and 1 Tex. Admin. Code § 371.1709, require the HHSC OIG to suspend all Medicaid payments to a provider in certain circumstances after HHSC OIG determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program. HHSC OIG may include the Dental Contractor's capitation payments in a suspension when an individual Provider is under investigation based upon credible allegations of fraud.

The Dental Contractor must cooperate with HHSC OIG timely and efficiently when HHSC OIG imposes payment suspensions or lifts a payment hold. When HHSC OIG sends notice to the Dental Contractor that payments to a provider have been suspended or the suspension lifted by HHSC OIG, the Dental Contractor must also suspend or lift suspension of payments to the provider within one Business Day of receiving the notice and notify HHSC OIG within three Business Days of the action taken. If the Dental Contractor fails to implement the payment hold or improperly releases funds, HHSC may assess actual damages in the amount not held or released improperly.

The Dental Contractor must report information on payment holds initiated by HHSC OIG or the Dental Contractor, as specified in **Chapter 5 of the UMCM**. The Dental Contractor must respond to the HHSC OIG request for payment hold amounts accurately and, in the manner, and format requested. HHSC may assess actual damages for the difference between the accurate adjudicated amount required to be reported by the Dental Contractor under **Chapter 5 of the UMCM** and the amount received by HHSC OIG. The Dental Contractor must follow the requirements set forth in a settlement agreement involving a Dental Contractor's Provider and HHSC OIG. The Dental Contractor must withhold the designated percentage of funds to be paid toward an identified overpayment. Upon HHSC OIG request, the Dental Contractor must forward the held funds to **HHSC OIG, Attn: Senior Case Analyst**, along with an itemized spreadsheet detailing the Provider's claims paid.

Dental Contractor must maintain all documents and claim data on Providers who are under HHSC OIG investigation or any internal investigations that are referred to HHSC OIG for recoupment. The Dental Contractor's failure to comply with this section and all state and federal laws and regulations relating to FWA are subject to administrative enforcement by HHSC OIG.

The Dental Contractor will have no claim to any funds that are recovered by the State of Texas or the United States Government from a Provider through an action under the Federal False Claims Act, Texas Medicaid Fraud Prevention Act, or similar laws. The recovery of an overpayment by a Dental Contractor from a Provider does not preclude the prosecution of, nor recovery from a Provider under the Federal False Claims Act, Texas Medicaid Fraud Prevention Act, or similar laws.

The Dental Contractor must apply payment holds to providers participating in cost reporting with HHSC, at the request of HHSC.

2.3.31.6 Treatment of Recoveries by the Dental Contractor for Fraud Waste and Abuse

Pursuant to 42 C.F.R. § 438.608(d)(1)(i), the Dental Contractor must comply with all state and federal laws pertaining to Provider recoveries including Texas Government Code § 531.1131 and § 353.1454.

The Dental Contractor must have internal policies and procedures for the documentation, retention, and recovery of all overpayments, specifically for the recovery of overpayments due to Fraud, Waste, and Abuse.

In cases identified by the HHSC OIG, the HHSC OIG has the right to recover any identified overpayment directly from the Provider or to require the Dental Contractor to recover the identified overpayment and distribute funds to the State:

1. The Dental Contractor will have no claim to any funds that are recovered by the State of Texas or the United States Government from a Provider through an action under the Federal False Claims Act, Texas Medicaid Fraud Prevention Act, or similar laws. The recovery of an overpayment by a Dental Contractor from a Provider does not preclude the prosecution of nor recovery from a Provider under the Federal False Claims Act, Texas Medicaid Fraud Prevention Act, or similar laws.
2. Upon discovery of Fraud, Waste, or Abuse the Dental Contractor shall:
    - i Submit a referral using the fraud referral form through the Waste, Abuse, and Fraud Electronic Reporting System (WAFERS);
    - ii Proceed with recovery efforts related to waste; and
    - iii Proceed with recovery efforts per 1 Tex. Admin. Code § 353.505.
3. The Dental Contractor may retain recovery amounts pursuant to Texas Government Code § 531.1131(c) and (c-1).
4. Pursuant to Government Code § 531.1131(c-3), the Dental Contractor is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a Provider when the issues, services, or claims upon which the recoupment or withhold are based meet one or more of the following criteria:
    a. Upon written notice from HHSC OIG that it has begun recovery efforts, the Dental Contractor is prohibited from taking any actions to recoup or withhold improperly paid funds.
        i. The prohibition described in this subsection shall be limited to a specific provider(s), for specific dates, and for specific issues, services, or claims. The Dental Contractor must not engage in any reprocessing, recoupments, and other payment recovery efforts or claims adjustments of any kind based on the parameters set by HHSC OIG.
        ii. The prohibition does not impact any current Dental Contractor contractual obligations as well as any reprocessing, recoupment, other payment recovery efforts, or claims adjustments for claims that fall outside those identified in the written notice from HHSC OIG.
    b. The improperly paid funds have already been recovered by HHSC OIG.
5. The Dental Contractor must report at least annually, or at the request of the HHSC OIG, to the status of their recoveries of overpayments in the manner specified by the HHSC OIG.

2.3.31.7 False Claims Act and Whistleblowing

In accordance with Section 1902(a)(68) of the Social Security Act (False Claims Act), Dental Contractor and its Subcontractors that receive or make annual Medicaid payments of at least $5 million must:

1. Establish written policies for all employees, managers, officers, contractors, Subcontractors, and agents of the Dental Contractor or Subcontractor, that provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A) of the Social Security Act;
2. Include detailed provisions regarding the Dental Contractor's or Subcontractor's policies and procedures must include for detecting and preventing FWA; and
3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A) of the Social Security Act, the rights of employees to be protected as whistleblowers, and the Dental Contractor's or Subcontractor's policies and procedures for detecting and preventing FWA.

2.3.32 Continuity of Care and Out-of-Network Providers

The Dental Contractor must ensure that the care of newly enrolled Dental Members is not disrupted or interrupted.

Upon notification from a Dental Member or Provider of the existence of a PA, the new Dental Contractor must ensure Dental Members receiving services through a PA from either another Dental Contractor or Fee-for-Service (FFS) receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following:

1. 90 Days after the transition to a new Dental Contractor;
2. Until the end of the current authorization period; or
3. Until the Dental Contractor has evaluated and assessed the Dental Member and issued or denied a new authorization. For instances in which a newly enrolled Dental Member transitioning from FFS to managed care was receiving a service that did not require a PA in FFS, but does require one by the new Dental Contractor, the Dental Contractor must ensure Dental Members receive services for the same amount, duration, and scope for the shortest period of one of the following:
   a. 90 Days; or
   b. Until the Dental Contractor has evaluated and assessed the Dental Member and issued or denied a new authorization.

Additionally, if a Dental Member is new to a Dental Contractor, and is completing one or more dental procedures initiated prior to joining, the Dental Contractor is only responsible for payment for the continued course of treatment, if such treatment is a Medically

Necessary Covered Dental Service and has not already been paid in full by the Dental Member's previous Dental Contractor.

The Dental Contractor must pay a Dental Member's existing Out-of-Network (OON) providers for Medically Necessary Covered Dental Services until the Dental Member's records, clinical information, and care can be transferred to a Network Provider, or until such time as the Member is no longer enrolled with that Dental Contractor, whichever is shorter. The Dental Contractor must comply with OON rules as described in 1 Tex. Admin. Code § 353.4.

The Dental Contractor must provide Dental Members with timely and adequate access to OON services for as long as those services are necessary and covered benefits are not available within the Network, in accordance with 42 C.F.R. § 438.206(b)(4). The Dental Contractor will not be obligated to provide a Dental Member with access to OON services if such services become available from a Network Provider.

The Dental Contractor must ensure that each Dental Member has access to a second opinion regarding any Medically Necessary Covered Dental Service. A Dental Member must be allowed access to a second opinion from a Network Provider or OON provider if a Network Provider is not available, at no cost to the Dental Member, in accordance with 42 C.F.R. § 438.206(b)(3). The requirements in this section regarding access to and payment of OON providers apply only to OON providers who are enrolled Texas Medicaid providers.

If a Medicaid Dental Member enrolled with a Dental Contractor for at least one month is receiving orthodontic treatment and either ages out of the Dental Program or loses eligibility, the Dental Contractor is responsible for completion of the course of treatment. The only exception is if the Medicaid Dental Member is disenrolled with cause but is still Medicaid eligible. For example, if a Medicaid Dental Member goes into a state supported living center, the Dental Contractor will no longer be responsible for services rendered.

2.3.33 PAYMENTS TO FEDERALLY QUALIFIED HEALTH CENTERS, RURAL HEALTH CLINICS, AND CERTAIN PHYSICIANS

The Dental Contractor must pay full encounter rates to Rural Health Clinics (RHCs) for Medically Necessary Covered Dental Services using the prospective payment methodology described in Social Security Act §§ 1902(bb) and 2107(e)(1). Because the Dental Contractor is responsible for the full payment amount in effect on the date of service for RHCs, HHSC cost settlements, or "wrap payments", will not apply.

When the Dental Contractor negotiates payment amounts with Federally Qualified Health Clinics (FQHCs), the amounts must be greater than or equal to the average of the Dental Contractor's payment terms for other Providers providing the same or similar services. Because the Dental Contractor may negotiate payment amounts with FQHCs, wrap payments apply. Dental Contractor may elect to pay the FQHC wrap payment at the time

of claim adjudication but no later than the 15th Day of the following month for claims paid in the prior month. After the Dental Contractor pays a wrap payment, HHSC will make a supplemental payment to the Dental Contractor in the amount of the wrap payment.

If a Dental Member visits an FQHC, RHC, or a Municipal Health Department's public clinic for Health Care Services (public clinic) at a time that is outside of normal business hours, as defined by HHSC in rules, including weekend days or holidays, the Dental Contractor must reimburse the FQHC, RHC, or public clinic for Medically Necessary Covered Dental Services. The Dental Contractor must do so at a rate that is equal to the allowable rate for those services as determined under Tex. Hum. Res. Code § 32.028. The Member does not need a referral from his or her Main Dentist. If a Member visits an Out-of-Network (OON) FQHC, the Dental Contractor is obligated to reimburse the FQHC a full encounter rate for Medically Necessary Covered Dental Services provided as if the OON FQHC were a Network Provider. This encounter rate is paid entirely as a wrap payment no later than the 15th Day of the following month for services provided in the prior month. After the Dental Contractor pays a wrap payment, HHSC will make a supplemental payment to the Dental Contractor in the amount of the wrap payment by the last day of the following month. An FQHC's OON claim is subject to the same claim standards requirements as the Dental Contractor's in-network providers. This section applies to services provided to Medicaid and CHIP Dental Members.

If a Dental Member who is an Indian enrollee visits an OON Indian Health Care Provider (IHCP) for Covered Services, the Dental Contractor is obligated to timely reimburse the IHCP in compliance with 42 C.F.R. § 438.14 or as follows:

1. At a rate negotiated between the Dental Contractor and the IHCP, or
2. If the Dental Contractor and IHCP have not negotiated a rate, at a rate not less than the level and amount the Dental Contractor would pay a participating provider that is not an IHCP for the services.

An IHCP's OON claim is subject to the same claims standards requirements as the Dental Contractor's Providers.

2.3.34 OBJECTION TO PROVIDE CERTAIN SERVICES

In accordance with 42 C.F.R. § 438.102, the Dental Contractor may file an objection to providing, reimbursing for, or providing coverage of, a counseling or referral service for a Covered Dental Service based on moral or religious grounds. The Dental Contractor must work with HHSC to develop a work plan to complete the necessary tasks and determine an appropriate date for implementation of the requested changes to the requirements related to Medically Necessary Covered Dental Services. The work plan will include timeframes for completing the necessary Contract and waiver amendments, adjustments to Capitation Rates, identification of the Dental Contractor and enrollment materials needing revision, and notifications to Dental Members.

In order to meet the requirements of this section, the Dental Contractor must notify HHSC of grounds for and provide detail concerning its moral or religious objections and the specific services covered under the objection, no less than 120 Days prior to the proposed effective date of the policy change.

The Dental Contractor must notify their Dental Members of any policy change 30 Days before the policy effective date and must inform Dental Members when these services are not covered and how to obtain information on receiving these services from HHSC.

2.3.35 PAYMENT BY ELIGIBLE MEDICAID MEMBERS

Except as provided in **Section 2.3.35.1**, Dental Contractor, Network Providers, and OON providers are prohibited from billing or collecting any amount from a Dental Member, their authorized representatives, LAR, or guardian, for Medically Necessary Covered Dental Services. See 1 Tex. Admin. Code § 354.1005.

As provided in **Section 10.10 of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**, the Dental Contractor must inform Dental Members of their responsibility to pay the costs for non-covered services, and must require its Providers to:

1. Inform Dental Members of costs for non-covered services prior to rendering such services; and
2. Obtain a signed private pay form from such Dental Members.

2.3.35.1 CHIP DENTAL CONTRACTOR

CHIP Network Providers and OON Providers may collect copayments from CHIP Dental Members as authorized in the CHIP State Plan. For purposes of this section, CHIP Dental Members will be referred to as member(s).

The EB will notify the Dental Contractor when a member's family's cost share limit has been reached. Upon such notification, the Dental Contractor must generate and mail to the member a new Dental Member ID card within five Days, showing that the member's cost-sharing obligation for that term of coverage has been met. No cost-sharing may be collected from these members for the balance of their term of coverage.

The Dental Contractor must ensure that Providers do not collect copayments at any income level for Medically Necessary Covered Dental Services that qualify as routine preventive and diagnostic dental services, as defined by Section 2103(e)(2) of the Social Security Act and 42 C.F.R. § 457.520.

Except for costs associated with unauthorized non-emergency services provided to a member by OON providers and for non-covered dental services, the copayments outlined in the CHIP Cost Sharing Table in **Chapter 6 of the UMCM** are the only amounts that a provider may collect from a CHIP-eligible family. Although the Emergency Dental Services described in **Section 2.3.7** are Non-capitated Services, the Dental Contractor must

educate members and Providers that cost sharing for such Emergency Dental Services is limited to the copayment amounts set forth in **Chapter 6 of the UMCM**. If the cost of a Covered Dental Service is less than the member's copayment for that Covered Dental Service, the copayment amount the member pays will be capped at the cost of the Covered Dental Service.

The Dental Contractor's Provider Contracts must limit the amount CHIP Providers may charge members for services in excess of the member's benefit limits. The Dental Contractor must ensure that a Provider agrees to limit charges to the Providers' contracted rates for services that would have been Covered Dental Services, if the services were within the benefit limit.

Federal law prohibits charging premiums, deductibles, coinsurance, copayments, or any other cost-sharing to members that are Native Americans or Alaskan Natives. The HHSC Administrative Dental Services Contractor will notify the Dental Contractor of members who are not subject to cost-sharing requirements. The Dental Contractor must train Providers regarding the cost-sharing waiver for this population.

The Dental Contractor's monthly Premium Payment will not be adjusted for a member's family's failure to make its CHIP premium payment. There is no relationship between the Premium Payment owed to the Dental Contractor for coverage provided during a month, and the family's payment of its CHIP premium obligations for that month.

2.3.36 COORDINATION WITH OTHER STATE HEALTH AND HUMAN SERVICES PROGRAMS

The Dental Contractor must coordinate with other state Health and Human Services Programs regarding the provision of essential public health care services. The Dental Contractor must meet the following requirements:

1. Cooperate and coordinate with managed care organizations or the Fee-for-Service Medical Transportation Program, as appropriate, to ensure Dental Members have access to NEMT Services.
2. Cooperate and coordinate with the THSteps outreach unit to ensure prompt delivery of services to Dental Members who miss dental checkups.
3. Cooperate and coordinate with HHSC, outreach programs, and THSteps regional program staff and agents to ensure prompt delivery of services to Farmworker Child(ren) and other migrant populations who may transition into and out of the Dental Contractor's Program more rapidly or unpredictably than the general population.
4. Coordinate care protocols for working with Dental Contractors, as well as protocols for reciprocal referral and communication of data and clinical information regarding the Member's Medically Necessary Covered Dental Services.

2.3.37 ATTORNEY GENERAL COOPERATION

To the extent HHSC, the State of Texas, or any other State agency is named in any lawsuit, the defense must be coordinated by Dental Contractor with the Office of the Attorney General, and Dental Contractor may not agree to any settlement without first obtaining the concurrence from the Office of The Attorney General.

2.3.38 CMS INTEROPERABILITY AND PATIENT ACCESS

Effective January 1, 2021, Dental Contractors and CHIP Dental Contractors are required by federal law to implement and maintain a Patient Access Application Programming Interface (API) and a Provider Directory API using the required Health Level 7 Fast Healthcare Interoperability Resources-based standards.

The Dental Contractor must comply with the Patient Access API requirements in 42 C.F.R. § 438.242(b)(5) and the Provider Directory API requirements in 42 C.F.R. § 438.242(b)(6), including the provider directory information specified in 42 C.F.R. § 438.10(h)(1) and (2). The CHIP Dental Contractor must comply with the Patient Access API requirements in 42 C.F.R. § 457.1233(d) and the Provider Directory API requirements in 42 C.F.R. § 457.1233, including the provider directory information specified in 42 C.F.R. § 438.10(h)(1) and (2). More detailed information regarding the federal compliance requirements can be found in the CMS Interoperability and Patient Access Final Rule in the May 1, 2020 issue of the Federal Register (85 FR 25510-01). Additional guidance can also be found in the 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program in the May 1, 2020 issue of the Federal Register.

2.3.38.1 PAYER-TO-PAYER DATA EXCHANGE

Effective January 1, 2022, the Dental Contractor must comply with an individual's request to have the individual's health data transferred from payer to payer.

The rule finalizes the requirements in 42 C.F.R. § 438.62(b)(1)(vi) and (vii) for the creation of a process for the electronic exchange of, at a minimum, the data classes and elements included in the United States Core Data for Interoperability (USCDI) content standard adopted at 45 C.F.R. § 170.213.

2.3.39 MATERIAL SUBCONTRACTORS

The Dental Contractor or its designee will conduct routine monitoring of each Material Subcontractor that is also a delegated entity or a third-party administrator, in accordance with its assessed risk process, to ensure compliance with the performance of all delegated functions. The Dental Contractor must maintain a monitoring plan for each Material Subcontractor that is also a delegated entity or a third-party administrator.

The Dental Contractor must maintain documentation as to the compliance of the Material Subcontractor with all requirements defined in the monitoring plan. This documentation must contain evidence that all appropriate and necessary actions were taken to correct any noncompliance.

The Dental Contractor must allow HHSC to attend meetings between the Dental Contractor and its Material Subcontractors and/or to receive the minutes from these meetings upon request. Upon request, the Dental Contractor must provide a final report of the routine monitoring results

2.4 PERFORMANCE INCENTIVES AND DISINCENTIVES

This section documents performance incentives and disincentives related to HHSC's value-based purchasing approach. For further information, refer to **ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS.**

The Dental Contractor must provide the Services and Deliverables, including Medically Necessary Covered Dental Services to enrolled Dental Members, in order for monthly Capitation Payments to be paid by HHSC.

Refer to **Article 9 of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS** for information concerning Capitation Rate development and for information and requirements on the:

1. Time and manner of payment (**Section 9.02**),
2. Adjustments to capitation payments (**Section 9.07**), and
3. Experience Rebate (**Section 9.08**).

Incentives and disincentives are subject to change by HHSC over the course of the Contract. The methodologies required to implement these strategies will be refined by HHSC after collaboration with contracting Dental Contractor. The Dental Contractor is prohibited from passing down financial disincentives or sanctions imposed on the Dental Contractor to Dental Providers, except on an individual basis and related to the individual Provider's inadequate performance.

2.4.1 NON-FINANCIAL INCENTIVES AND DISINCENTIVES

HHSC will distribute information on key performance indicators to Dental Contractor on a regular basis, identifying a Dental Contractor's performance, and comparing that performance to other Dental Contractors, and HHSC standards or external Benchmarks. HHSC may recognize the Dental Contractor that attains superior performance or improvement. HHSC may post its final determination regarding poor or exceptional Dental Contractor peer group performance comparisons on its website.

2.4.1.1 PERFORMANCE INDICATOR DASHBOARD FOR QUALITY MEASURES

HHSC will track key indicators of Dental Contractor performance through the use of a performance indicator dashboard for quality measures, described in **Chapter 10 of the UMCM**. HHSC will compile the performance indicator dashboard based on Dental Contractor submissions, data from the EQRO, and other data available to HHSC. The performance indicator dashboard is not an all-inclusive set of performance measures; HHSC will measure other aspects of the Dental Contractor's performance as well. The performance indicator dashboard assembles performance indicators that assess many of the most important dimensions of the Dental Contractor's performance, and includes measures that when publicly shared, will also serve to incentivize excellence.

2.4.1.2 AUTO-ASSIGNMENT METHODOLOGY FOR MEDICAID DENTAL CONTRACTOR

HHSC may revise its auto-assignment methodology for enrollees who do not select a Dental Contractor based on Dental Contractor performance.

2.4.2 FINANCIAL INCENTIVES AND DISINCENTIVES

Financial Incentives and Disincentives of the Contract are set forth below.

2.4.2.1 DENTAL PAY-FOR-QUALITY

Under the dental pay-for-quality (P4Q) program, HHSC will place each Dental Contractor at risk for a percentage of the capitation payment(s) for performance in a calendar year. HHSC may modify the percentage of the capitation payment placed at risk.

HHSC will pay the Dental Contractor the full monthly capitation payments as described in **Article 9 of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**. At the end of the dental P4Q data collection period, HHSC will evaluate the Dental Contractor's performance and assign points and dollar amounts using the measures and methodology set out in **Chapter 6 of the UMCM**.

Failure to timely provide HHSC with necessary data related to the calculation of the dental P4Q performance indicators will result in HHSC's assignment of a zero percent performance rate for each related performance indicator.

Dental Contractor must report actual capitation payments received on the FSRs during the FSR Reporting Periods that are at risk (i.e., the Dental Contractor will not report Revenues at a level equivalent to, for example, 96% of the payments received, leaving some percentage as contingent). Any subsequent loss of the at-risk amount that may be realized will be reported below the income line as an informational item, and not as an offset to Revenues or as an allowable cost as described in the **Chapter 5 of the UMCM**.

HHSC may modify the methodology and measures of the dental P4Q program as it deems necessary and appropriate, in order to motivate, recognize, and reward Dental Contractor for superior performance.

2.4.3 REMEDIES AND LIQUIDATED DAMAGES

All areas of responsibility and all requirements in the Dental Contract will be subject to performance evaluation by HHSC. HHSC may impose remedies for violations of any and all responsibilities or requirements that the Dental Contractor has not fulfilled. Refer to the Attachment A, "HHSC Dental Contract Terms and Conditions," and Attachment F, "Deliverables/Liquidated Damages Matrix", for performance standards that carry liquidated damage values

2.4.4 FREW INCENTIVES AND DISINCENTIVES

As required by the *Frew v. Smith* "Corrective Action Order: Managed Care," this Contract includes a system of incentives and disincentives associated with Children of Migrant Farm Workers Reports. These incentives and disincentives apply only to Medicaid.

The incentives and disincentives and corresponding methodology are set forth in **Chapter 12 of the UMCM**.

2.4.5 ADDITIONAL INCENTIVES AND DISINCENTIVES

HHSC will evaluate all performance-based incentive and disincentive methodologies annually and in consultation with the Dental Contractor. HHSC may modify the methodologies as needed, or develop additional methodologies, as funds become available, or as mandated by court decree, statute, or rule in order to promote and recognize Dental Contractor's' performance under the Contract. The Dental Contractor must participate in any incentive or disincentive programs or methodologies as determined by HHSC.

2.5 ADDITIONAL CHILDREN'S MEDICAID DENTAL SERVICES SCOPE OF WORK

The following provisions apply only to the Children's Medicaid Dental Members. The Children's Medicaid Dental Members will be referred to as "members" throughout **Section 2.5**.

2.5.1 PROVISIONS RELATED TO MEDICALLY NECESSARY COVERED DENTAL SERVICES FOR CHILDREN'S MEDICAID DENTAL MEMBERS

2.5.1.1 TEXAS HEALTH STEPS (EPSDT) DENTAL CHECKUPS

The Dental Contractor must develop effective methods to ensure that children birth through age 20 receive Texas Health Steps (THSteps) dental services and must arrange for these services for all eligible members, except when a member knowingly and voluntarily declines or refuses services after receiving sufficient information to make an informed decision.

The Dental Contractor must provide dental checkups to its members every 6 months, starting at 6 months of age. Children from 6 through 35 months of age who are participating in the First Dental Home services may be eligible for visits every 3 months, if determined Medically Necessary. Newly enrolled members must receive a dental checkup no later than 90 Days after enrollment. The Dental Contractor must ensure dental checkups are provided in a timely manner to its members.

The Dental Contractor must cooperate and coordinate with the THSteps outreach unit and THSteps regional program staff and agents to ensure prompt delivery of services to all members, but particularly for Farmworker Child(ren) who may transition into and out of the Dental Contractor's Dental Program more rapidly or unpredictably than the general population.

2.5.1.2 TEXAS HEALTH STEPS EDUCATION/OUTREACH

The Dental Contractor must ensure that Members are provided information and educational materials about the dental services available through the THSteps Program, and how and when Members may obtain the services. The information must inform the Members how they can obtain dental benefits, NEMT Services through their managed care organizations or the Fee-for-Service Medical Transportation Program, and advocacy and assistance from the Dental Contractor. The Dental Contractor must use the standard language describing THSteps services as provided in **Chapter 3 of the UMCM**. Any additions to or deviations from the standard language must be reviewed and approved by HHSC prior to publication and distribution to Members.

Each month, the Dental Contractor must retrieve from the HHSC EB bulletin board system a list of Members who are due for THSteps dental checkups. Using these lists and its own internally generated list, the Dental Contractor must contact such Members to encourage scheduling the service as soon as possible.

The Dental Contractor must cooperate and coordinate with the Texas Health Steps Outreach and Informing Unit to ensure prompt delivery of services to Members who miss dental checkups.

The Dental Contractor must coordinate and cooperate with existing community and school-based health and education programs that offer services to school-aged children in a location that is convenient to the Members. Upon request from a Head Start program, the Dental Contractor must coordinate with the Head Start program to assist Members with scheduling THSteps dental checkups. This coordination should include informing Head Start programs how to request scheduling assistance from the Dental Contractor when a member needs a THSteps dental checkup.

2.5.1.3 TEXAS HEALTH STEPS DATA VALIDATION

The Dental Contractor must require all Providers delivering THSteps services to submit claims for services paid, either on a capitated or fee-for service basis, on the ADA claim form, and use the HIPAA compliant code set required by HHSC.

2.5.1.4 FARMWORKER CHILD(REN)

The Dental Contractor must identify community and statewide groups that work with Farmworker Child(ren) (FWC) in Texas. The Dental Contractor must cooperate and coordinate with as many of these groups as possible and encourage the groups to assist with identification of FWC.

The Dental Contractor must make efforts to reach identified FWC to provide timely THSteps dental checkups and needed follow-up care. Checkups and follow-up care must be in accordance with the timeframes in the Contract for appointment availability.

For purposes of this section, "Accelerated Services" are services that are needed by FWC prior to leaving their home area for work in other states. Accelerated Services include the provision of preventive services that will be due during the time the FWC is out of Texas, as well as treatment services that should not be delayed until after the return to Texas. When necessary, the Dental Contractor must provide Accelerated Services to FWC members. The need for Accelerated Services must be determined on a case-by-case basis and according to the needs of the FWC.

The Dental Contractor must maintain accurate lists of all identified FWC. Additionally, the Dental Contractor must maintain confidentiality of information about the identity of the FWC.

In accordance with **Chapter 12 of the UMCM**, the Dental Contractor must submit an annual report that describes:

1. Methods used to identify FWC enrolled with the Dental Contractor and encourage timely checkups;
2. Efforts to coordinate with community and statewide groups working with FWC;
3. Methods used to assess FWC oral health needs and provide Accelerated Services when necessary;

4. How the Dental Contractor maintains accurate lists of FWC enrolled in the Dental Program; and
5. How the Dental Contractor maintains confidentiality about the identify of FWC.

2.5.1.5 MEDICAID NON-CAPITATED SERVICES

The following Texas Medicaid programs, services, or benefits have been excluded from Medically Necessary Covered Dental Services. Members are eligible to receive these Non-capitated Services on another basis, such as a Fee-for-Service basis, or through a Medical Dental Contractor for most medical services. Dental Contractor should refer to relevant chapters in **ATTACHMENT H, TEXAS MEDICAID PROVIDER PROCEDURES MANUAL** for more information:

1. THSteps environmental lead investigation;
2. Early Childhood Intervention case management/service coordination;
3. Case Management for Children and Pregnant Women;
4. Texas School Health and Related Services;
5. HHSC's Fee-for-Service Medical Transportation Program and NEMT Services; and
6. Emergency Dental Services as described in **Section 2.3.7**.

Members are eligible to receive these Non-capitated Services on a Fee-for-Service basis. Dental Contractor should refer to relevant chapters in the Texas Medicaid Provider Procedures Manual for more information.

2.5.1.6 REFERRALS FOR NON-CAPITATED SERVICES

The Dental Contractor must educate members regarding the availability of Non-capitated Services and provide appropriate referrals for members to obtain or access these services. The Dental Contractor is responsible for informing Providers that bills for Non-capitated Services must be submitted to HHSC's Claims Administrator or Dental Contractor for reimbursement. The Dental Contractor is not responsible for paying for or reimbursing for these services described in 1 Tex. Admin. Code §§ 380.101, *et seq*., and 25 Tex. Admin. Code §§ 27.1 *et seq.*

2.5.2 PROVIDER COMPLAINTS AND INTERNAL DENTAL CONTRACTOR APPEALS

The following sections outline minimum requirements for the Dental Contractor's Provider Complaints and Internal Appeals process.

2.5.2.1 PROVIDER COMPLAINTS

The Dental Contractor must develop, implement, and maintain a system for tracking and resolving all Provider Complaints. The Dental Contractor must resolve Provider Complaints within 30 Days from the date the Complaint is received by the Dental Contractor. The Dental Contractor's tracking system must include the status and final disposition of each Provider complaint. Dental Contractor must also resolve Provider Complaints received by HHSC in accordance with **Chapter 3 of the UMCM**. The Dental Contractor must provide information specified in 42 C.F.R. § 438.10(g)(2)(xi) about the Complaints and internal Dental Contractor Appeals system to all Providers and Subcontractors at the time they enter into a contract.

2.5.2.2 PROVIDER APPEAL OF DENTAL CONTRACTOR CLAIMS DETERMINATIONS

The Dental Contractor must develop, implement, and maintain a system for tracking and resolving all Provider Internal Appeals related to claims payment, as required by Tex. Gov't Code § 533.005(a)(15). Within this process, the Dental Contractor must respond fully and completely to each Provider's claims payment appeal and establish a tracking mechanism to document the status and final disposition of each Provider's claims payment appeal. In addition, the Dental Contractor's process must comply with the requirements of Tex. Gov't Code § 533.005(a)(19).

The Dental Contractor must contract with dentists who are OON providers to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a Provider appeal. The dentist resolving the dispute must not be an employee of the Dental Contractor's Medicaid or CHIP business but may be an employee in the Dental Contractor's commercial lines of business. The determination of the dentist resolving the dispute must be binding on the Dental Contractor and the Provider. The dentists resolving the dispute must be licensed in the State of Texas and hold the same specialty or a related specialty as the appealing Provider. HHSC may amend this process to include an independent review process established by HHSC for final determination on these disputes.

2.5.3 MEMBER RIGHTS AND RESPONSIBILITIES

In accordance with 42 C.F.R. § 438.100, all Dental Contractor must maintain written policies and procedures for informing members of their rights and responsibilities and must notify their members of their right to request a copy of these rights and responsibilities. The Member Handbook must include notification of member rights and responsibilities, as set forth in **the UMCM**.

2.5.4 MEMBER COMPLAINTS AND INTERNAL APPEALS SYSTEM

The Dental Contractor must develop, implement, and maintain a Member Complaints and Internal Appeals system for tracking, resolving, and reporting member's Complaints regarding its services, processes, procedures, and staff and for tracking, resolving, and reporting Member Internal Appeals regarding the denial or limited authorization of a requested service, including the type or level of service and the denial, in whole or in part, of payment for service that complies with the requirements in applicable federal and state laws and regulations, including 42 C.F.R. § 431.200, 42 C.F.R. Part 438, Subpart F and the provisions of 1 Tex. Admin. Code Chapter 357 relating to Medicaid managed care organizations. The Dental Contractor must not identify a member Complaint as any form of inquiry or request. The Dental Contractor must acknowledge the Member's Complaint, in writing, within five Business Days after the Dental Contractor receives the Complaint unless the complaint is an Initial Contact Complaint. As the Texas Department of Insurance does not require the reporting of those issues to TDI (see 28 Tex. Admin. Code §3.9202(2)), the Dental Contractor must report this subcategory of Complaints to HHSC as "Initial Contact Complaint."

The Dental Contractor must ensure that member Complaints are resolved within 30 Days after receipt. The State will refer member Complaints that it receives regarding the Dental Contractor to the Dental Contractor for resolution.

Dental Contractor also must resolve Member Complaints received by HHSC no later than the due date indicated on HHSC's notification form. HHSC will provide Dental Contractor up to ten Business Days to resolve such Complaints, depending on the severity or urgency of the Complaint and no more than the maximum Days allowed as stated in **Chapter 3 of the UMCM** unless an extension has been granted. Dental Contractor must provide a valid reason for the extension request prior to the due date and the request must include requirements in **Chapter 3 of the UMCM**. HHSC may, in its discretion, grant a written extension if the Dental Contractor demonstrates good cause.

The Complaints and Appeals system must include a Complaints process, an Appeals process, and access to HHSC's State Fair Hearing System. The procedures must be the same for all members and must be reviewed and approved in writing by HHSC. Modifications and amendments to the Member Complaint and Internal Dental Contractor Appeal system must be submitted for HHSC's approval at least 30 Days prior to their implementation.

The Dental Contractor must ensure that standard and expedited Member Internal Appeals are resolved within the specified timeframes, unless the Dental Contractor can document that the member requested an extension, or the Dental Contractor shows there is a need for additional information and the delay is in the member's interest. The Dental Contractor must respond fully and completely to each Internal Appeal and establish a tracking mechanism to document the status and final disposition of each Internal Appeal.

2.5.4.1 MEMBER ADVOCATES

The Dental Contractor must provide Member Advocates to assist members. Member Advocates must be physically located within the state unless an exception is approved by HHSC. Member Advocates must inform members of the following:

1. Their rights and responsibilities;
2. The Complaints process;
3. The Appeals process;
4. Available Medically Necessary Covered Dental Services, including preventive services; and
5. Available Non-capitated Services.

Member Advocates must assist members in writing Complaints and are responsible for monitoring the Complaint through the Dental Contractor's Complaints process.

Member Advocates are responsible for making recommendations to the Dental Contractor's management on any changes needed to improve either the dental services provided, or the way dental services are delivered. Member Advocates are also responsible for helping or referring members to community resources available to meet member needs that are not available from the Dental Contractor as Medically Necessary Covered Dental Services.

2.5.4.2 DENTAL CONTRACTOR MEMBER COMPLAINTS PROCESS

For purposes of this section, an "authorized representative" is any person or entity acting on behalf of the member and with the member's written consent. A Provider may be an authorized representative.

The member or member's authorized representative may file a Complaint either orally or in writing. The Dental Contractor must also inform members how to file a Complaint directly with HHSC, once the member has exhausted the Dental Contractor's Complaints process.

The Dental Contractor must designate an officer of the Dental Contractor who has primary responsibility for ensuring that Complaints are resolved in compliance with written policy and within the required timeframe. For purposes of this section, an "officer" of the Dental Contractor means a president, vice president, secretary, treasurer, or chairperson of the board for a corporation, the sole proprietor, the managing general partner of a partnership, or a person having similar executive authority in the organization.

The Dental Contractor must have a routine process to detect patterns of Complaints. Dental Contractor's management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Complaints.

The Dental Contractor's Complaints process must be provided to members in writing and through oral interpretive services. A written description of the Dental Contractor's

Complaints process must be available in Prevalent Languages identified by HHSC, at no more than a 6th grade reading level. The Dental Contractor must provide such oral interpretive service to callers free of charge.

The Dental Contractor must include a written description of the Complaints process in the Member Handbook. The Dental Contractor must maintain and publish in the Member Handbook, at least one toll-free telephone number with Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capabilities for making Complaints.

The Dental Contractor's process must require that every Complaint received in person, by telephone, or in writing must be acknowledged and recorded in a written record and logged with the following details:

1. A description of the reason for the member's Complaint;
2. The date received;
3. The date of each review or, if applicable, review meeting;
4. Resolution at each level of the member's Complaint if applicable;
5. Date of resolution at each level, if applicable; and
6. Name of the member for whom the Complaint was filed.

The records must be accurately maintained in a manner accessible to HHSC and available upon request to CMS.

For Complaints that are received in person or by telephone, the Dental Contractor must provide members or their representatives with written notice of resolution, if the Complaint cannot be resolved within one working day of receipt.

The Dental Contractor is prohibited from discriminating or taking punitive action against a member or his or her representative for making a Complaint.

If a member makes a request for disenrollment from a Dental Contractor and wants to select a different Dental Contractor, or if a member is voluntarily enrolled in the Dental Program and would like to disenroll, the Dental Contractor must give the member information on the disenrollment process and direct the member to the EB. If the member is enrolled in the Dental Program on a mandatory basis and requests disenrollment, the Dental Contractor must direct the member to the HHSC Ombudsman. If the request for disenrollment includes a Complaint by the member, the Complaint will be processed separately from the disenrollment request, through the Complaint process.

The Dental Contractor will cooperate with HHSC to resolve all member Complaints. Such cooperation may include, but is not limited to, providing information or assistance to HHSC.

The Dental Contractor must provide designated Member Advocates, as described in **Section 2.5.4.1**, to assist members in understanding and using the Dental Contractor's Complaints process. The Dental Contractor's Member Advocates must assist members in

writing or filing a Complaint and monitoring the Complaint through the Dental Contractor's Complaints process until the issue is resolved.

2.5.4.3 MEDICAID DENTAL CONTRACTOR'S INTERNAL APPEALS PROCESS

The Dental Contractor must develop, implement, and maintain an Internal Appeals process that complies with state and federal laws and regulations, including 42 C.F.R. § 431.200 and 42 C.F.R. Part 438, Subpart F. An Appeal is a disagreement with a Dental Contractor Adverse Benefit Determination as further defined in **ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**. The Internal Appeals process must be the same for all members. When a member or his or her authorized representative, LAR, or guardian expresses orally or in writing any dissatisfaction or disagreement with an Adverse Benefit Determination, the Dental Contractor must regard the expression of dissatisfaction as a request to Appeal an Action.

Texas Medicaid is using the External Medical Review process provided in 42 C.F.R. 438.408(f)(1)(ii). Medicaid Dental Contracts are still expected to comply with the other applicable requirements of the Texas Insurance Code, including Chapter 4201.

The Dental Contractor must have policies and procedures in place outlining the Dental Director's role in an Appeal of an Action. The Dental Director must have a significant role in monitoring, investigating, and hearing Appeals. In accordance with 42 C.F.R. § 438.406, the Dental Contractor's policies and procedures must require that individuals who make decisions on Appeals are not involved in any previous level of review or decision-making, and are dental care professionals who have the appropriate dental expertise in treating the member's dental condition or disease.

The Dental Contractor must provide designated Member Advocates, as described in **Section 2.5.4.1**, to assist members in understanding and using the Internal Appeals process. The Dental Contractor's Member Advocates must assist members in writing or filing an Appeal and monitoring the Appeal through the process until the issue is resolved.

The Dental Contractor must have a routine process to detect patterns of Internal Appeals. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Internal Appeals.

The Dental Contractor's Internal Appeals process must be provided to members in writing and through oral interpretive services. A written description of the Internal Appeals process must be available in Prevalent Languages identified by HHSC, at no more than a 6th grade reading level. The Dental Contractor must include a written description of the Appeals process in the Member Handbook. The Dental Contractor must maintain and publish in the Member Handbook at least one toll-free telephone number with TTY/TDD and interpreter capabilities for requesting an Internal Appeal. The Dental Contractor must provide such oral interpretive service to callers free of charge.

The Dental Contractor's process must treat every oral request for a Dental Contractor Internal Appeal in the same manner as a written request. The date of the oral request should be treated as the filing date of the request. All Dental Contractor's Internal Appeals must be recorded in a written record and logged with the following details:

1. A general description of the reason for the member's Internal Appeal.
2. The date received.
3. The date of each review or, if applicable, review meeting.
4. Resolution at each level of the member's Internal appeal, if applicable.
5. Date of resolution at each level, if applicable.
6. Name of the covered person from whom the Internal Appeal was filed.

The record must be accurately maintained in a manner accessible to the HHSC and available upon request to CMS.

A member must file a request for a Dental Contractor Internal Appeal within 60 Days from receipt of the notice of the Adverse Benefit Determination. To ensure continuation of currently authorized services, the member must file the Internal Appeal on or before the later of:

1. Ten Days following the Dental Contractor's sending of the notice of the Adverse Benefit Determination, or
2. The intended effective date of the proposed Adverse Benefit Determination.

The Dental Contractor must send a letter to the member within five Business Days acknowledging receipt of the Internal Appeal request. Except for the resolution of an Expedited Dental Contractor Internal Appeal as provided in **Section 2.5.4.4**, the Dental Contractor must complete the entire Internal Appeal process within 30 Days after receipt of the initial written or oral request for Appeal. The timeframe for an Internal Appeal may be extended up to 14 Days if the member or his or her representative requests an extension; or the Dental Contractor shows that there is a need for additional information and how the delay is in the member's interest. If the timeframe is extended, the Dental Contractor must give the member written notice of the reason for delay, if the member had not requested the delay. The Dental Contractor must designate an officer who has primary responsibility for ensuring that Internal Appeals are resolved within these timeframes and in accordance with the Dental Contractor's written policies.

During the Internal Appeals process, the Dental Contractor must provide the member a reasonable opportunity to present evidence and any allegations of fact or law, in person, as well as, in writing. The Dental Contractor must inform the member of the time available for providing this information and in the case of an expedited resolution, that a limited time will be available.

The Dental Contractor must provide the member and his or her representative opportunity, before and during the Internal Appeals process, to examine the member's case file, including dental records and any other documents considered during the Appeal process.

The Dental Contractor must include, as parties to the Appeal, the member and his or her representative or the legal representative of a deceased member's estate.

In accordance with 42 C.F.R. § 438.420, the Medicaid Dental Contractor must continue the benefits currently being received by the member, including the benefit that is the subject of the Appeal, if all of the following criteria are met:

1. The member or his or her representative files the Appeal timely as defined in the Contract;
2. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
3. The services were ordered by an authorized Provider;
4. The original period covered by the original authorization has not expired; and
5. The member requests an extension of the benefits.

If, at the member's request, the Medicaid Dental Contractor continues or reinstates the member's benefits while the Appeal is pending, the benefits must be continued until one of the following occurs:

1. The member withdraws the Appeal or request for a State Fair Hearing;
2. Ten Days pass after the Dental Contractor mails the notice resolving the Appeal against the member, unless the member, within the ten-day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision can be reached; or
3. A State Fair Hearing officer issues a hearing decision adverse to the member, or the time period or service limits of a previously authorized service have been met.

In accordance with state and federal regulations, if the final resolution of the Internal Appeal is adverse to the member and upholds the Dental Contractor's Action, then, to the extent that the services were furnished to comply with the Contract, the Dental Contractor must not recover such costs from the member without written permission from HHSC.

If the Dental Contractor, Independent Review Organization (IRO), or State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the Internal Appeal was pending, the Dental Contractor must authorize or provide the disputed services as expeditiously as the member's health condition requires; but no later than 72 hours from the date it receives notice reversing the determination.

If the Dental Contractor, IRO, or State Fair Hearing Officer reverses a decision to deny authorization of services and the member received the disputed services while the Internal Appeal was pending, the Dental Contractor is responsible for the payment of services.

The Dental Contractor is prohibited from discriminating or taking punitive action against a member or his or her representative for making an Internal Appeal and is subject to corrective action or remedies for any action against a member or their LAR, guardian, or authorized representative for making an Internal Appeal.

2.5.4.4 EXPEDITED MEDICAID DENTAL CONTRACTOR'S INTERNAL APPEALS PROCESS

In accordance with 42 C.F.R. § 438.410, the Dental Contractor must establish and maintain an expedited review process for Internal Appeals, when the Dental Contractor determines (for a request from a member) or the Provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain or regain maximum function. The Dental Contractor must follow all Internal Appeals requirements as set forth in **Section 2.5.4.3**, except where differences are specifically noted in this section.

The Dental Contractor must accept oral or written requests for Expedited Internal Appeals. A Dental Contractor must provide access to the member's case file free of charge and sufficiently in advance of the timeframe for the Expedited Internal Appeal.

Members must exhaust the Expedited Internal Appeal process before making a request for an expedited State Fair Hearing/EMR. After the Dental Contractor receives the request for an Expedited Internal Appeal, it must hear an approved request for a member to have such an appeal and notify the member of the outcome within 72 hours.

The timeframe for notifying the member of the outcome may be extended up to 14 Days, if the member requests an extension or the Dental Contractor shows, to the satisfaction of HHSC, upon HHSC's request, that there is a need for additional information and how the delay is in the member's interest. If the timeframe is extended, the Dental Contractor must give the member written notice of the reason for delay, if the member had not requested the delay.

If the decision is adverse to the member, the Dental Contractor must follow the procedures relating to the notice in **Section 2.5.4.5.1**. The Dental Contractor is responsible for notifying the member of his or her right to access an EMR and/or an expedited State Fair Hearing from HHSC. The Dental Contractor will be responsible for providing documentation to HHSC and the member, indicating how the decision was made, prior to HHSC's expedited State Fair Hearing.

The Dental Contractor is prohibited from discriminating or taking punitive action against a member or his or her representative for requesting an Expedited Internal Appeal. The Dental Contractor must ensure that punitive action is not taken against a Provider who requests an Expedited Internal Appeal or supports a member's request. The Dental Contractor is subject to corrective action or remedies for any action against a member, their authorized representative, LAR, guardian or a Provider for making an Expedited Internal Appeal.

If the Dental Contractor denies a request for expedited resolution of an Appeal, it must:

1. Transfer the Appeal to the timeframe for standard resolution, and

2. Make a reasonable effort to give the member prompt oral notice of the denial and follow up within two Days with a written notice.

2.5.4.5 ACCESS TO STATE FAIR HEARING AND EXTERNAL MEDICAL REVIEW FOR MEDICAID MEMBERS

The Dental Contractor must inform members that they have the right to access the State Fair Hearing process, with or without an External Medical Review (EMR), only after exhausting its Internal Appeal process. The Member may request an EMR and/or State Fair Hearing if the Dental Contractor fails to respond to the Member's Appeal within the timeframe in 42 C.F.R. § 438.408. The Dental Contractor must notify Members that they may be represented by an authorized representative in the State Fair Hearing process. The Dental Contractor must notify members that they may be represented by an authorized representative, LAR, or guardian in the State Fair Hearing process.

The EMR is an optional, extra step a Member may request to further review the Dental Contractor's Adverse Benefit Determination. The EMR will not consider new evidence. The Dental Contractor must provide the IRO the same set of records the Dental Contractor reviewed to determine service denial. EMRs will be conducted by Independent Review Organizations (IROs) contracted by HHSC. The role of the IRO is to act as an objective arbiter and decide whether the Dental Contractor's original Adverse Benefit Determination must be reversed or affirmed. The EMR will take place between the Dental Contractor Internal Appeal and the State Fair Hearing. The Dental Contractor is responsible for implementing the IRO EMR decisions of "overturned" or "partially overturned" within 72 hours of receiving the EMR decision from the IRO.

If a member requests a State Fair Hearing, the Dental Contractor will complete and submit the request via facsimile to the appropriate State Fair Hearings office, within five Days of the member's request for the hearing. If the Member requests an EMR, the Dental Contractor will enter the request into TIERS, along with MCO Internal Appeal decision supporting documentation, and submit the request via TIERS to the HHSC Intake Team within three Days of the Member's request for EMR.

Within five Days of notification that the State Fair Hearing is set, the Dental Contractor will prepare an evidence packet for submission to the HHSC Fair Hearings staff and send a copy of the packet to the member. The evidence packet must comply with HHSC's State Fair Hearings requirements.

The Dental Contractor must ensure that the appropriate staff members who have firsthand knowledge of the member's Appeal, in order to be able to speak and provide relevant information on the case, attend all scheduled State Fair Hearings.

2.5.4.5.1 INDEPENDENT REVIEW ORGANIZATION (IRO) REIMBURSEMENT FOR EXTERNAL MEDICAL REVIEWS (EMRS)

The Dental Contractor is responsible for all IRO costs for EMRs related to Adverse Benefit Determinations of medical necessity. The Dental Contractor must reimburse HHSC for such costs within the timeframes specified by HHSC. The Dental Contractor must not pass any IRO-related costs on to providers or Members.

The Dental Contractor will reimburse the, HHSC at a rate calculated by HHSC, for an EMR HHSC assigns to the IRO which the Member subsequently withdraws prior to or on the 10-Day due date of the IRO EMR decision.

Dental Contractor will pay the IRO $300.00 if the Member withdraws a non-expedited EMR request within five Calendar Days from the date the IRO receives notice of the EMR request, provided the IRO has not rendered an EMR decision.

2.5.4.6 NOTICES OF ADVERSE BENEFIT DETERMINATION AND DISPOSITION OF INTERNAL DENTAL CONTRACTOR APPEALS FOR MEDICAID MEMBERS

The Dental Contractor must notify the member, in accordance with 1 Tex. Admin. Code Chapter 357, whenever the Dental Contractor takes an Adverse Benefit Determination. The notice must, at a minimum, include:

1. The dates, types, and amount of service requested;
2. The Adverse Benefit Determination the Dental Contractor has taken or intends to take;
3. The reasons for the Adverse Benefit Determination. If the Adverse Benefit Determination taken is based upon a determination that the requested service is not Medically Necessary, the Dental Contractor must provide an explanation of the medical basis for the decision, application of policy or accepted standards of dental practice to the individual's oral health condition, in its notice to the member;
4. The member's right to access the Dental Contractor's Internal Appeal process;
5. The procedures by which the member may Appeal the Dental Contractor's Action;
6. The circumstances under which expedited resolution is available and how to request it;
7. The circumstances under which a member may continue to receive benefits pending resolution of the Internal Appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services;
8. The date the Adverse Benefit Determination will be taken;

9. A reference to the Dental Contractor policies and procedures supporting the Dental Contractor's Action;
10. An address where written requests may be sent and a toll-free number that the member can call to request the assistance of a member representative, file an Internal Appeal, or request a State Fair Hearing;
11. An explanation that members may represent themselves, or be represented by a Provider, a friend, a relative, legal counsel, or another spokesperson;
12. A statement that if the member wants a State Fair Hearing on the Action, the member must make the request for a State Fair Hearing within 120 Days of the date on the notice or the right to request a hearing is waived;
13. A statement explaining that the Dental Contractor must make its decision within 30 Days from the date the Internal Appeal is received by the Dental Contractor, or 72 hours in the case of an Expedited Internal Appeal; and
14. A statement explaining that the hearing officer must make a final decision within 90 Days from the date a State Fair Hearing is requested.

Note to Respondents. The above services may not have been incorporated into the UMCM at the time this Contract was awarded. In the event they have not been, such services will be as part of the current HHSC UMCM change process. The Contract will be amended appropriately at that time.

2.5.4.7 TIMEFRAME FOR NOTICE OF ACTION

In accordance with 42 C.F.R. § 438.404(c), the Dental Contractor must mail a notice of Adverse Benefit Determination within the following timeframes:

1. For termination, suspension, or reduction of previously authorized Medicaid-Covered Dental Services, at least 15 Business Days before the termination, suspension, or reduction of previously authorized services, or within the timeframes specified in 42 C.F.R. §§ 431.211, 431.213, and 431.214;
2. For denial of payment, at the time of Adverse Benefit Determination affecting the claim;
3. For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R. § 438.210(d)(1);
4. If the Dental Contractor extends the timeframe in accordance with 42 C.F.R. § 438.210(d)(1), it must:
    a. Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file an Internal Appeal if he or she disagrees with that decision; and
    b. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires;
5. For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d), which constitutes a denial and is thus an Adverse Benefit Determination, on the date that the timeframes expire; and

6. For expedited service authorization decisions, within the timeframes specified in 42 C.F.R. § 438.210(d): and
7. All timeframes required in **Chapter 3.21 of the UMCM**.

2.5.4.8 NOTICE OF DISPOSITION OF INTERNAL APPEAL

In accordance with 42 C.F.R. § 438.408(e), the Dental Contractor must provide written notice of disposition of all Internal Appeals, including Expedited Internal Appeals. The written resolution notice must be sent to the member and legal representative acting on behalf of the member and must include the results and date of resolution. For decisions not wholly in the member's favor, the notice must contain:

1. The right to request a State Fair Hearing/EMR;
2. How to request a State Fair Hearing/EMR;
3. The circumstances under which the member may continue to receive benefits pending a State Fair Hearing/EMR;
4. How to request the continuation of benefits;
5. If the Dental Contractor's Adverse Benefit Determination is upheld in a State Fair Hearing, the member may be liable for the cost of any services furnished to the member while the Internal Appeal is pending; and

Any other information required by 1 Tex. Admin. Code Chapter 357 that relates to a managed care organization's notice of disposition of an Internal Appeal.

2.5.4.9 Timeframe for Notice of Resolution of Appeals

In accordance with 42 C.F.R. § 438.408, the Dental Contractor must provide written notice of resolution of Appeals, including Expedited Dental Contractor Appeals, as expeditiously as the Member's health condition requires, but the notice must not exceed the timelines provided in this section for Appeals or Expedited Dental Contractor Appeals. For expedited resolution of Appeals, the Dental Contractor must make reasonable efforts to give the Member prompt oral notice of resolution of the Appeal and follow up with a written notice within the timeframes set forth in this section. If the Dental Contractor denies a request for expedited resolution of an Appeal, the Dental Contractor must transfer the Appeal to the timeframe for resolution as provided in this section, and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two Days with a written notice.

2.5.5 THIRD PARTY LIABILITY, RECOVERY, AND COORDINATION OF BENEFITS

Medicaid is the payer of last resort for Covered Dental Services when coordinating benefits with all other insurance coverage, unless an exception applies under federal or state law. Coverage provided under Medicaid will pay benefits for Medically Necessary Covered

Dental Services that remain unpaid after all other insurance coverage has been paid. For Network Providers and OON providers with written reimbursement arrangements with the Dental Contractor, the Dental Contractor must pay the unpaid balance for Medically Necessary Covered Dental Services up to the agreed rates. For OON providers with no written reimbursement arrangement, the Dental Contractor must pay the unpaid balance for Medically Necessary Covered Dental Services in accordance with HHSC's administrative rules regarding OON payment. 1 Tex. Admin. Code § 353.4

The Dental Contractor has 120 Days from the date of adjudication of a claim that is subject to TPR to attempt recovery of the costs for services that should have been paid through a third party. The Dental Contractor must obtain recovery of payment from a liable third party and not from the provider, unless the provider received payment from both the Dental Contractor and the liable third party. The Dental Contractor must provide HHSC, on a monthly basis, by the tenth Day of each month, a report indicating the claims where the Dental Contractor has billed or made a recovery up to the 120th Day from adjudication of a claim that is subject to TPR.

The Dental Contractor must establish and document a plan and process, referred to as the Third Party Liability (TPL) Dental Contractor Action Plan, in accordance with UMCM Chapter 5, for avoiding and recovering costs for services that should have been paid through a third party, including health insurers, self-insured plans, group health plans, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1166(1), service benefit plans, managed care organizations, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a dental care item or service.

The TPL Dental Contractor Action Plan and process must be in accordance with state and federal law and regulations, including Sections 1902(a)(25)(E) and (F) of the Social Security Act, which require Dental Contractors to first pay and later seek recovery from liable third parties:

1. For preventive pediatric care, and
2. Services provided to an individual on whose behalf child support enforcement is being carried out by the State agency under Part D of title IV of the Social Security Act.

Each Dental Contractor must submit the TPL Dental Contractor Action Plan to the Office of Inspector General-Third Party Recoveries (OIG-TPR), in accordance with UMCM Chapter 5, no later than September 1 for the upcoming state fiscal year for review and approval. Dental Contractors must submit any change requests to the TPL Dental Contractor Action Plan for review and approval no later than 90 Days prior to the date of the proposed changes. The projected amount of TPR that the Dental Contractors is expected to recover may be factored into the rate setting process.

HHSC will provide the Dental Contractor, by plan code, a daily member file, also known as a TPR Client Insurance File, which is an extract of those Dental Members who are known to have other insurance. The file contains any Third Party Recovery (TPR) data that HHSC's claims administrator has on file for individual Dental Members, organized by name and Dental Member number, and adding additional relevant information where available, such as the insured's name and contact information, type of coverage, the insurance carrier, and the effective dates. The file will be considered the system of record. The Dental Contractor is required to continue to share other insurance information for its enrolled Dental Members with HHSC that differs or is not included on the TPR Client Insurance File, in accordance with **Chapter 5 of the UMCM**, per the current process of submitting the TPR Dental Contractor Referral Form found in the **Chapter 5 of the UMCM**.

The Dental Contractor must provide financial reports to HHSC, as stated in Section 2.3.28.2.2, "Financial Reporting Requirements" in accordance with UMCM Chapter 5.

The Dental Contractor must provide all TPR reports to OIG-TPR at the frequency stated in and in accordance with **Chapter 5 of the UMCM**.

After 120 Days, HHSC will attempt recovery for any claims in which the Dental Contractor did not attempt recovery and will retain, in full, all funds received as a result of the HHSC-initiated TPR. The Dental Contractor is precluded from attempting to bill for any recovery after 120 Days from the claim adjudication date. Any collections by the Dental Contractor billed after 120 Days from claim adjudication date must be sent to OIG-TPR in the format prescribed in **Chapter 5 of the UMCM**. The Dental Contractor is to continue to cost avoid and cost recover where applicable.

After 365 Days from adjudication of a claim, the Dental Contractor loses all rights to pursue or collect any recoveries subject to TPR. HHSC has sole authority for recoveries of any claim subject to TPR after 365 Days from the date of adjudication of a claim. Should the Dental Contractor receive payment on a HHSC-initiated recovery, the Dental Contractor must send the payment to the OIG-TPR in the format prescribed in **Chapter 5 of the UMCM**.

HHSC retains the responsibility to pursue, collect, and retain recoveries of all resources and insurances other than health insurance wherein payments have been made on behalf of a Dental Member. These resources and other insurances include, but are not limited to: casualty insurance, liability insurance, estates, child support, and personal injury claims. The Dental Contractor must pay valid claims for Covered Dental Services provided to Dental Members who have, or may have, resources and insurances other than health insurance. Since HHSC retains the right of recovery for such resources and insurances other than health insurance, the Dental Contractor is not permitted to cost avoid or seek recovery for such items. Should the Dental Contractor receive payment on a claim in which resources or insurances other than health insurance are utilized, the Dental Contractor must send the payment to OIG-TPR in the format prescribed in **Chapter 5 of the UMCM**.

Dental Members with these other resources shall remain enrolled with the Dental Contractor.

2.6 SSI MEMBERS

A Member's SSI status is effective the date the State's eligibility system identifies the Member as Type Program 13 (TP13). HHSC is responsible for updating the State's eligibility system within 45 Days of official notice of the Member's SSI eligibility by the Social Security Administration. For CHIP Dental Program Members identified as TP13, when HHSC has updated the State's eligibility system, following standard eligibility cut-off rules, HHSC will allow the CHIP Member to prospectively move to the Medicaid Dental Program. HHSC will not retroactively disenroll a Dental Member from the CHIP Dental Program.

2.7 ADDITIONAL CHIP SCOPE OF WORK

Dental Contractor must not avoid costs for Covered Services by referring Members to publicly funded health care resources.

The provisions in 2.7 only apply to CHIP.

2.7.1 CHIP PROVIDER COMPLAINT AND INTERNAL DENTAL CONTRACTOR APPEALS

CHIP Provider Complaints and claims payment appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. The Dental Contractor must resolve Provider complaints and claims payment appeals within 30 Days from the date of receipt.

2.7.2 COMPLAINTS FROM PROVIDERS

The Dental Contractor must develop, implement, and maintain a system for tracking and resolving all Provider Complaints. The Dental Contractor must respond fully and completely to each Complaint and establish a tracking mechanism to document the status and final disposition of each Provider Complaint that is received.

Dental Contractor must resolve Provider Complaints received by HHSC by the due date indicated on HHSC's notification form, but no later than ten Business Days from receipt of Complaint from HHSC. If a Dental Contractor cannot resolve a complaint by the due date indicated on the notification form, it must submit a written request to HHSC to extend the deadline. HHSC may grant a written extension if the Dental Contractor demonstrates good cause for an extension in its written request.

2.7.3 APPEAL OF PROVIDER CLAIMS

The Dental Contractor must develop, implement, and maintain a system for tracking and resolving all Appeals from Providers and OON providers related to claims payment. Within this process, the Dental Contractor must respond fully and completely to each provider's claims payment appeal. The Dental Contractor must establish a tracking mechanism to document the status and final disposition of each Provider's claims payment appeal. The Dental Contractor must finalize all claims, including appealed claims, within 24 months of the date of service.

2.7.4 CHIP MEMBER COMPLAINTS AND APPEALS PROCESSES

CHIP Member Complaints and Appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. HHSC will require the Dental Contractor to resolve Complaints and Appeals that are not elevated to TDI within 30 Days from the date the Complaint or Appeal is received unless the Dental Contractor can document that the CHIP Dental Member requested an extension, or the Dental Contractor demonstrates to HHSC there is a need for additional information and the delay is in the CHIP Dental Member's interest. If the Dental Contractor extends the timeframes not at the request of the CHIP Dental Member, it must make reasonable efforts to give the Member prompt oral notice of the delay; within two Days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file an appeal if the Dental Member disagrees with that decision; and resolve the appeal as expeditiously as the Dental Member's health condition requires and no later than the date the extension expires. Any person, including those dissatisfied with a Dental Contractor's resolution of a CHIP Dental Member's Complaint or Appeal, may report an alleged violation to TDI.

2.7.5 THIRD PARTY LIABILITY AND RECOVERY AND COORDINATION OF BENEFITS

CHIP is the payer of last resort for Covered Dental Services when coordinating benefits with all other insurance coverage, unless an exception applies under federal law. Coverage provided under CHIP will pay benefits for Medically Necessary Covered Dental Services that remain unpaid after all other insurance coverage has been paid. For Network Providers and Out-of-Network providers with written reimbursement arrangements with the Dental Contractor, the Dental Contractor must pay the unpaid balance for Covered Dental Services up to the agreed CHIP rates. For Out-of-Network providers with no written reimbursement arrangement, the Dental Contractor must pay the unpaid balance for Covered Dental Services in accordance with 1 Tex. Admin. Code §353.4 regarding Out-of-Network payment.

The Dental Contractor is responsible for establishing and documenting a plan and process, referred to as the Third Party Liability (TPL) Dental Contractor Action Plan, in accordance with **Chapter 5 of the UMCM**, for avoiding and recovering costs for services that should have been paid through a third party in accordance with applicable state and federal laws, rules, and regulations (including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service).

The TPL Dental Contractor Action Plan and process must be in accordance with state and federal laws and regulations, including Sections 1902(a)(25)(E) and (F) of the Social Security Act, which require Dental Contractors to first pay and later seek recovery from liable third parties for (1) preventive pediatric care, and (2) services provided to a Dental Member on whose behalf child support enforcement action is being carried out by the State agency under Part D of title IV of the Social Security Act. Each Dental Contractor must submit the TPL Dental Contractor Action Plan to the Office of Inspector General, Third Party Recoveries (OIG-TPR), in accordance with **Chapter 5 of the UMCM**, no later than September 1 for the upcoming state fiscal year for review and approval. Dental Contractors must submit any change requests to the TPL Dental Contractor Action Plan for review and approval no later than 90 calendar Days prior to the date of the proposed changes.

The projected amount of TPR that the Dental Contractor is expected to recover may be factored into the rate setting process.

The Dental Contractor must provide financial reports that include TPR data to HHSC, as stated in Section 2.3.28.2.2, Financial Reporting Requirements.

The Dental Contractor must provide all TPR reports to Office of Inspector General-Third Party Recoveries (OIG-TPR) at the frequency and in accordance with the **Chapter 5 of the UMCM**.

The Dental Contractor has 120 Days from the date of adjudication of a claim that is subject to TPR to attempt recovery of the costs for services that should have been paid through a third party. The Dental Contractor must obtain recovery of payment from a liable third party and not from the provider, unless the provider received payment from both the Dental Contractor and the liable third party. The Dental Contractor shall provide to HHSC, on a monthly basis by the tenth Day of each month, a report indicating the claims where the Dental Contractor has billed and made a recovery up to the 120th Day from adjudication of a claim that is subject to TPR. After 120 Days, HHSC will attempt recovery for any claims in which the Dental Contractor did not attempt recovery and will retain, in full, all funds received as a result of the any state-initiated TPR. The Dental Contractor is precluded from attempting to bill for any recovery after 120 Days from claim adjudication date. Any collections by the Dental Contractor billed after 120 Days from the claim adjudication date must be sent to OIG-TPR in the format prescribed in **Chapter 5 of the UMCM**. The Dental

Contractors are to continue to cost avoid and cost recover where applicable.

After 365 Days from adjudication of a claim, the Dental Contractor loses all rights to pursue or collect any recoveries subject to TPR. HHSC has sole authority for recoveries of any claim subject to TPR after 365 Days from the date of adjudication of a claim. Should the Dental Contractor receive payment on a HHSC-initiated recovery, the Dental Contractor must send the payment to the OIG-TPR in the format prescribed in **Chapter 5 of the UMCM**.

HHSC retains the responsibility to pursue, collect, and retain recoveries of all resources and insurances other than health insurance wherein payments have been made on behalf of a Dental Member. These resources and other insurances include, but are not limited to: casualty insurance, liability insurance, estates, child support, and personal injury claims. The Dental Contractor must pay valid claims for Covered Dental Services provided to Dental Members who have, or may have, resources and insurances other than health insurance. Since HHSC retains the right of recovery for such resources and insurances other than health insurance, the Dental Contractor is not permitted to cost avoid or seek recovery for such items. Should the Dental Contractor receive payment on a claim in which resources or insurances other than health insurance are utilized, the Dental Contractor must send the payment to OIG-TPR in the format prescribed in **Chapter 5 of the UMCM**. Dental Members with these other resources shall remain enrolled with the Dental Contractor.

2.8 TURNOVER REQUIREMENTS

This section presents the Turnover Phase. The Dental Contractor is required to perform all required activities prior to, or upon, and following termination, expiration, merger, or acquisition of the Contract in accordance with the HHSC-approved Turnover Plan.

2.8.1 TURNOVER PLAN

Twelve months after the Effective Date, the Dental Contractor must provide a Turnover Plan covering the turnover of the records, information, and services maintained or performed by the Dental Contractor to either HHSC or a subsequent contractor. The Turnover Plan will be updated annually and submitted to HHSC.

If the Dental Contractor intends to terminate the Contract, or intends to allow the Contract to expire, Dental Contractor shall remain obligated to continue performing under this Contract, subject to the same terms, conditions, and rates, for the period of time necessary to complete Turnover to the satisfaction of HHSC.

The Turnover Plan must detail the proposed schedule, activities, and resource requirements associated with the Turnover.

The Turnover Plan describes the Dental Contractor's policies and procedures that will assure:

1. The least disruption in the delivery of Dental Care Services to Dental Members who are enrolled with the Dental Contractor during the transition to a subsequent vendor;
2. The least disruption in authorization and payment to Providers contracted with the Dental Contractor during transition to a subsequent contractor;
3. Cooperation with HHSC and the subsequent contractor in notifying Dental Members and Providers of the transition, as requested and in the form required or approved by HHSC;
4. Cooperation with HHSC and the subsequent contractor in transferring information to the subsequent contractor, as requested and in the form required or approved by HHSC; and
5. The Turnover Plan must also include information about third-party software used by the Dental Contractor in the performance of duties under this Contract, including the manner in which the software is used and terms of the software license agreement, so that HHSC can determine if this software is needed to transition operations.

The Turnover Plan must be approved by HHSC, and include:

1. The Dental Contractor's approach and schedule for the transfer of data and information, as described above;
2. The quality assurance process that the Dental Contractor must use to monitor Turnover; and
3. The Dental Contractor's approach to training HHSC or a subsequent contractor's staff in the operation of its business processes;

HHSC may require additional information, as needed, from the Dental Contractor or require the modification of the Turnover Plan as necessary.

2.8.2 TRANSFER OF DATA AND INFORMATION

The Dental Contractor must transfer to HHSC or a subsequent contractor all data and information necessary to transition operations, including: data and reference tables; data entry software; license agreements for third-party software and modifications, if required by HHSC; documentation relating to software and interfaces; functional business process flows; and operational information, including correspondence, documentation of ongoing or outstanding issues, operations support documentation, and operational information regarding Subcontractors. For purposes of this section, "documentation" means all operations, technical and user manuals used in conjunction with the software, Medically

Necessary Covered Dental Services, Services and Deliverables, in whole or in part, that HHSC determines are necessary to view and extract application data in a proper format. The Dental Contractor must provide the documentation in the formats in which such documentation exists at the expiration or termination of the Contract. See **Article 15 of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS** for additional information concerning intellectual property rights.

In addition, the Dental Contractor must provide to HHSC the following:

1. Data, information and services necessary and sufficient to enable HHSC to map all Dental Contractor program data from the Dental Contractor's system(s) to the replacement system(s) of HHSC or a successor contractor, including a comprehensive data dictionary as defined by HHSC;
2. All necessary data, information and services will be provided in the format defined by HHSC, and must be HIPAA compliant; and
3. All of the data, information and services mentioned in this section must be provided and performed in a manner by the Dental Contractor using its best efforts to ensure the efficient administration of the Contract.

The data and information must be supplied in media and format specified by HHSC and according to the schedule approved by HHSC in the Turnover Plan. The data, information and services provided pursuant to this section must be provided at no additional cost to HHSC.

All relevant data and information must be received and verified by HHSC or the subsequent contractor. If HHSC determines that data or information are not accurate, complete, or HIPAA compliant, HHSC may hire an independent contractor to assist HHSC in obtaining and transferring all the required data and information and to ensure that all the data are HIPAA compliant. The reasonable cost of providing these services will be borne by the Dental Contractor.

2.8.3 TURNOVER SERVICES

Twelve (12) months prior to the end of the Contract Period, including any extensions, the Dental Contractor must update its Turnover Plan and submit it to HHSC. If HHSC terminates the Contract prior to the expiration of the Contract Period, then HHSC may require the Dental Contractor to submit an updated Turnover Plan sooner than twelve (12) months prior to the termination date. In such cases, HHSC's notice of termination will include the date the Turnover Plan is due.

2.8.4 POST TURNOVER SERVICES

Within 30 Days of the Turnover, the Dental Contractor must provide HHSC with a Turnover results report documenting the completion and results of each step of the

Turnover Plan. Turnover will not be considered complete until this report is approved by HHSC.

If the Dental Contractor does not provide the required data or information necessary for HHSC or the subsequent contractor to assume the operational activities successfully, the Dental Contractor must reimburse HHSC for all travel costs incurred by HHSC to carry out inspection, audit, review, analysis, reproduction and transfer functions at the location(s) of such records. Reimbursement by the Dental Contractor will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the Dental Contractor. The Dental Contractor may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

Texas Health & Human Services Commission

HHSC Dental Contract Terms and Conditions

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Article 1: Introduction

Section 1.01 Purpose.

The purpose of this Contract is to set forth the terms and conditions for the Dental Contractor's participation as a dental indemnity insurer or single-service health maintenance organization, also referred to as a "dental maintenance organization" or "DMO,'' for the statewide Dental Program. Under the terms of this Contract, the Dental Contractor will provide comprehensive Medically Necessary Covered Dental Services to eligible Medicaid and CHIP Members through a Network of licensed dentists contracted with the Dental Contractor.

Section 1.02 Risk-based Contract.

This is a risk-based contract.

Section 1.03 Inducements.

In making the award of this Contract, HHSC relied on Dental Contractor's assurances of the following:

(a) Dental Contractor is an established dental indemnity insurance provider or DMO that arranges for the delivery of Medically Necessary Covered Dental Services, and:

(1) Is currently licensed as such in the State of Texas and is fully authorized to conduct business in the Service Area; or

(2) Will be fully authorized by TDI to conduct business in the Service Area no later than 120 days after the Contract's Effective Date;

(b) Dental Contractor and its Material Subcontractors have the skills, qualifications, expertise, financial resources, and experience necessary to provide the Services and Deliverables described in this Contract in an efficient, cost-effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities;

(c) Dental Contractor has thoroughly reviewed, analyzed, and understood the RFP, has timely raised all questions or objections to the RFP, and has had the opportunity to review and fully understand HHSC's current Dental Program and operating environment for the activities that are the subject of this Contract and the needs and requirements of HHSC during the Contract term;

(d) Dental Contractor has had the opportunity to review and understand HHSC's stated objectives in entering into this Contract and, based on such review and understanding, Dental Contractor currently has the capability to perform in accordance with the terms and conditions of this Contract;

(e) Dental Contractor also has reviewed and understands the risks associated with the Dental Program as described in the RFP, including the risk of non-appropriation of funds.

Accordingly, on the basis of the terms and conditions of this Contract, HHSC desires to engage Dental Contractor to perform the Services and provide the Deliverables described in this Contract under the terms and conditions set forth in this Contract.

Section 1.04 Construction of the Contract.

(a) Scope of Introductory Article.

The provisions of any introductory article to the Contract are intended to be a general introduction and are not intended to expand the scope of the Parties' obligations under the Contract or to alter the plain meaning of the terms and conditions of the Contract.

(b) References to the "State."

References in the Contract to the "State" mean the State of Texas unless otherwise specifically indicated and must be interpreted, as appropriate, to mean or include HHSC and other agencies of the State of Texas that may participate in the administration of the Dental Program, provided, however, that no provision will be interpreted to include any entity other than HHSC as the contracting agency.

(c) Severability.

If any provision of this Contract is construed to be illegal or invalid, such interpretation will not affect the legality or validity of any of its other provisions. The illegal or invalid provision will be deemed stricken and deleted to the same extent and effect as if never incorporated in this Contract, but all other provisions will remain in full force and effect.

(d) Survival of terms.

Termination or expiration of this Contract for any reason will not release either Party from any liabilities or obligations set forth in this Contract that:

(1) The Parties have expressly agreed will survive any such termination or expiration; or

(2) Arose prior to the effective date of termination and remain to be performed, or by their nature would be intended to be applicable following any such termination or expiration.

(e) Headings.

The article, section, and paragraph headings in this Contract are for reference and convenience only and may not be considered in the interpretation of this Contract.

(f) Global drafting conventions.

(1) The terms "include," "includes," and "including" are terms of inclusion, and where used in this Contract, are deemed to be followed by the words "without limitation."

(2) Any references to "sections," "appendices," "exhibits" or "attachments" are deemed to be references to sections, appendices, exhibits, or attachments to this Contract.

(3) Any references to laws, rules, regulations, and manuals in this Contract are deemed references to these documents as amended, modified, or supplemented from time to time during the term of this Contract.

Section 1.05 No Implied Authority.

The authority delegated to Dental Contractor by HHSC is limited to the terms of this Contract. HHSC is the state agency designated by the Texas Legislature to administer Medicaid and CHIP, and no other agency of the State grants Dental Contractor any authority related to these programs unless directed through HHSC. Dental Contractor may not rely upon implied authority, and specifically is not delegated authority under this Contract to:

(a) Make public policy;

(b) Promulgate, amend, or disregard administrative regulations or program policy decisions made by State and federal agencies responsible for administration of HHSC Programs; or

(c) Unilaterally communicate or negotiate with any federal or State agency or the Texas Legislature on behalf of HHSC regarding the HHSC Programs.

Dental Contractor is required to cooperate to the fullest extent possible to assist HHSC in communications and negotiations with state and federal governments and agencies concerning matters relating to the scope of the Contract and the Dental Program, as directed by HHSC.

Section 1.06 Legal Authority.

(a) HHSC is authorized to enter into this Contract under Chapters 531 and 533, Texas Government Code; Section 2155.144, Texas Government Code; or Chapter 62, Texas Health & Safety Code. Dental Contractor is authorized to enter into this Contract pursuant to the authorization of its governing board or controlling owner or officer.

(b) The person or persons signing and executing this Contract on behalf of the Parties, or representing themselves as signing and executing this Contract on behalf of the Parties, warrant and guarantee that he, she, or they have been duly authorized to execute this Contract and to validly and legally bind the Parties to all of its terms, performances, and provisions.

Section 1.07 Loss of Program Authority.

Should any part of the Scope of Work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Dental Contractor must do no work on that part after the effective date of the loss of program authority. HHSC must adjust capitation rates, or non-risk payments as applicable, to remove costs that are specific to any program or activity that is no longer authorized by law. If the Dental Contractor works on a

program or activity no longer authorized by law after the date the legal authority for the work ends, the Dental Contractor will not be paid for that work. If HHSC paid the Dental Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to HHSC. However, if the Dental Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and HHSC included the cost of performing that work in its payments to the Dental Contractor, the Dental Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

Article 2: Definitions

As used in this Contract, the following terms and conditions have the meanings assigned below:

Abuse means provider practices that are inconsistent with sound fiscal, business, medical, or dental practices and result in an unnecessary cost to the Dental Program, or in reimbursement for services that fail to meet professionally recognized standards for dental care. It also includes member practices that result in unnecessary cost to the Dental Program.

Account Name means the name of the individual who lives with the child(ren) and who applies for the CHIP coverage on behalf of the child(ren).

Adjudicate means to deny or pay a Clean Claim.

Adverse Benefit Determination means:
(1) the denial or limited authorization of a Member or Provider requested Services, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
(2) the reduction, suspension, or termination of a previously authorized service;
(3) the denial in whole or in part of payment for service;
(4) the failure to provide services in a timely manner as determined by the State;
(5) the failure of a Dental Contractor to act within the timeframes set forth in the Contract and 42 C.F.R. § 438.408(b); or

(6) the denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Affiliate means any individual or entity that meets any of the following criteria:

(a) Owns or holds more than a five percent interest in the Dental Contractor, either directly, or through one or more intermediaries;

(b) In which the Dental Contractor owns or holds more than a five percent interest either directly, or through one or more intermediaries;

(c) Any parent entity or subsidiary entity of the Dental Contractor, regardless of the organizational structure of the entity;

(d) Any entity that has a common parent with the Dental Contractor, either directly, or through one or more intermediaries;

(e) Any entity that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the Dental Contractor; or,

(f) Any entity that would be considered to be an affiliate by any Securities and Exchange Commission or Internal Revenue Service regulation, Federal Acquisition Regulations, or by another applicable regulatory body.

Agency Sensitive Information means information that is not subject to specific legal, regulatory or other external requirements, but is considered HHS sensitive and is not readily available to the public. "Agency Sensitive Information" could be subject to disclosure under the Texas Public Information Act, but disclosure should be controlled due to sensitivity

Allowable Expenses means all expenses related to the Contract between HHSC and the Dental Contractor that are incurred during the Contract Term, are not reimbursable or recovered from another source, and that conform with the Chapter 6.1 of Attachment "C".

Appeal (CHIP only) means the formal process by which the Dental Contractor or its Utilization Review agent addresses Adverse Determinations.

Auxiliary Aids and Services means an accommodation that ensures that no individual with a disability is excluded, denied services, segregated, or otherwise treated differently than other individuals that do not need such accommodations and includes:

(a) Qualified interpreters or other effective methods of making aurally delivered materials understood by persons with hearing impairments;

(b) Taped texts, large print, Braille, or other effective methods to ensure visually delivered materials are available to individuals with visual impairments; and

(c) Other effective methods to ensure that materials, delivered both aurally and visually, are available to those with cognitive or other Disabilities affecting communication.

Batch Processing is a technique that allows providers to send billing information all at once in a "batch" rather than in separate individual transactions.

Benchmark means a target or standard based on historical data, or an objective, or goal.

Breach means the unauthorized acquisition, access, use, or disclosure of protected health information in a manner as described in 45 C.F.R. § 164.402.

Business Continuity Plan (BCP) means a day-to- day plan that provides for a quick and smooth restoration of MIS operations after a disruptive event, and includes business impact analysis, BCP development, testing, awareness, training, and maintenance.

Business Day means any day other than a Saturday, Sunday, or a State or federal holiday on which HHSC's offices are closed.

CAHPS means the Consumer Assessment of Healthcare Providers and Systems. This survey is conducted annually by the EQRO.

Case-by-case Services means additional services for coverage beyond those specified in Attachments B-2 and B-2.1; however, services required by EPSDT are not considered Case-by-case Services

Case Head means the head of the household that is applying for Medicaid.

C.F.R. means the Code of Federal Regulations.

Children's Health Insurance Program (CHIP) means the health insurance program authorized and funded pursuant to Title XXI, Social Security Act (42 U.S.C. §§ 1397aa-1397jj) and administered by HHSC.

CHIP Program means the State of Texas program in which HHSC contracts with Dental Contractors to provide, arrange for, and coordinate Medically Necessary Covered Dental Services for enrolled CHIP members.

Claims Administrator means a HHSC-contracted entity, often referred to as the Texas Medicaid and Healthcare Partnership (TMHP), performing provider enrollment, and claims, and Encounter processing for the Dental Program.

Clean Claim means a claim submitted by a dental provider for dental services rendered to a Dental Member, with documentation reasonably necessary for the Dental Contractor to adjudicate and accurately report the claim. A Clean Claim must meet all requirements for accurate and complete data as defined in the appropriate 837- (claim type) encounter guides as follows:

(1) 837 Dental Implementation Guide; and

(2) 837 Dental Companion Guide;

CMS means the Centers for Medicare and Medicaid Services, which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid and CHIP.

Competent Interpreter means a person who is proficient in both English and the other language being used and has had orientation or training in the ethics of interpreting, including accuracy and impartiality in interpretation.

Complainant means a Dental Member or a treating Dental Provider or other individual designated to act on behalf of the Dental Member who filed the Complaint.

Complaint means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the Dental Contractor, about any matter related to the Dental Contractor other than an Adverse Benefit Determination. Complaint has the same meaning as grievance, as provided by 42 C.F.R. § 438.400(b). Possible subjects for Complaints include the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Member's rights, regardless of whether remedial action is requested. Complaint includes the Member's right to dispute an extension of time (if authorized by law) proposed by the Dental Contractor to make an authorization decision. There is no exception for an Initial Contact Complaint

A Complainant's oral or written dissatisfaction with an Adverse Benefit Determination is considered a request for a Dental Contractor Appeal.

Comprehensive Care Program see Texas Health Steps.

Confidential Information means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to Dental Contractor or that Dental Contractor may create, receive, maintain, use, disclose, or have access to on behalf of HHS that consists of or includes any or all of the following:

(1) Education records as defined in the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g; 34 C.F.R. Part 99

(2) Federal Tax Information as defined in Internal Revenue Code § 6103 and Internal Revenue Service Publication 1075;

(3) Personal Identifying Information (PII) as defined in Texas Business and Commerce Code, Chapter 521;

(4) Protected Health Information (PHI) in any form including without limitation, Electronic Protected Health Information or Unsecured Protected Health Information as defined in 45 C.F.R. § 160.103;

(5) Sensitive Personal Information (SPI) as defined in Texas Business and Commerce Code, Chapter 521;

(6) Social Security Administration Data, including without limitation Medicaid information, means disclosures of information made by the Social Security Administration or CMS from a federal system of records for administration of federally funded benefit programs under the Social Security Act, 42 U.S.C., Chapter 7;

(7) All privileged work product;

(8) All information designated as confidential under the constitution and laws of the State of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

Consolidated FSR Reporting or **Consolidated Basis** means FSR reporting results for the Dental Program and any other managed care or capitated contract with HHSC operated by the Dental Contractor or its Affiliates, including those under separate contracts between the Dental

Contractor or its Affiliates and HHSC. Consolidated FSR Reporting does not include revenues or expenses from any of the Dental Contractor's or its Affiliates' business activities or operations outside of their contracts with HHSC.

Consumer Assessment of Healthcare Providers and Systems means the survey conducted annually by the EQRO.

Contract or Agreement means this formal, written, and legally enforceable contract between the Parties, and all amendments and attachments thereto.

Contract Term means the Initial Contract Period plus any Contract extensions.

Contractor or **Dental Contractor** means the Dental Contractor that is a party to this Contract.

Copayment (CHIP only) means the amount that a member is required to pay when utilizing certain CHIP Medically Necessary Covered Dental Services.

Corrective Action Plan means the detailed written plan required by HHSC to correct or resolve a deficiency or event causing the assessment of a remedy or damage against Dental Contractor.

Covered Services or Covered Dental Services means dental services the Dental Contractor must arrange to provide to Dental Members, including all services required by the Contract and State and federal law.

Credentialing means the process of collecting, assessing, and validating qualifications and other relevant information pertaining to a dental provider to determine eligibility and to deliver Medically Necessary Covered Dental Services.

Cultural Competency means the ability of individuals and systems to provide services effectively to people of various cultures, races, ethnic backgrounds, and religions in a manner that recognizes, values, affirms, and respects the worth of those served people and protects and preserves their dignity.

Date of Disenrollment means the last day of the last month for which the Dental Contractor receives payment for a Dental Member.

Day means a calendar day unless specified otherwise.

Default Enrollment means the processes established by HHSC to assign an enrollee, who has not selected a Dental Contractor or Main Dentist, to a Dental Contractor or Main Dentist. See 1 Tex. Admin. Code § 353.403 for Medicaid default enrollment processes, and 1 Tex. Admin. Code § 370.303 for CHIP default enrollment processes.

Deliverable means a written or recorded work product or data prepared, developed, or procured by Dental Contractor as part of the Services under the Contract for the use or benefit of HHSC or the State.

Dental Administrative Services means the performance of services or functions other than the direct delivery of Medically Necessary Covered Dental Services necessary for the management of the delivery of and payment for Medically Necessary Covered Dental Services, including Network, quality management, service authorization, claims processing, and MIS operation and

reporting. This term also includes the infrastructure development for, preparation of, and delivery of, all required Deliverables under the Contract, outside of the Medically Necessary Covered Dental Services.

Dental Contractor or Contractor means the Dental Contractor that is a party to this Contract

Dental Contractor Internal Appeal means the formal process by which a Member or his or her representative requests a review of the Dental Contractor's Action by the Dental Contractor.

Dental Contractor Internal Appeal and Complaint System means the process the Dental Contractor implements to handle Dental Contractor Internal Appeals of a Complaint or Adverse Benefit Determination, as well as the process to collect and track information about the Dental Contractor Internal Appeals of a Complaint or Adverse Benefit Determination.

Dental Health-related Materials are materials developed by the Dental Contractor or obtained from a third party relating to the prevention, diagnosis or treatment of a dental condition.

Dental Member means a person who has met Medicaid or CHIP dental services eligibility criteria and is enrolled with a Dental Contractor.

Dental Program means the State of Texas' managed care program in which HHSC contracts with a Dental Contractor to provide, arrange for, and coordinate Medically Necessary Covered Dental Services and benefit limitations for Texas Children's Medicaid Dental Services and CHIP Dental Services.

Dental Reporting Regions means state-wide regions desginated by HHSC, which will be used to measure the Network adequacy of each Dental Contractor. These state-wide regions mirror the designated service areas under HHSC's managed care programs, as included in Attachment M.

Diagnostic means an assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a provider to determine existing pathology or disease or lack thereof.

Disability means a physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working.

Disability-related Access means that facilities are readily accessible to and usable by individuals with disabilities, and that Auxiliary Aids and Services are provided to ensure effective communication, in compliance with Title III of the Americans with Disabilities Act.

Disaster Recovery Plan means the document developed by the Dental Contractor that outlines details for the restoration of the MIS in the event of an emergency or disaster.

Discovery/Discovered has the meaning assigned by 45 C.F.R. § 164.410.

DMO means dental maintenance organization.

EDI means electronic data interchange.

Effective Date means the effective date of this Contract.

Effective Date of Coverage means the first day of the month for which the Dental Contractor has received payment for a Dental Member.

Eligibles means Medicaid or CHIP-eligible individuals residing in the State of Texas.

Emergency Dental Services mean covered inpatient and outpatient services needed to evaluate or stabilize an emergency dental condition furnished by a provider qualified to furnish these services under this title. This is a Non-capitated Service for the Dental Contractor.

Encounter means a Medically Necessary Covered Dental Service or group of Medically Necessary Covered Dental Services delivered by a Provider to a Dental Member during a visit between the Dental Member and Provider, including Value-added Services.

Encounter Data means a representation of a claim received and adjudicated by a Dental Contractor without alteration or omission, unless specifically directed by HHSC. The data must include information on receipt of items or services including billing and rendering provider.

Enrollment Report/File means the daily or monthly list of Eligibles that are enrolled with the Dental Contractor as Members on the day or for the month the report is issued.

EPSDT means the federally mandated Early and Periodic Screening, Diagnosis and Treatment program contained at 42 U.S.C. § 1396d(r). HHSC refers to EPSDT as Texas Health Steps.

Expedited Appeal means an appeal to the Dental Contractor in which the decision is required quickly based on the Dental Member's health status, and the amount of time necessary to participate in a standard Appeal could jeopardize the Member's life, or health, or ability to attain, maintain, or regain maximum function.

Experience Rebate means the portion of the Dental Contractor's Net Income Before Taxes that may be returned to the State in accordance with **Section 10.08** "Experience Rebate" below.

External Medical Review (EMR) - is an independent review of the relevant information the Dental Contractor used related to an Adverse Benefit Determination based on functional necessity or medical necessity. EMRs are conducted by third party organizations, known as Independent Review Organizations (IROs), contracted by HHSC.

External Quality Review Organization (EQRO) means the entity that contracts with HHSC to provide external review of access to and quality of dental care provided to Dental Members.

Expiration Date means the expiration date of this Contract, as specified in the HHSC Dental Program Contract.

Farmworker Child(ren) (FWC) means a child or children birth through age 17 of a Migrant Farmworker.

Federal Poverty Level (FPL) means the Federal Poverty Level updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 U.S.C. § 9902(2) and as in effect for the applicable budget period used to determine an individual's eligibility in accordance with 42 C.F.R. § 435.603(h).

Fee-for-Service (FFS) means the traditional Medicaid Health Care Services payment system under which providers receive a payment for each unit of service, after the service is provided, according to rules adopted pursuant to Chapter 32 Texas Human Resources Code.

Financial Statistical Report (FSR) means a report designed by HHSC, and submitted to HHSC by the Dental Contractor in accordance with Contract requirements. The FSR is a form of modified income statement, subject to audit, and contains revenue, cost, and other data, as defined by the Contract. Not all incurred expenses may be included in the FSR.

First Dental Home is a group of benefits designed to establish a Dental Home, provide preventive care, identify oral health problems, provide treatment, and parental or guardian oral health anticipatory guidance to eligible Medicaid members 6 months through 35 months of age.

Force Majeure Event means any failure or delay in performance of a duty by a Party under this Contract that is caused by fire, flood, hurricane, tornadoes, earthquake, an act of God, an act of war, riot, civil disorder, or any similar event beyond the reasonable control of such Party and without the fault or negligence of such Party.

FQHC means a Federally Qualified Health Center, certified by CMS to meet the requirements of Section 1861(aa)(3) of the Social Security Act as a federally qualified health center, that is enrolled as a provider in the Texas Medicaid program.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person and includes any act that constitutes fraud under applicable federal or state law.

FSR Reporting Period is the period of months that are measured on a given FSR. Generally, the FSR Reporting Period is a twelve-calendar-month period corresponding to the State Fiscal Year, but it can vary by Contract and by year. If an FSR Reporting Period is not defined in the Contract, then it will be deemed to be the twelve months following the end of the prior FSR Reporting Period.

Health and Human Services Commission (HHSC) means the administrative agency within the executive department of Texas state government established under Chapter 531, Texas Government Code or its designee, or authorized agent, including but not limited to, the Texas Health and Human Services agencies.

Healthcare Effectiveness Data and Information Set (HEDIS), is a registered trademark of NCQA and is a set of standardized performance measures.

HHS Agency means the Texas Health and Human Service agencies subject to HHSC's oversight under Chapter 531, Texas Government Code, and their successor agencies.

HHSC Administrative Services Contractor (ASC) means an entity performing administrative services functions, including Member eligibility and enrollment functions, for the Dental Program under a separate contract with HHSC.

HHSC Enrollment Broker (EB) means a State-contracted entity performing administrative services associated with Dental Member enrollment functions for the Dental Program.

HHSC Office of the Inspector General In accordance with Texas Government Code § 531.102, the HHSC Office of Inspector General is responsible for the prevention, detection, audit, inspection, review, and investigation of Fraud, Waste, and Abuse in the provision and delivery of all health and human services in the State, including services through any state-administered health or human services program that is wholly or partly federally funded or services provided by the Department of Family and Protective Services, and the enforcement of State law relating to the provision of those services.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (August 21, 1996), as amended or modified.

Independent Review Organization (IRO) is a third-party organization contracted by HHSC that conducts an External Medical Review (EMR) during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity.

Indian Health Care Provider has the meaning assigned to it in 42 C.F.R. § 438.14. and means a health care program operated by the Indian Health Service (IHS) or by an Indian tribe, tribal organization, or urban Indian organization, otherwise known as an I/T/U as those terms are defined in section 4 of the Indian Health Care Improvement Act, 25 U.S.C. § 1603.

Information Resources means the procedures, equipment, and software that are employed, designed, built, operated, and maintained to collect, record, process, store, retrieve, display, and transmit information, and associated personnel including consultants and contractors as defined in 44 U.S.C. § 3502, NIST SP 800-53 rev 4.

Information Technology Conduit Services Provider means an entity that transports information but does not access it other than on a random or infrequent basis as necessary for the performance of the transportation service or as required by law.

Initial Contact Complaint means a Complaint that is resolved within one Business Day.

Initial Contract Period means the Effective Date of the Contract through August 31, 2023.

Inquiry means a request by a member or Provider for information about HHS programs or services.

Internal Dental Contractor Appeal (Medicaid only) means the formal process by which an eligible Medicaid member or his or her representative request a review of a Complaint or the Dental Contractor's Action.

Joint Interface Plan (JIP) means a document used to communicate basic system interface information. This information includes: file structure, data elements, frequency, media, type of file, receiver and sender of the file, and file identification.

Key Personnel means the critical management and technical positions identified by the Dental Contractor in accordance with **Article 4.02** below**.**

Legally Authorized Representative (LAR) means the Dental Member's representative defined by State or federal law, including Tex. Occ. Code § 151.002(6), Tex. Health & Safety Code § 166.164, and Tex. Estates Code Ch. 752.

Limited English Proficient (LEP) has the meaning assigned to it in 42 C.F.R. § 438.10 and means potential members and Dental Members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English.

Linguistic Access means translation and interpreter services for written and spoken language to ensure effective communication, and includes sign language interpretation, and the provision of other Auxiliary Aids and Services to persons with Disabilities.

Main Dental Home Provider, Main Dentist or Dental Home means the ongoing relationship between the dentist and the member, inclusive of all aspects of oral health care delivered in a comprehensive continually accessible, coordinated, and family-centered way and includes referrals to dental specialists when appropriate.

Main Dentist means a provider who has agreed with a Dental Contractor to provide a Main Dental Home to Dental Members and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to Dental Members, maintaining the continuity of Dental Member care, and initiating referral for care. Provider types that can serve as Main Dental Home Providers are FQHCs, RHCs, and individuals who are general dentists or pediatric dentists.

Major Population Group means any population, which represents at least 10% of the Dental Program population in the Service Area.

Major Systems Change means a change that affects a mission critical component of the system, or a change which requires more than 4 hours planned outage to implement, or other specified timeframe in the Contract.

Management Information System (MIS) means the information systems and subsystems, applications, and automations used to support the delivery of managed care services.

Marketing means any communication from the Dental Contractor to a Medicaid or CHIP Eligible who is not enrolled with the Dental Contractor that can reasonably be interpreted as intended to influence the Eligible to:

(a) Enroll with the Dental Contractor; or

(b) Not enroll in or to disenroll from another Dental Contractor.

Marketing Materials means materials that are produced in any medium by or on behalf of the Dental Contractor and can reasonably be interpreted as intending to market to potential members. Health-related materials are not Marketing Materials.

Material Subcontract means any contract, Subcontract, or agreement between the Dental Contractor and another entity that meets any of the following criteria:

(a) The other entity is an Affiliate of the Dental Contractor;

(b) The Subcontract is considered by HHSC to be for a key type of service or function, including:

(1) Administrative Services, including third party administrator, Network administration, and claims processing;

(2) Delegated Networks, including behavioral health, dental, pharmacy, and vision;

(3) Management services, including management agreements with parent;

(4) Reinsurance; or

(5) Call lines, including nurse and medical consultation; or

(c) Any other Subcontract that exceeds, or is reasonably expected to exceed, the lesser of

(1) $500,000 per year, or

(2) One percent of the Dental Contractor's annual revenues under this Contract. Any Subcontracts between the Dental Contractor and a single entity that are split into separate agreements by time period, Program, or otherwise, will be consolidated for the purpose of this definition.

For the purposes of this Contract, Material Subcontracts do not include contracts with any non-Affiliates for any of the following, regardless of the value of the contract: utilities (e.g., water, electricity, telephone, Internet, trash), mail or shipping, office space, maintenance, security, or computer hardware.

Material Subcontractor means any entity with a Material Subcontract with the Dental Contractor. For the purposes of this Contract, Material Subcontractors do not include Providers in the Dental Contractor's Provider Network. Material Subcontractors may include, Affiliates, subsidiaries, and affiliated and unaffiliated third parties.

Medicaid means the medical assistance entitlement program authorized and funded pursuant to Title XIX, Social Security Act (42 U.S.C. §§ 1396 *et seq*.) and administered by HHSC.

Medically Necessary has the meaning defined in 1 Tex. Admin. Code. § 353.2 (Medicaid) and 1 Tex. Admin. Code. § 370.4 (CHIP).

Medically Underserved Areas (MUA) means areas or populations designated by the Health Resources and Services Administration as having: too few primary care providers, high infant mortality, high poverty or high elderly population. MUAs may be a whole county or a group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts in which residents have a shortage of personal health services.

Member means a person who has met Medicaid or CHIP eligibility criteria and is enrolled in the Dental Contractor's dental plan.

Member Advocate means the person with the primary responsibility for providing advocacy and assistance to Dental Members.

Member Materials means all written materials produced or authorized by the Dental Contractor and distributed to Dental Members or potential members containing information concerning the

Dental Program. Member Materials include, but are not limited to, Member ID cards, Member handbooks, Provider directories, and Marketing Materials.

Member Month means one Dental Member enrolled with the Dental Contractor during any given month. The total Member Months for each month of a year comprise the annual Member Months.

Migrant Farmworker means a migratory agricultural worker, generally defined as an individual:

(a) Whose principal employment is in agriculture on a seasonal basis;

(b) Who has been so employed within the last 24 months;

(c) Who performs an activity directly related to the production or processing of crops, dairy products, poultry, or livestock for initial commercial sale or as a principal means of personal subsistence; and

(d) Who establishes, for the purposes of such employment, a temporary abode.

National CLAS Standards means *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (the *National CLAS Standards*). These standards were developed by the U.S. Department of Health and Human Services - Office of Minority Health and are "intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services." Originally developed in 2000, the CLAS Standards were updated in 2013. For the list of CLAS Standards, see the Think Cultural Health website: https://www.thinkculturalhealth.hhs.gov/clas/standards.

Net Income Before Taxes or **Pre-tax Income** means an aggregate excess of Revenues over Allowable Expenses.

Network means all Dental Providers that have a Provider Contract with the Dental Contractor, or any Subcontractor, for the delivery of Medically Necessary Covered Dental Services to the Dental Contractor's members.

Non-capitated Services benefits of Texas Medicaid or CHIP that are excluded from Medically Necessary Covered Dental Services.

Non-emergency Medical Transportation (NEMT) Services means non-emergency transportation-related services available under the Medicaid state plan.

Nonmedical Transportation (NMT) Services has the meaning assigned by Tex. Gov't Code § 533.00258(a)(1).

Non-provider Subcontracts means contracts between the Dental Contractor and a third party that performs a function, excluding delivery of Medically Necessary Covered Dental Services that the Dental Contractor is required to perform under its Contract with HHSC.

Open Panel means Main Dentists who are accepting new patients for the Dental Program.

Open Practice means specialist dental providers who are accepting new patients for the Dental Program.

Operational Start Date means the first day on which the Dental Contractor is responsible for providing Medically Necessary Covered Dental Services to Dental Members in exchange for a Premium Payment under the Contract.

Operations Phase means the period of time when the Dental Contractor is responsible for providing the Medically Necessary Covered Dental Services and all related Contract functions and begins on the Operational Start Date.

Out-of-Network (OON) means an appropriately licensed individual, facility, agency, institution, organization, or other entity that has not entered into a contract with the Dental Contractor for the delivery of Medically Necessary Covered Dental Services to the Dental Contractor's Dental Members.

Overpayment means any payment made to a Network Provider by a MCO, PIHP, or PAHP to which the Network Provider is not entitled to under Title XIX or Title XXI of the Act or any payment to a MCO, PIHP, or PAHP by HHSC to which the MCO, PIHP, or PAHP is not entitled to under Title XIX or Title XXI of the Act.

Parties mean HHSC and the Dental Contractor, collectively.

Party means HHSC or the Dental Contractor, individually.

Pended Claim means a claim for payment that requires additional information before the claim can be adjudicated as a Clean Claim.

Person-Centered means the opportunity to achieve greater independence and community integration, through exercising self-direction, incorporation of individual perceptions and experiences, personal preferences and choices, and control with respect to services and providers, while ensuring medical and non-medical needs are met via means that are exclusively for the benefit of the individual in reaching their personal outcomes and allowing them to have the quality of life and level of independence they desire.

Population Risk Group means a distinct group of Dental Members identified by age, age range, gender, type of program, eligibility category, or other criteria established by HHSC.

PPACA means the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), together known as the Affordable Care Act (ACA).

Premium Payment means the aggregate amount paid by HHSC to the Dental Contractor on a monthly basis for the provision of Medically Necessary Covered Dental Services to enrolled Dental Members, including associated administrative services, in accordance with the Premium Rates in the Contract.

Premium Rate means a fixed predetermined fee paid by HHSC to the Dental Contractor each month in accordance with the Contract, for each enrolled Dental Member in a defined Rate Cell, in exchange for the Dental Contractor arranging for or providing a defined set of Medically

Necessary Covered Dental Services to such a Dental Member, regardless of the amount of Medically Necessary Covered Dental Services used by the enrolled Dental Member that are within the defined limits as stated in the Medically Necessary Covered Dental Services described in **Section 2.5.4** of the Statement of Work.

Prevalent Language has the meaning assigned to it in 42 C.F.R. § 438.10 and means a non-English language determined to be spoken by a significant number or percentage of potential members and Dental Members that are LEP. For the purposes of the Contract the terms "significant number or percentage" will mean ten percent of the population in a Service Area who speak the non-English language.

Preventive means aspects of oral health concerned with promoting good oral health and function by preventing or reducing the onset or development of oral diseases or deformities, and the occurrences of orofacial injuries.

Program means a managed care program operated by HHSC for either Children's Medicaid Dental Services or CHIP Dental Services.

Proposal means the submission by the Dental Contractor in response to the RFP.

Provider means an appropriately credentialed and licensed dentist facility, agency, institution, organization, or other entity, and its employees and subcontractors, who has a Provider Contract with the Dental Contractor for the delivery of Medically Necessary Covered Dental Services to Dental Members.

Provider Contract means a contract entered into by a direct provider of dental services and the Dental Contractor, or an intermediary entity, for the provision of Covered Dental Services to the Dental Contractor's Members.

Provider Materials means all written materials produced or authorized by the Dental Contractor or its administrative services Subcontractors concerning the Dental Program that are distributed to Providers and include the Dental Contractor's Provider Manual, training materials regarding the Dental Contractor's Dental Program requirements, and mass communications directed to all or a large group of Providers, e-mail or fax "blasts". Provider Materials do not include written correspondence between the Dental Contractor or its administrative services Subcontractors and a Provider regarding individual business matters.

Public Information means information that:

(a) Is collected, assembled, or maintained under a law or ordinance or in connection with the transaction of official business by a governmental body or for a governmental body; and

(b) The governmental body owns or has a right of access to.

Quality Improvement means a system to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

Rate Cell means a Population Risk Group for which a Premium Rate has been determined.

Real-Time Captioning also known as Communication Access Real-Time Translation (CART) means a process by which a trained individual uses a shorthand machine, a computer, and real-time translation software to type and simultaneously translate spoken language into text on a computer screen. Real Time Captioning is provided for individuals who are deaf, have hearing impairments, or have unintelligible speech. It is usually used to interpret spoken English into text English; but may be used to translate other spoken languages into text.

Readily Accessible has the meaning assigned to it in 42 C.F.R. § 438.10 and means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, and section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor version.

Readiness Review means HHSC or its agent's process of review, assessment, and determination of Dental Contractor's ability, preparedness, and availability to fulfill its obligations under the Contract.

Request for Proposals (RFP) means the procurement solicitation instrument issued by HHSC under which the Contract is awarded, and all RFP addenda, corrections or modifications.

Retaliation means an action, including refusal to renew or termination of a contract against a Provider because the Provider filed a complaint against the Dental Contractor or appealed an Action of the Dental Contractor on behalf of a Member.

Revenue means all revenue received by the Dental Contractor pursuant to the Contract during the Contract Term, including retroactive adjustments made by HHSC and includes any funds earned on Medicaid or CHIP managed care funds such as investment income and earned interest. Revenue excludes any reinsurance recoveries, which shall be shown in the FSR as a contra-cost, or reported offset to reinsurance expense. Revenues are reported at gross, and are not netted for any reinsurance premiums paid. See also the **Chapter 6 of the UMCM.**

Risk means the potential for loss as a result of expenses and costs of the Dental Contractor exceeding payments made by HHSC under the Contract.

Rural Health Clinic (RHC) means an entity that meets all of the requirements for designation as a rural health clinic under Section 1861(aa)(1) of the Social Security Act and approved for participation in the Texas Medicaid Program.

Scope of Work means the description of Services and Deliverables specified in the Contract, and any agreed modifications thereto.

SDX means State Data Exchange.

Security Plan means a document that contains detailed management, operational, and technical information about a system, its security requirements, and the controls implemented to provide protection against risks and vulnerabilities.

Service Area means geographic area wherein the Dental Program's Medically Necessary Covered Dental Services are available to Dental Members, which is statewide and includes all counties in the State of Texas.

Services mean the tasks, functions, and responsibilities assigned and delegated to the Dental Contractor under the Contract.

Significant Traditional Provider **(STP)** means dental providers identified by HHSC as having provided a significant level of care to Medicaid or CHIP clients.

Software means all operating system and applications software used by the Dental Contractor to provide the Services under the Contract.

Specialty Provider means a pediatric dentist, endodontist, oral surgeon, orthodontist, periodontist, or prosthodontist.

SSA means the Social Security Administration.

State Fair Hearing means the process adopted and implemented by HHSC in 1 Tex. Admin Code Chapter 357, in compliance with federal regulations and state rules relating to Medicaid Fair Hearings.

State Fiscal Year (SFY) means a 12-month period beginning on September 1st and ending on August 31.

Subcontract means any written Contract between the Dental Contractor and another party to fulfill the requirements of the Contract.

Subcontractor has the same meaning as assigned in 42 C.F.R. § 438.2.

Subsidiary means an Affiliate controlled by such person or entity directly, or indirectly through one or more intermediaries.

Supplemental Security Income (SSI) means a Federal income supplement program funded by general tax revenues, not Social Security taxes, designed to help aged, blind, and disabled people with little or no income by providing cash to meet basic needs for food, clothing, and shelter.

TDD means telecommunication device for the deaf. It is interchangeable with the term Teletype machine or TTY.

TDI means the Texas Department of Insurance.

Texas Health Steps is the name adopted by the State of Texas for the federally mandated EPSDT program, and includes the State's Comprehensive Care Program extension to EPSDT, which adds benefits to the federal EPSDT requirements contained in 42 U.S.C. § 1396d(r), and defined and codified at 42 C.F.R. §§ 440.40 and 441.56-62. HHSC's administrative rules governing Texas Health Steps and Comprehensive Care Program services are contained in 25 T.A.C. Chapter 33, relating to Early and Periodic Screening, Diagnosis and Treatment.

Texas Health Steps Outreach and Informing Unit means the HHSC Texas Health Steps vendor contracted to provide outreach and education to parents, caretakers, and older children about Texas Health Steps benefits and services.

Texas Medicaid Provider Procedures Manual means the policy and procedures manual published by or on behalf of HHSC that contains policies and procedures required of all health and dental care providers who participate in the Texas Medicaid program.

Texas Public Information Act refers to the provisions of Chapter 552 of the Texas Government Code.

Therapeutic means beneficial therapy or treatment, including the following categories of service: restorative, endodontic, periodontic, prosthodontic, oral and maxillofacial surgery, and orthodontic.

Third Party Liability (TPL) means the legal responsibility of another individual or entity to pay for all or part of the services provided to Dental Members under the Contract. See 1 T.A.C. §§ 354.2301 *et seq*., relating to Third Party Resources.

Third Party Recovery (TPR) means the recovery of payments on behalf of a Dental Member by HHSC or the Dental Contractor from an individual or entity with the legal responsibility to pay for the Medically Necessary Covered Dental Services.

TP 13 means Type Program 13 that is a Medicaid program eligibility type assigned to persons determined eligible for federal SSI assistance by the Social Security Administration (SSA). If a subsequent eligibility system uses a different identifier for this eligibility type, references to TP 13 include the subsequent identifier.

Transition Phase includes all activities the Dental Contractor is required to perform between the Effective Date and the Operational Start Date resulting from an award through procurement or an assignment and assumption due to termination, merger, or acquisition.

Transition Plan means the written proposal for readiness developed by the Dental Contractor, approved by HHSC, to be employed during the Transition Phase.

Turnover Phase includes all activities the Dental Contractor is required to perform prior to, upon, and following the termination of the Contract or the Expiration Date in order to close-out the Contract and transition Contract activities and operations to HHSC or a subsequent contractor.

Turnover Plan means the written proposal developed by the Dental Contractor, approved by HHSC, to be employed during the Turnover Phase.

Uniform Managed Care Manual (UMCM) means the manual published by or on behalf of HHSC that contains policies and procedures required of the Dental Contractor. The UMCM, as amended or modified, is incorporated by reference into the Contract.

Utilization Review means the system for retroactive, prospective, or concurrent review of the appropriateness of dental services being provided or proposed to be provided to a Dental Member. The term does not include elective requests for clarification of coverage.

Value-added Services (VAS) may be actual dental services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improve oral health outcomes among Dental Members. VAS must promote oral health, healthy lifestyles, or other initiatives approved

by HHSC. If approved by HHSC, VAS may also include transportation. Best practice approaches to delivering Medically Necessary Covered Dental Services are not considered VAS.

Waste means practices that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items, or services.

Article 3. General Contract Terms and Conditions

Section 3.01 Contract Elements.

(a) Contract documentation.

The Contract between the Parties will consist of the Dental Program Contract documents and all attachments and amendments to these documents.

(b) Order of documents.

In the event of any conflict or contradiction between or among these Contract documents, the documents must control in the following order of precedence:

(1) The final executed HHSC Dental Contract signature document, and all amendments thereto;

(2) Contract **Attachment A** – "HHSC's Dental Contract Terms and Conditions," and all amendments thereto;

(3) Contract **Attachment B** – "Scope of Work," and all attachments and amendments thereto;

(4) Contract **Attachment C -** HHSC's UMCM, and amendments thereto; and

(5) Contract **Attachment D** – "Dental Contractor's Proposal."

Section 3.02 Term of the Contract.

The term of the Contract will begin on the Effective Date and will conclude on the expiration date. The Parties may renew the Contract for a period or periods, but the Contract Term may not exceed a total of eight operational years. Subject to the provisions of **Section 12.04(e)**, all reserved contract extensions beyond the expiration date will be subject to good faith negotiations between the Parties and mutual agreement to the extensions.

Section 3.03 Funding.

This Contract is expressly conditioned on the availability of state and federal appropriated funds. The Dental Contractor will have no right of action against HHSC in the event that HHSC is unable to perform its contractual obligations as a result of the suspension, termination, withdrawal, or failure of funding to HHSC, or lack of sufficient funding of HHSC for any Services or Deliverables contained within the scope of the Contract. If funds become unavailable, the provisions of **Article 12** ("Remedies and Disputes") will apply. HHSC will use all reasonable efforts to ensure that such funds are available and will negotiate in good faith with

Dental Contractor to resolve any claims for payment by the Dental Contractor that represent accepted Services or Deliverables that are pending at the time funds become unavailable. HHSC will use best efforts to provide reasonable advance written notice to Dental Contractor upon learning that funding for the Contract may be unavailable.

Section 3.04 Delegation of Authority.

Whenever, by any provision of the Contract, any right, power, or duty is imposed or conferred on HHSC, the right, power, or duty so imposed or conferred is possessed and exercised by HHSC's Executive Commissioner unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of HHSC. The Executive Commissioner will reduce any such delegation of authority to writing and HHSC will provide a copy to Dental Contractor on request.

Section 3.05 No Waiver of Sovereign Immunity.

The Parties expressly agree that no provision of the Contract is in any way intended to constitute a waiver by HHSC or the State of any immunities from suit, or from liability that HHSC or the State may have by operation of law.

Section 3.06 Force Majeure.

Neither Party will be liable for any failure or delay in performing its obligations under the Contract if such failure or delay is due to a Force Majeure Event. The existence of such causes of delay or failure will extend the period of performance in the exercise of reasonable diligence until after the causes of delay or failure have been removed. Each Party must inform the other in writing with proof of receipt within five Business Days of the existence of a Force Majeure Event.

Section 3.07 Publicity.

(a) Dental Contractor may use the name of HHSC, the State of Texas, any HHS agency, and the name of the HHSC Dental Program in any media release, public announcement, or public disclosure relating to the Contract or its subject matter only if, at least seven Days prior to distributing the material, the Dental Contractor submits the information to HHSC for review and comment. The Dental Contractor may not use the submitted information without prior approval from HHSC. HHSC reserves the right to object to and require changes to the publication if, at HHSC's sole discretion, it determines that the publication does not accurately reflect the terms of the Contract or the Dental Contractor's performance under the Contract.

(b) Dental Contractor will provide HHSC at least three copies of any information described in subsection 3.07(a) prior to public release. Dental Contractor will provide additional copies at HHSC's request.

(c) The requirements of subsection 3.07(a) do not apply to:

(1) Proposals or reports submitted to HHSC, an administrative agency of the State, or a governmental agency, or unit of another state, or the federal government;

(2) Information concerning the Contract's terms, subject matter, and estimated value:

(i) In any report to a governmental body to which the Dental Contractor is required by law to report such information, or

(ii) That the Dental Contractor is otherwise required by law to disclose.

(3) Member Materials: the Dental Contractor must comply with the UMCM's provisions regarding the review and approval of Member Materials.

Section 3.08 Assignment.

(a) Assignment by Dental Contractor.

Dental Contractor must not assign all or any portion of its rights under or interests in the Contract without prior written consent of HHSC. Any written request for assignment must be accompanied by written acceptance by the party to whom the assignment is made. Except where otherwise agreed in writing by HHSC, assignment will not release Dental Contractor from its obligations pursuant to the Contract.

(b) Assignment by HHSC.

Dental Contractor understands and agrees HHSC may, in one or more transactions, assign, pledge, transfer, or hypothecate the Contract. This assignment will only be made to another State agency or a non-State agency that is contracted to perform agency support.

(c) Assumption.

Each party to whom an assignment is made (an "Assignee") must assume all of the assigned interests in and responsibilities under the Contract and any documents executed with respect to the Contract, including without limitation, its obligation for all or any portion of the purchase payments, in whole or in part.

Section 3.09 Cooperation with Other Vendors and Prospective Vendors.

HHSC may award supplemental contracts for work related to the Contract, or any portion thereof. Dental Contractor will reasonably cooperate with such other vendors and will not commit or permit any act that may interfere with the performance of work by any other vendor.

Section 3.10 Renegotiation and Reprocurement Rights.

(a) Renegotiation of Contract terms.

Notwithstanding anything in the Contract to the contrary, HHSC may at any time during the term of the Contract exercise the option to notify Dental Contractor that HHSC has elected to renegotiate certain terms of the Contract. Upon Dental Contractor's receipt of any notice pursuant to this section, Dental Contractor and HHSC will undertake good faith negotiations of

the subject terms of the Contract, and may execute an amendment to the Contract in accordance with Article 8 "Amendments and Modifications".

(b) Reprocurement of the services or procurement of additional services.

Notwithstanding anything in the Contract to the contrary, whether or not HHSC has accepted or rejected Dental Contractor's Services or Deliverables provided at any time during the Contract Term, HHSC may at any time issue requests for proposals or offers to other potential contractors for performance of any portion of the Services covered by the Contract or services similar or comparable to the Services performed by Dental Contractor under the Contract.

(c) Termination rights upon reprocurement.

If HHSC elects to procure the Services or Deliverables or any portion of the Services or Deliverables from another vendor in accordance with this Section, HHSC will have the termination rights set forth in Article 12 "Remedies and Disputes".

Section 3.11 RFP Errors and Omissions.

Dental Contractor will not take advantage of any errors or omissions in the RFP or the resulting Contract. Dental Contractor must promptly notify HHSC of any such errors or omissions that are discovered.

Section 3.12 Attorneys' Fees.

In the event of any litigation, appeal, or other legal action to enforce any provision of the Contract, Dental Contractor agrees to pay all reasonable expenses of such action, if HHSC is the prevailing Party.

Section 3.13 Preferences Under Service Contracts.

Dental Contractor is required in performing the Contract to purchase products and materials produced in the State when they are available at a price and time comparable to products and materials produced outside the State.

Section 3.14 Time of the Essence.

In consideration of the need to ensure uninterrupted and continuous Services to Dental Program Members, time is of the essence in the performance of the Services under the Contract.

Section 3.15 Notice.

(a) Any notice or other legal communication required or permitted to be made or given by either Party pursuant to the Contract will be in writing, and will be deemed to have been given:

(1) Three Business Days after the date of mailing if sent by registered or certified U.S. mail, postage prepaid, with return receipt requested;

(2) When transmitted if sent by facsimile, provided a confirmation of transmission is produced by the sending machine; or

(b) When delivered if delivered personally or sent by express courier service.

(c) The notices described in this section may not be sent by electronic mail.

(d) All notices must be sent to the program contact identified in the Contract. In addition, legal notices must be sent to the legal contact identified in the Contract.

(e) Routine communications that are administrative in nature will be provided in a manner agreed to by the Parties.

Article 4. Contract Administration and Management

Section 4.01 Qualifications, Retention and Replacement of Dental Contractor Employees.

Dental Contractor agrees to maintain the organizational and administrative capacity and capabilities to carry out all duties and responsibilities under the Contract. The personnel Dental Contractor assigns to perform the duties and responsibilities under the Contract will be properly trained and qualified for the functions they are to perform. Notwithstanding transfer or turnover of personnel, Dental Contractor remains obligated to perform all duties and responsibilities under this Contract without degradation and in accordance with the terms of this Contract.

Section 4.02 Dental Contractor's Key Personnel.

(a) Designation of Key Personnel.

Dental Contractor must designate key management and technical personnel who will be assigned to the Contract. For the purposes of this requirement, Key Personnel are those with management responsibility or principal technical responsibility for the following functional areas:

(1) Member services;

(2) Management Information Systems;

(3) Claims processing,

(4) Network development and management;

(5) Benefit administration and utilization and care management;

(6) Quality Improvement;

(7) Financial functions;

(8) Reporting;

(9) Security Official as required in 45 C.F.R. § 164.308(a)(2); and Privacy Official as required in 45 C.F.R. § 164.530(a)(2).

(10) Executive Directors, as defined in Section 4.03;

(11) Dental Director, as defined in **Section 4.04 below ("Dental Director")**; and

(12) Special Investigative Unit (SIU)

(b) Support and Replacement of Key Personnel.

Dental Contractor must maintain, throughout the Contract Term, the ability to supply its Key Personnel with the required resources necessary to meet Contract requirements and comply with applicable law. Dental Contractor must ensure project continuity by timely replacement of Key Personnel, if necessary, with a sufficient number of persons having the requisite skills, experience and other qualifications. Regardless of specific personnel changes, Dental Contractor must maintain the overall level of expertise, experience, and skill reflected in Dental Contractor's Proposal.

(c) Notification of replacement of Key Personnel.

Dental Contractor must notify HHSC in writing within 15 Business Days of any change in Key Personnel. Hiring or replacement of Key Personnel must conform to all Contract requirements. If HHSC determines that a satisfactory working relationship cannot be established between certain Key Personnel and HHSC, it will notify the Dental Contractor in writing. Upon receipt of HHSC's notice, HHSC and Dental Contractor will attempt to resolve HHSC's concerns on a mutually agreeable basis.

Section 4.03 Executive Director.

(a) Dental Contractor must employ a qualified individual to serve as the Executive Director for the Dental Program. The Executive Director must be employed full-time by Dental Contractor, be primarily dedicated to the Dental Program, and must hold a Senior Executive or Management position in Dental Contractor's organization, except that Dental Contractor may propose an alternate structure for the Executive Director position, subject to HHSC's prior review and written approval.

(b) The Executive Director must be authorized and empowered to represent Dental Contractor regarding all matters pertaining to the Contract prior to such representation. The Executive Director must act as liaison between Dental Contractor and HHSC and must have responsibilities that include, but are not limited to:

(1) Ensuring Dental Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

(2) Receiving and responding to all inquiries and requests made by HHSC related to the Contract, in the timeframes and formats specified by HHSC. Where practicable, HHSC will consult with Dental Contractor to establish timeframes and formats reasonably acceptable to the Parties;

(3) Attending and participating in regular meetings or conference calls with HHSC;

(4) Attending and participating in regular HHSC Regional Advisory Committees (RACs) for managed care. The Executive Director may designate key personnel to attend a RAC if the Executive Director is unable to attend;

(5) Making best efforts to promptly resolve any issues identified either by Dental Contractor or HHSC that may arise and are related to the Contract;

(6) Meeting with HHSC representative(s) on a periodic or as needed basis to review Dental Contractor's performance and resolve issues, and

(7) Meeting with HHSC at the time and place requested by HHSC, if HHSC determines that Dental Contractor is not in compliance with the requirements of the Contract.

Section 4.04 Dental Director.

(a) Dental Contractor must have a qualified full-time individual to serve as the Dental Director for the Dental Program. The Dental Director must be currently licensed in Texas as a Doctor of Dentistry with no restrictions or other licensure limitations. The Dental Director must comply with applicable federal and state statutes and regulations.

(b) The Dental Director, or his or her designee meeting the qualifications described in Section 4.04(a), must be available during normal business hours for Utilization Review decisions, and must be authorized and empowered to represent Dental Contractor regarding clinical issues, Utilization Review and quality of care inquiries.

Section 4.05 Responsibility for Dental Contractor Personnel and Subcontractors.

(a) Dental Contractor employees and Subcontractor employees will not be considered employees of HHSC or the State; but will be considered for all purposes as Dental Contractor's employees or its Subcontractor's employees, as applicable.

(b) Except as expressly provided in the Contract, neither Dental Contractor nor any of Dental Contractor's employees or Subcontractors may act in as agents or representatives of HHSC or the State.

(c) Dental Contractor agrees that anyone employed by Dental Contractor to fulfill the terms of the Contract is an employee of Dental Contractor and remains under Dental Contractor's sole direction and control. Dental Contractor assumes sole and full responsibility for its acts and the acts of its employees and Subcontractors.

(d) Dental Contractor agrees that any claim on behalf of any person arising out of employment or alleged employment by Dental Contractor, including, but not limited to, claims of discrimination against Dental Contractor, its officers, or its agents, is the sole responsibility of Dental Contractor and not the responsibility of HHSC. Dental Contractor will indemnify and hold harmless the State from any and all claims asserted against the State arising out of such employment or alleged employment by Dental Contractor. Dental Contractor understands that any person who alleges a claim arising out of employment or alleged employment by Dental Contractor will not be entitled to any compensation, rights, or benefits from HHSC including, but not limited to, tenure rights, medical and hospital care, sick and annual or vacation leave, severance pay, or retirement benefits.

(e) Dental Contractor agrees to be responsible for the following in respect to its employees:

(1) Damages incurred by Dental Contractor's employees within the scope of their duties under the Contract; and

(2) Determination of the hours to be worked and the duties to be performed by Dental Contractor's employees.

(f) Dental Contractor agrees and will inform its employees and Subcontractor(s) that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to them by Dental Contractor pursuant to the Contract or any judgment rendered against the Dental Contractor. HHSC's liability to the Dental Contractor's employees, agents, and Subcontractors, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Prac. & Rem. Code §§ 101.001 et seq.).

(g) Dental Contractor understands that HHSC does not assume liability for the actions of, or judgments rendered against, Dental Contractor, its employees, agents, or Subcontractors. Dental Contractor agrees that it has no right to indemnification, or contribution from HHSC for any such judgments rendered against Dental Contractor or its Subcontractors.

Section 4.06 Cooperation with HHSC and State Administrative Agencies.

(a) Cooperation with other HHSC Dental Contractors.

Dental Contractor agrees to reasonably cooperate and work with the State's contractors, including other Dental Contractors, Subcontractors and third-party representatives as requested by HHSC. To the extent permitted by HHSC's financial and personnel resources, HHSC agrees to reasonably cooperate with Dental Contractor and to use its best efforts to ensure that other HHSC contractors reasonably cooperate with the Dental Contractor.

(b) Cooperation with state and federal administrative agencies.

Dental Contractor must ensure that Dental Contractor personnel cooperate with HHSC or other state or federal administrative agency personnel at no charge to HHSC for purposes relating to the administration of the Dental Program including, but not limited to the following purposes:

(1) The investigation and prosecution of fraud, abuse, and waste in the HHSC programs;

(2) Audit, inspection, or other investigative purposes; and

(3) Testimony in judicial or quasi-judicial proceedings relating to the Services or Deliverables under this Contract or other delivery of information to HHSC or other agencies' investigators or legal staff.

(4) Conduct of Dental Contractor personnel and Subcontractors.

Section 4.07 Conduct of Dental Contractor Personnel and Subcontractors.

(a) While performing the Services, Dental Contractor's personnel and Subcontractors must:

(1) Comply with applicable State laws, rules, and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations; and

(2) Otherwise conduct themselves in a businesslike and professional manner.

(b) If HHSC determines in good faith that a particular employee or Subcontractor is not conducting himself or herself in accordance with the Contract, HHSC may provide Dental Contractor with notice and documentation concerning such conduct. Upon receipt of such notice, Dental Contractor must promptly investigate the matter and take appropriate action that may include:

(1) Removing the employee or Subcontractor from the project;

(2) Providing HHSC with written notice of such removal; and

(3) Replacing the employee or Subcontractor with a similarly qualified individual or Subcontractor acceptable to HHSC.

(c) Nothing in the Contract will prevent Dental Contractor, at the request of HHSC, from replacing any personnel who are not adequately performing their assigned responsibilities or who, in the reasonable opinion of HHSC's project manager, after consultation with Dental Contractor, are unable to work effectively with the members of HHSC's staff. In such event, Dental Contractor will provide replacement personnel with equal or greater skills and qualifications as soon as reasonably practicable. Replacement of Key Personnel will be subject to HHSC review. The Parties will work together in the event of any such replacement so as not to disrupt the overall project schedule.

(d) Dental Contractor agrees that anyone employed or retained by Dental Contractor to fulfill the terms of the Contract remains under Dental Contractor's sole direction and control.

(e) Dental Contractor must have policies regarding disciplinary action for all employees who have failed to comply with federal or state laws and the Dental Contractor's standards of conduct, policies and procedures, and contract requirements. Dental Contractor must have policies regarding disciplinary action for all employees who have engaged in illegal or unethical conduct.

Section 4.08 Subcontractors and Agreements with Third Parties.

(a) Dental Contractor remains fully responsible for the obligations, services, and functions performed by its Subcontractors to the same extent as if such obligations, services, and functions were performed by Dental Contractor's employees, and for purposes of the Contract such work will be deemed work performed by Dental Contractor. The Dental Contractor must ensure its contracts with Subcontractors comply with all of the requirements of 42 C.F.R. 438.230. HHSC reserves the right to require the replacement of any Subcontractor found by HHSC to be unacceptable and unable to meet the requirements of the Contract, and to object to the selection of a Subcontractor.

(b) Dental Contractor must:

(1) Actively monitor the quality of care and Services, as well as the quality of reporting data, provided under a Subcontract;

(2) Provide HHSC with a copy of TDI filings of delegation agreements;

(3) Unless otherwise provided in this Contract, provide HHSC with written notice no later than:

(i) 3 Business Days after receiving notice from a Material Subcontractor of its intent to terminate a Subcontract;

(ii) 180 Days prior to the termination date of a Material Subcontract for MIS systems operation or reporting;

(iii) 90 Days prior to the termination date of a Material Subcontract for non-MIS Dental Administrative Services; and

(iv) 30 Days prior to the termination date of any other Material Subcontract.

HHSC may grant a written exception to these notice requirements if, in HHSC's reasonable determination, Dental Contractor has shown good cause for a shorter notice period.

(c) During the Contract Term, Readiness Reviews by HHSC or its designated agent may occur if:

(1) A new Material Subcontractor is employed by Dental Contractor;

(2) An existing Material Subcontractor provides services in a new area;

(3) An existing Material Subcontractor changes locations or changes its MIS and or operational functions;

(4) An existing Material Subcontractor changes one or more of its MIS subsystems, claims processing or operational functions; or

(5) A Readiness Review is requested by HHSC.

Dental Contractor must submit information required by HHSC for each proposed Material Subcontractor as indicated in **RFP Section 2.4**, "Transition Phase Scope." Refer to **RFP Sections 2.5.2**, "Additional Operational Readiness Reviews and Monitoring Efforts," and **2.5.29**, "Management Information System (MIS) Requirements" for additional information regarding Dental Contractor Readiness Reviews during the Contract Term.

(d) Dental Contractor must not disclose HHSC's or the State's Confidential Information to a Subcontractor unless Subcontractor has agreed in writing to protect the confidentiality of such Confidential Information in the manner required of Dental Contractor under the Contract.

(e) Dental Contractor must identify any Subcontractor that is a subsidiary or entity formed after the Effective Date of the Contract, whether or not an Affiliate of the Dental Contractor. Dental Contractor must substantiate the proposed Subcontractor's ability to perform the subcontracted Services, and certify to HHSC that no loss of service will occur as a result of the performance of such Subcontractor. Dental Contractor will be the sole point of contact with regard to contractual matters.

(f) Except as provided herein, all Subcontracts must be in writing and must provide HHSC the right to examine the Subcontract and complete and unredacted originals or copies of all Subcontractor records and information relating to the Contract and the Subcontract. This requirement does not apply to agreements with non-affiliate utility or mail service providers.

If Dental Contractor intends to report compensation or any other payments paid to any third party, including an Affiliate as an Allowable Expense under the Contract, and the amounts paid to the third party exceed $200,000, or are reasonably anticipated to exceed $200,000, in a SFY, or in any contiguous twelve-month period, then Dental Contractor's agreement with the third party must be in writing. The agreement must provide HHSC the right to examine the agreement and complete and unredacted originals or copies of all records and information relating to the agreement.

For any third party agreements not in writing valued under $200,000 per SFY that are reported as Allowable Expenses, the Dental Contractor must maintain standard financial records and data sufficient to verify the accuracy of those expenses in accordance with the requirements of Article 9, "Audit & Financial Compliance." Any agreements that are, or could be interpreted to be, with a single party, must be in writing if the combined total is more than $200,000. This would include payments to individuals or entities that are related to each other.

(g) A Subcontract or any other agreement in which Dental Contractor receives rebates, recoupments, discounts, payments, incentives, fees, free goods, bundling arrangements, retrocession payments, as described in **Chapter 6 of the UMCM**, or any other consideration from a Subcontractor or any other third party, including Affiliates as related to the Contract must be in writing. Dental Contractor must allow HHSC and the Office of the Attorney General to examine the Subcontract or agreement and complete and unredacted originals or copies of all related records and information.

(h) All Subcontracts or agreements described in subsections (f) and (g) must show the dollar amount or the value of any consideration that Dental Contractor pays to or receives from the Subcontractor or any other third party.

(i) Dental Contractor must submit a copy of each Material Subcontract and any agreement covered under subsection (g) executed prior to the Effective Date of the Contract to HHSC no later than 30 days after the Effective Date of the Contract. For Material Subcontracts or Section 4.08(g) agreements executed or amended after the Effective Date of the Contract, the Dental Contractor must submit a copy to HHSC no later than 5 Business Days after execution or amendment.

(j) HHSC reserves the right to reject any Subcontract or require changes to any provisions that do not comply with the requirements or duties and responsibilities of the Contract or create significant barriers for HHSC in monitoring compliance with the Contract.

(k) Dental Contractor and its Subcontractors must provide all information required under Section 4.08 to HHSC, or to the Office of the Attorney General, if requested, at no cost.

Section 4.09 HHSC's Ability to Contract with Subcontractors.

Dental Contractor may not limit or restrict, through a covenant not to compete, employment contract or other contractual arrangement, HHSC's ability to contract with Subcontractors or former employees of the Dental Contractor.

Section 4.10 This Section Intentionally Left Blank.

Section 4.11 Prohibition Against Performance Outside the United States.

(a) All work performed under this Agreement must be performed exclusively within the United States.

(1) All information obtained by the Dental Contractor or a Subcontractor under the Contract must be stored and maintained within the United States.

(2) The performance of any work or the maintenance of any information relating or obtained pursuant to this Contract is forbidden to occur outside of the United States.

(b) For the purpose of this Contract "within the United States" and "outside the United States" means the following:

(1) As used in this **Section 4.11**, the term "within the United States" means any location inside the territorial boundaries comprising the republic of the United States of America, including any of the 48 coterminous states in North America, the states of Alaska and Hawaii, and the District of Columbia.

(2) Conversely, the phrase "outside the United States" means any location that is not within the territorial boundaries comprising the republic of the United States of America, including any of the 48 coterminous states in North America, the states of Alaska and Hawaii, and the District of Columbia.

(c) Maintenance of Confidential Information.

(1) The Dental Contractor and all Subcontractors, vendors, agents, and service providers of or for the Dental Contractor must not allow any Confidential Information that the Dental Contractor receives from or on behalf of HHSC to be moved outside the United States by any means, physical or electronic, at any time, for any period of time, for any reason.

(2) The Dental Contractor and all Subcontractors, vendors, agents, and service providers of or for the Dental Contractor must not permit any person to have remote access to HHSC information, systems, or Deliverables from a location outside the United States.

(d) Performance of Work.

(1) Subject to the exceptions specified in this subparagraph, the Dental Contractor and all Subcontractors, vendors, agents, and service providers of or for the Dental Contractor must perform all services under this Contract, including all tasks, functions, and responsibilities assigned and delegated to the Dental Contractor under this Contract, within the United States.

(i) This obligation includes, but is not limited to, all Services, including information technology services, processing, transmission, storage, archiving, data center services, disaster recovery sites and services, customer support, medical, dental, laboratory and clinical services.

(ii) All custom software prepared for performance of the Contract, and all modifications of custom, third party, or vendor proprietary software, must be performed within the United States.

(2) Subject to the exceptions specified in this subparagraph, the Dental Contractor and all Subcontractors, vendors, agents, and service providers of or for the Dental Contractor must not permit any person to perform work under the Contract from a location outside the United States.

(e) Exceptions.

(1) COTS software. The foregoing requirements will not preclude the acquisition or use of commercial off-the-shelf software that is developed outside the United States or hardware/ that is generically configured outside the United States.

(2) Foreign-made products and supplies. The forgoing requirements will not preclude the Dental Contractor from acquiring, using, or reimbursing products or supplies that are manufactured outside the United States, provided such products or supplies are commercially available within the United States for acquisition or reimbursement by HHSC.

Section 4.12 Employment Verification (E-Verify Program).

(a) Dental Contractors must confirm the eligibility of all persons employed by the Dental Contractor to perform duties within Texas and all persons, including subcontractors, assigned by the Dental Contractor to perform work pursuant to the Contract.

(b) The Dental Contractor may not knowingly have a relationship with the following:

(1) An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(2) An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, of a person described in (b) (1) of this section.

A relationship as described in this section is as follows:

(1) A director, officer, or partner of the Dental Contractor.
(2) A subcontractor of the Dental Contractor as governed by 42 C.F.R. § 438.230.
(3) A person with ownership of 5 percent or more of the Dental Contractor.

(4) A person with an employment, consulting or other arrangement with the Dental Contractor for the provision of items and services that relate to the Dental Contractor's obligations under its contract with the State.

(c) The Dental Contractor must confirm the identity and determine the exclusion status, any subcontractor of the Dental Contractor (as governed by 42 C.F.R. § 438.230), as well as any person with an ownership or control interest, or who is an agent or managing employee of the Dental Contractor as defined in (b) of this section upon contract execution and through checks of federal databases that include the:

(1) U.S. Department of Health and Human Services, Office of Inspector General's List of Excluded Individuals and Entities (LEIE);
(2) System for Awards Management (SAM) [the successor to the Excluded Parties List System (EPLS)];
(3) Social Security Administration's Death Master File (SSA-DMF); and
(4) National Plan & Provider Enumeration System.

(d) The Dental Contractor must consult the databases upon contracting and no less frequently than monthly thereafter. If the Dental Contractor finds a party that is excluded, it must promptly notify the entity and take action consistent with 42 C.F.R. § 438.610(c).

(e) The Dental Contractor must maintain records demonstrating compliance with this section in accordance with Section 9.01 below.

By entering into this Contract, Dental Contractor certifies and ensures that it utilizes and will continue to utilize, for the term of this Contract, the U.S. Department of Homeland Security's verify system to determine the eligibility of all persons, including Subcontractors, assigned by the Dental Contractor to perform work pursuant to the Contract.

Article 5. Member Eligibility, Enrollment, and Disenrollment

Section 5.01 Eligibility Determination and Disenrollment

The HHSC Enrollment Broker determines Medicaid and CHIP eligibility. Should a Member become ineligible for Medicaid, HHSC will disenroll the Member from the managed care plan. If a Dental Contractor becomes aware that a Member has moved outside of the Dental Contractor service area or that a Member is no longer Medicaid-eligible, for example the Member has moved outside of the state or is deceased, the Dental Contractor must inform HHSC within 10 Business Days.

Section 5.02 General Information Concerning Member Enrollment and Disenrollment.

(a) HHSC or the HHSC Enrollment Broker will enroll and disenroll eligible individuals in the Dental Program. The HHSC Enrollment Broker will use HHSC's default assignment

methodologies, as described in 1 Tex. Admin. Code § 353.403 and § 370.303, to enroll individuals who do not select a Dental Plan or Main Dentist. Once an eligible individual is enrolled, a file is sent to the Dental Contractor to notify the Dental Contractor that the individual is enrolled as a Medicaid or CHIP Member. The Dental Contractor is not allowed to induce or accept disenrollment from a Member. The Dental Contractor must refer the Member to the HHSC Enrollment Broker for information regarding enrollment or disenrollment.

(b) HHSC makes no guarantees or representations to the Dental Contractor regarding the number of eligible Members who will ultimately be enrolled into the Dental Contractor's plan, or the length of time Members will remain enrolled in the Dental Contractor's plan. The Dental Contractor has no ownership interest in its Member base, and therefore cannot sell or transfer this base to another entity.

(c) The HHSC Enrollment Broker will electronically transmit to the Dental Contractor new Member information and change information applicable to active Members.

Section 5.03 Medicaid Member Enrollment and Disenrollment.

(a) Medicaid Members are given the opportunity to request a termination or change enrollment from one dental plan to another. A Medicaid Member can request to change dental plans for any reason during the first 90 days of enrollment in a dental plan, and once thereafter. A Medicaid Member can also request to change dental plans for "good cause" at any time. HHSC or its designee will determine "good cause" events that qualify a Member to change dental plans. If a Member requests a change, the change will be prospective, and the effective date will be the first day of the month in which the Member appears on the Member eligibility file for the receiving dental plan.

(b) In cases where a Member loses Medicaid eligibility, if Medicaid eligibility is re-instated or re-established within 6 months from the date of loss, HHSC will retroactively restore a Member's managed care enrollment to avoid a gap in coverage. In these cases, the HHSC Enrollment Broker will retroactively enroll the Member into the same dental plan the Member was in before losing coverage. The retro-enrolled Members will be sent on a daily file to the Dental Contractor and the Dental Contractor must upload the daily Enrollment File into its system within 24 hours of receipt.

(c) A Medicaid Dental Contractor has a limited right to request a Member be disenrolled from Dental Contractor without the Member's consent. HHSC must approve any Dental Contractor request for disenrollment of a Member for cause. HHSC may permit disenrollment of a Member under the following circumstances:

(1) Member misuses or loans Member's membership card to another person to obtain services.

(2) Member's behavior is disruptive or uncooperative to the extent that Member's continued enrollment in the Dental Contractor seriously impairs Dental Contractor's or Provider's ability to provide services to either the Member or other Members, and Member's

behavior is not related to a developmental, intellectual, or physical disability or behavioral health condition.

(3) Member steadfastly refuses to comply with managed care restrictions.

(4) Dental Contractor must take reasonable, documented measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

(d) HHSC must notify the Member of HHSC's decision to disenroll the Member if all reasonable measures have failed to remedy the problem.

(e) If the Member disagrees with the decision to disenroll the Member from Dental Contractor, HHSC must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's Fair Hearing process.

(f) Dental Contractor cannot request a disenrollment based on adverse change in the Member's health status or utilization of services that are Medically Necessary for treatment of a member's condition.

(g) Members taken into conservatorship by the Department of Family and Protective Services (DFPS) will be disenrolled from the Dental Contractor effective the date of conservatorship and enrolled in the STAR Health Program unless otherwise determined by DFPS.

Section 5.04 CHIP Eligibility and Enrollment.

(a) Children enrolled in the CHIP Program with incomes at or below the Medicaid eligibility threshold receive Dental Program coverage for 12 months. Children enrolled in CHIP with incomes above the Medicaid eligibility threshold receive Dental Program coverage for up to 12 months and are required to verify income eligibility at month 6 of their 12-month coverage period. Should a Member become ineligible for CHIP, HHSC will disenroll the Member from the managed care plan. If a Dental Contractor becomes aware that a Member is no longer CHIP-eligible, for example the Member has moved outside of the state or is deceased, the Dental Contractor must inform HHSC within five Business Days.

(b) CHIP Members are given the opportunity to request a termination or change enrollment from one dental plan to another within the first 90 days after Dental Program coverage begins. If a Member requests a change from one dental plan to another, the change will be prospective, and the effective date will be the first day of the month in which the Member appears on the Member eligibility file for the receiving dental plan.

(c) HHSC Enrollment Broker enrolls and disenrolls Members from dental plans. HHSC Enrollment Broker will not allow Members to change dental plans after their first 90 days of coverage unless granted an exception for a "good cause" event. HHSC and the HHSC Enrollment Broker determine "good cause" events that qualify a CHIP Member to change dental plans. Additionally, HHSC Enrollment Broker will not allow CHIP Members who have exhausted their annual benefit limits to change dental plans.

Section 5.05 Default Enrollment.

The following special Default Enrollment process will apply to and be calculated separately for Medicaid and CHIP program recipients.

(a) Special Default Enrollment Process.

(1) Prior to the Operational Start Date, HHSC's Administrative Service Contractor will notify all Dental Members and new enrollees of their choice in dental plans. If a Dental Member does not select a dental plan by the due date established by HHSC, the Dental Member will remain with the Dental Member's current dental plan. If a new enrollee does not select a dental plan by the due date established by HHSC, HHSC will utilize the following special default enrollment process:

i. if the new enrollee has a dental plan affiliation within the last 12 months, assign the new enrollee to the affiliated dental plan;

ii. if a household member of the new enrollee is enrolled in a dental plan, assign the new enrollee to the household member's dental plan; or

iii. if the new enrollee does not have a dental plan affiliation within the last 12 months or a household member that is enrolled in a dental plan, assign the new enrollee to any dental plan below the minimum enrollment threshold in an equal manner.

(2) HHSC will assign new enrollees to a dental plan accordance with this subsection until all dental plans meet the minimum enrollment threshold. The minimum enrollment threshold is 300,000 Members in Medicaid and 80,000 Members in CHIP.

(3) During this maintenance period, if one or more dental plans' enrollment falls below the threshold, HHSC will enroll all individuals who have not made a dental plan selection into these dental plans on a Round Robin basis until they reach the required Member threshold again it will receive 100 percent of the unassociated Member default enrollments until the threshold is reached. If more than one plans' enrollment falls below the threshold, the default population will be split between the plans.

(4) To offset incumbent plans' advantage with prior coverage and household associations, an incremental default process will begin for the incoming plan and continue through operational year one after the enrollment threshold is met.

(5) The default process will incrementally decrease the percentage of unassociated defaults from the initial 100 percent of unassociated defaults down to 33.33 percent over the remaining months of operational year one. The incremental decline will be calculated by dividing 66.67 percent (incumbents' portion of the unassociated defaults) by the number of remaining months left in operational year one. If the incoming plan reaches the enrollment ceiling of one-third of the total dental managed care enrollment population in either Medicaid or CHIP, HHSC will stop the incremental default process for that program and begin the ongoing standard default process, described below in Section

5.05(c), in which all plans receive an equal distribution of the default pool. If the incoming plan fails to meet the enrollment thresholds during year one, the incremental default process will not go into effect.

(6) Medicaid and CHIP default processes will be evaluated separately. For example, if the enrollment minimum threshold is reached in Medicaid but not in CHIP, the initial default process will continue in CHIP and Medicaid will move to an incremental approach.

(7) HHSC reserves the right to revisit these processes if monitoring of enrollment trends or other factors indicate an adjustment to the default enrollment strategy is needed (e.g., due to a significant shift in enrollments).

(8) HHSC will provide notice to the dental plans at least 30 Days in advance of any changes to the final default enrollment strategy outlined above.

(b) Standard Default Enrollment Process.

(1) The standard default enrollment process is a process by which HHSC, on a monthly basis:

i. determines the total number of Dental Members who have not selected a dental plan; and

ii. from this total number, assigns an equal number of Dental Members to each dental plan to the extent possible.

(2) HHSC uses the standard default enrollment process if:

(i) in operational year one, all of the dental plans meet Indie the enrollment ceiling of one-third of the total dental managed care enrollment population in either Medicaid or CHIP (as applicable, Medicaid and CHIP ceilings are treated separately); or

(ii) in a year other than operational year one:

(A) all dental plans meet the enrollment threshold; or
(B) all dental plan's six-month maintenance period have expired.

(c) Changing Assigned Dental Plan.

Defaulted Dental Members may change their assigned dental plan under the conditions described in **Section 5.03** for Medicaid members and **Section 5.04** for CHIP members.

Article 6. Service Levels and Performance Measurement

Section 6.01 Performance Measurement.

(a) Satisfactory performance of this Contract will be measured by:

(b) Adherence to this Contract, including all representations and warranties;

(c) Compliance with project work plans, schedules, and milestones as proposed by Dental Contractor in its Proposal and as revised by Dental Contractor and finally approved by HHSC;

(d) Delivery of the Services and Deliverables in accordance with the Contract's requirements;

(e) Results of audits performed by HHSC or its representatives in accordance with **Article 9** ("Audit and Financial Compliance");

(f) Timeliness, completeness, and accuracy of required Deliverables; and

(g) Achievement of contractual performance measures.

Article 7. Governing Law and Regulations

Section 7.01 Governing Law and Venue.

This Contract is governed by the laws of the State of Texas and interpreted in accordance with Texas law. Provided Dental Contractor first complies with the procedures set forth in **Section 12.13** ("Dispute Resolution,") proper venue for claims arising from this Contract will be in the State District Court of Travis County, Texas.

Section 7.02 Dental Contractor Responsibility for Compliance with Laws and Regulations.

(a) Dental Contractor must comply, to the satisfaction of HHSC, with all provisions set forth in this Contract, and all provisions of state and federal laws, rules, regulations, federal waivers, policies and guidelines that govern the performance of the Services including, but not limited to, all applicable provisions of the following:

(1) Titles XIX and XXI of the Social Security Act;

(2) The Immigration and Nationality Act (8 U.S.C. §§ 1101 *et seq.*) and all subsequent immigration laws and amendments.

(3) The Patient Protection and Affordable Care Act ("PPACA"; Public Law 111-148);

(4) The Health Care and Education Reconciliation Act of 2010 ("HCERA"; Public Law 111-152) 42 C.F.R. Part 455;

(5) Health Insurance Portability and Accountability Act (Public Law 104-191) 45 C.F.R. Parts 160-164;

(6) Clinical Laboratory Improvement Amendments (CLIA, 42 C.F.R. Part 493) (for purposes of the Contract, the Dental Contractor must require its Providers to agree that the Dental Contractor and HHSC are "authorized persons");

(7) 42 C.F.R. Parts 417, 438, 455, and 457, as applicable;

(8) 45 C.F.R. Parts 74 and 92;

(9) 48 C.F.R. Part 31;

(10) 2 C.F.R. Part 200;

(11) Chapters 62, 63, 109, and 181 Texas Health and Safety Code;

(12) Chapter 531 and 533, Texas Government Code;

(13) Chapter 35ATexas Penal Code;

(14) Chapters 32 and 36 Texas Human Resources Code, except as provided in Section 2.5.17, the Texas Dental Practice Act requiring all dental services to be provided by licensed Texas dentists and auxiliary personnel working under the supervision of licensed Texas dentists;

(15) 1 Tex. Admin. Code Chapter 353;

(16) 1 Tex. Admin. Code Chapter 354, Subchapters B and J;

(17) 1 Tex. Admin. Code. Chapters 361, 370, 371, 391, and 392;

(18) Consent Decree and Corrective Action Orders, Frew, et al. v. Smith, et al., (applies to Medicaid only);

(19) The Dental Contractor is prohibited from requiring a Network Provider who is a governmental entity to agree to indemnify the Dental Contractor if such indemnification by the governmental entity is prohibited by law.

(b) The Parties acknowledge that the federal or state laws, rules, regulations, policies, or guidelines that affect the performance of the Services may change from time to time or be added, judicially interpreted, or amended by competent authority. Dental Contractor acknowledges that the Dental Program will be subject to continuous change during the term of the Contract and, except as provided in **Section 8.02**. Dental Contractor has provided for or will provide for adequate resources, at no additional charge to HHSC, to reasonably accommodate such changes. The Parties further acknowledge that Dental Contractor was selected, in part, because of its expertise, experience, and knowledge concerning applicable federal or state laws, rules, regulations, policies, or guidelines that affect the performance of the Services. In keeping with HHSC's reliance on this knowledge and expertise, Dental Contractor is responsible for identifying the impact of changes in applicable federal or state legislative enactments and regulations that affect the performance of the Services or the State's use of the Services. Dental Contractor must timely notify HHSC of such changes and must work with HHSC to identify the impact of such changes on how the State uses the Services.

(c) HHSC will notify Dental Contractor of any changes in applicable law, rule, regulation, policy, or guidelines that HHSC becomes aware of in the ordinary course of its business.

(d) The Dental Contractor is responsible for compliance with changes in federal and state law that occur during the course of the contract term. If there are any conflicts between rules promulgated by CMS, including the C.F.R., and this Contract, then the federal rule takes

precedence over the Contract and the Dental Contractor must comply with the C.F.R unless CMS has waived applicability of the C.F.R. provision to Texas Medicaid via a waiver.

(e) Dental Contractor is responsible for any fines, penalties, or disallowances imposed on the State or Dental Contractor arising from any noncompliance with the laws and regulations relating to the delivery of the Services or Deliverables by the Dental Contractor, its Subcontractors or agents.

(f) Dental Contractor is responsible for ensuring each of its employees, agents, or Subcontractors who provide Services or Deliverables under the Contract is properly licensed, certified, and/or has proper permits to perform any activity related to the Services or Deliverables.

(g) Dental Contractor warrants that the Services and Deliverables will comply with all applicable federal, state, and county laws, regulations, codes, ordinances, guidelines, and policies. Dental Contractor will indemnify HHSC from and against any losses, liability, claims, damages, penalties, costs, fees, or expenses arising from or in connection with Dental Contractor's failure to comply with or violation of any such law, rule, regulation, code, ordinance, or policy.

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Section 7.04 This Section Intentionally Left Blank.

Section 7.05 Compliance with State and Federal Anti-discrimination Laws.

(a) Dental Contractor agrees to comply with state and federal anti-discrimination laws, including without limitation:

(1) Title VI of the Civil Rights Act of 1964 (42 U.S.C. §§ 2000d *et seq*.);

(2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794);

(3) Americans with Disabilities Act of 1990 (42 U.S.C. §§ 12101 *et seq*.);

(4) Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-6107);

(5) Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681-1688 regarding education programs and activities);

(6) Food and Nutrition Act of 2008 (7 U.S.C. §§ 2011 *et. seq*.); and

(7) The HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

Dental Contractor agrees to comply with all amendments to the above-referenced laws, and all requirements imposed by the regulations issued pursuant to these laws. These laws provide in part that no persons in the United States may, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service or other benefits provided by Federal or State funding, or otherwise be subjected to discrimination.

(b) Dental Contractor agrees to comply with Title VI of the Civil Rights Act of 1964, and its implementing regulations at 45 C.F.R. Part 80 or 7 C.F.R. Part 15, prohibiting a contractor from adopting and implementing policies and procedures that exclude or have the effect of excluding or limiting the participation of clients in its programs, benefits, or activities on the basis of national origin. Applicable state and federal civil rights laws require contractors to provide alternative methods for ensuring access to services for applicants and recipients who cannot express themselves fluently in English. Dental Contractor agrees to ensure that its policies do not have the effect of excluding or limiting the participation of persons in its programs, benefits, and activities on the basis of national origin. Dental Contractor also agrees to take reasonable steps to provide services and information, both orally and in writing, in appropriate languages other than English, in order to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities.

(c) Dental Contractor agrees to comply with Section 1557 of the Patient Protection and Affordable Care Act;

(d) Dental Contractor agrees to comply with Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16. These provide in part that any organization that participates in programs funded by direct financial assistance from the United States Department of Agriculture or the United States Department of Health and Human Services must not, in providing services, discriminate against a program beneficiary or prospective program beneficiary on the basis of religion or religious belief.

(e) Upon request, Dental Contractor will provide HHSC Civil Rights Office with copies of all of the Dental Contractor's civil rights policies and procedures.

(f) Dental Contractor must notify HHSC's Civil Rights Office of any civil rights complaints received relating to its performance under this Agreement. This notice must be delivered no more than ten Days after receipt of a complaint. Notice provided pursuant to this section must be directed to:

HHSC Civil Rights Office

701 W. 51st Street, Mail Code W206

Austin, Texas 78751

Phone Toll Free: (888) 388-6332

Phone: (512) 438-4313

TTY Toll Free: (877) 432-7232

Fax: (512) 438-5885.

Section 7.06 Environmental Protection Laws.

Dental Contractor must comply with the applicable provisions of federal environmental protection laws as described in this Section:

(a) Pro-Children Act of 1994.

Dental Contractor must comply with the Pro-Children Act of 1994 (20 U.S.C. §§ 6081 *et seq*.), as applicable, regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products.

(b) National Environmental Policy Act of 1969.

Dental Contractor must comply with any applicable provisions relating to the institution of environmental quality control measures contained in the National Environmental Policy Act of 1969 (42 U.S.C. §§ 4321 *et seq*.) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality").

(c) Clean Air Act and Water Pollution Control Act regulations.

Dental Contractor must comply with any applicable provisions relating to required notification of facilities violating the requirements of Executive Order 11738 ("Providing for Administration of the Clean Air Act and the Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, or Loans").

(d) State Clean Air Implementation Plan.

Dental Contractor must comply with any applicable provisions requiring conformity of federal actions to State (Clean Air) Implementation Plans under § 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§ 740 *et seq*.).

(e) Safe Drinking Water Act of 1974.

Dental Contractor must comply with applicable provisions relating to the protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (21 U.S.C. § 349; 42 U.S.C. §§ 300f to 300j-9).

Section 7.07 HIPAA.

(a) Dental Contractor must comply with applicable provisions of HIPAA. This includes the requirement that the Dental Contractor's MIS system comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to HIPAA. Dental Contractor must comply with HIPAA EDI requirements.

(b) Additionally, Dental Contractor must comply with HIPAA notification requirements, including those set forth in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. §§ 17931 *et seq*. If, in HHSC's determination, Dental Contractor has not provided notice in the manner or format prescribed by the HITECH Act, then HHSC may require the Dental Contractor to provide this notice.

(c) Dental Contractor must notify HHSC of all breaches or potential breaches of unsecured protected health information, as that term is defined by the HITECH Act. As noted in **Article 2**, "Definitions," Confidential Information includes HIPAA-defined protected health information. Therefore, any breach of that information is also subject to the requirements, including notice requirements, in **Article 11**, "Disclosure & Confidentiality of Information."

(d) The Dental Contractor must use or disclose protected health information as authorized and in response to another HIPAA-covered entity's inquiry about a Member for authorized purposes of treatment, payment, healthcare operations, or as required by law under HIPAA.

(e) The Dental Contractor must comply with rights of individual access by a Member or a Member's Legally Authorized Representative to Member's protected health information. The Dental Contractor may permit limited disclosures of protected health information as permissible under HIPAA for a family member, other relative, or close personal friends of the Member or anyone identified in the Member's protected health information directly relevant to the Member's involvement with the Member's healthcare or payment related to the Member's healthcare. The Dental Contractor should refer to 45 C.F.R. § 164.510(b) and related regulatory guidance for additional information.

Section 7.08 Privacy, Security and Breach Notification Laws

(a) The Dental Contractor must comply with all applicable privacy, security and breach notification laws and regulations, including the following, if applicable to the type of Confidential Information and the authorized purpose for which it is being used:

(1) 1 Tex. Admin. Code Chapter 202, Subchapter B;

(2) The Privacy Act of 1974;

(3) OMB Memorandum 17-12;

(4) The Federal Information Security Management Act of 2002 (FISMA);

(5) The Health Insurance Portability and Accountability Act of 1996 (HIPAA);

(6) Internal Revenue Publication 1075 - Tax Information Security Guidelines for Federal, State, and Local Agencies;

(7) National Institute of Standards and Technology (NIST) Special Publication 800-66 Revision 1 - An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security Rule;

(8) NIST Special Publications 800-53 and 800-53A - Recommended Security Controls for Federal Information Systems and Organizations, as currently revised;

(9) NIST Special Publications 800-47 - Security Guide for Interconnecting Information Technology Systems;

(10) NIST Special Publication 800-88, Guidelines for Media Sanitization;

(11) NIST Special Publication 800-111, Guide to Storage of Encryption Technologies for End User Devices containing PHI;

(12) Family Educational Rights and Privacy Act

(b) Any other State or Federal law, regulation, or administrative rule relating to the specific HHS program area that the Dental Contractor supports on behalf of HHS.

(c) The Dental Contractor must notify HHSC of all Breaches or potential Breaches of Confidential Information in compliance with applicable laws and regulations as specified in **Article 11** of this Contract.

Section 7.09 Historically Underutilized Business Participation Requirements.

(a) Definitions.

For purposes of this Section:

(1) "Historically Underutilized Business" or "HUB" means a minority or women-owned business as defined by Texas Government Code, Chapter 2161.

(2) "HSP" means a HUB Subcontracting Plan for Dental Administrative Services.

(b) HUB Requirements.

(1) In accordance with Attachment G, the Dental Contractor must submit an HSP with its Proposal for HHSC's approval and maintain the HSP thereafter.

(2) The Dental Contractor must report to HHSC's contract manager and HUB Office monthly, in the format required by **Chapter 5.4.4.5 of the UMCM,** its use of HUB Subcontractors to fulfill the subcontracting opportunities identified in the HSP.

(3) The Dental Contractor must obtain prior written approval from the HHSC HUB Office before making any changes to the HSP. The proposed changes must comply with HHSC's good faith effort requirements relating to the development and submission of HSPs.

(4) The Dental Contractor must submit a revised HSP to the HHSC HUB Office when it: changes the dollar amount of, terminates, or modifies an existing Subcontract for Dental Administrative Services; or enters into a new Subcontract for Dental Administrative Services. All proposed changes to the HSP must comply with the requirements of this Agreement.

(5) HHSC will determine if the value of Subcontracts to HUBs meet or exceed the HUB subcontracting provisions specified in the Dental Contractor's HSP. If HHSC determines that the Dental Contractor's subcontracting activity does not demonstrate a good faith effort, the Contractor may be subject to provisions in the Vendor Performance and Debarment Program (1 Tex. Admin. Code § 20.585), and subject to remedies for breach.

Section 7.10 Compliance with Fraud, Waste, and Abuse Requirements.

Dental Contractor, Dental Contractor's personnel, and all Subcontractors must comply with all fraud, waste, and abuse requirements found in HHS Circular C-027. The Dental Contractor must comply with Circular C-027 requirements in addition to other fraud, waste, and abuse provisions in the contract and in state and federal law.

Article 8. Amendments and Modifications

Section 8.01 Mutual Contract.

This Contract may be amended at any time by mutual agreement of the Parties. The amendment must be in writing and signed by individuals with authority to bind the Parties.

Section 8.02 Changes in Law or Contract.

If federal or state laws, rules, regulations, policies or guidelines are adopted, promulgated, judicially interpreted or changed, or if contracts are entered or changed, the effect of which is to alter the ability of either Party to fulfill its obligations under this Contract, the Parties will promptly negotiate in good faith appropriate modifications or alterations to the Contract and any schedules or attachments made a part of this Contract. Such modifications or alterations must be in writing and signed by individuals with authority to bind the Parties, equitably adjust the terms and conditions of this Contract, and must be limited to those provisions of this Contract affected by the change.

Section 8.03 Modifications as a Remedy.

This Contract may be modified under the terms of **Article 12** ("Remedies and Disputes").

Section 8.04 Modification Process.

(a) If HHSC seeks modifications to the Contract as a condition of any Contract extension, HHSC's notice to Dental Contractor will specify those modifications to the Scope of Work, the Contract pricing terms, or other Contract terms and conditions.

(b) Dental Contractor must respond to HHSC's proposed modification within the timeframe specified by HHSC, generally within ten Business Days of receipt. Upon receipt of Dental Contractor's response to the proposed modifications, HHSC may enter into negotiations with Dental Contractor to arrive at mutually agreeable Contract amendments. In the event that HHSC determines that the Parties will be unable to reach agreement on mutually satisfactory contract modifications, then HHSC may provide written notice to Dental Contractor of its intent to terminate the Contract or not to extend the Contract beyond the Contract Term then in effect.

Section 8.05 Modification of HHSC Uniform Managed Care Manual.

(a) HHSC will provide Dental Contractor with at least ten Business Days advance written notice before implementing a substantive and material change in the HHSC Uniform Managed Care Manual (UMCM). For purposes herein, this would refer to a change that materially and substantively alters the Dental Contractor's ability to fulfill its obligations under the Contract. The UMCM, and all modifications thereto, are incorporated by reference into this Contract. HHSC will provide Dental Contractor with a reasonable amount of time to comment on such changes, generally at least five Business Days. HHSC is not required to provide advance written notice of changes that are not material and substantive in nature, such as corrections of clerical errors or policy clarifications.

(b) The Parties agree to work in good faith to resolve disagreements concerning material and substantive changes to the UMCM. If the Parties are unable to resolve issues relating to material and substantive changes, then either Party may terminate the agreement in accordance with **Article 12** ("Remedies and Disputes").

(c) Changes will be effective on the date specified in HHSC's written notice, which will not be earlier than the Dental Contractor's response deadline, and such changes will be incorporated into the HHSC UMCM. If the Dental Contractor has raised an objection to a material and substantive change to the UMCM and submitted a notice of termination in accordance with **Section 12.04(e)**, HHSC will not enforce the change during the period of time between the receipt of the notice and the date of Contract termination.

Section 8.06 Required Compliance with Amendment and Modification Procedures.

No different or additional services, work, or products will be authorized or performed except as authorized by this Article. No waiver of any term, covenant, or condition of this Contract will be valid unless executed in compliance with this Article. Dental Contractor will not be entitled to payment for any services, work or products that are not authorized by a properly executed Contract amendment or modification.

Article 9. Audit and Financial Compliance and Litigation Hold

Section 9.01 Record Retention and Audit.

(a) The State, CMS, the OIG, the Comptroller, the Attorney General and their designees have the right to investigate, audit, inspect, and review complete and unredacted originals or copies of records and information related to this Contract of the Dental Contractor or to contracts between the Dental Contractor and the Dental Contractor's Subcontractors for ten years from the final date of the Contract Term or from the date of any audit, whichever is later.

(b) Dental Contractor agrees to maintain, and require its Subcontractors to maintain, records, books, documents, and information (collectively "records") that are adequate to ensure that the services provided and are made payments in accordance with the requirements of this Contract, including **Chapter 18 of the UMCM** and applicable Federal and State requirements (e.g., 45 C.F.R. § 74.53). Such records must be retained by Dental Contractor and its Subcontractors for a period of ten years after the Contract Expiration Date or until the resolution of all litigation, claims, financial management reviews or audits pertaining to this Contract, whichever is longer.

(c) The Dental Contractor and the Dental Contractor's Subcontractors must retain, as applicable, enrollee grievance and appeal records under 42 C.F.R. § 438.16, base data in 42 C.F.R. § 438.5(c), MLR reports under 42 C.F.R. § 438.8(k), and the data, information, and documentation specified under 42 C.F.R. § 438.604, § 438.606, § 438.608, and § 438.610 for a period no less than ten years from the expiration date of this Contract or from the date of the completion of any audit, whichever is later.

(d) Additionally, Dental Contractor agrees to retain and to require its Subcontractors to retain all records in accordance with any litigation hold that is provided to them by HHSC and actively participate in the discovery process if required to do so, at no additional charge to HHSC. Litigation holds may require the Dental Contractor or its Subcontractors to keep the records longer than other records retention schedules. The Dental Contractor will be required to retain all records subject to the litigation hold until notified by HHSC when the litigation hold ends and then other approved records retention schedule(s) may resume. If Dental Contractor or its Subcontractors fail to retain the pertinent records after receiving a litigation hold from HHSC, the Dental Contractor agrees to pay to HHSC all damages, costs, and expenses incurred by HHSC arising from such failure to retain.

This Article survives any termination or expiration of the Contract.

Section 9.02 Access to Records, Books, and Documents.

(a) Upon reasonable notice, Dental Contractor must provide, and cause its Subcontractors to provide, at no cost to the officials and entities identified in this Section prompt, reasonable, and adequate access to complete and unredacted originals or copies of any records and information that are related to the scope of this Contract.

(b) Dental Contractor and its Subcontractors must provide the access described in this Section upon HHSC's request. This request may be for, but is not limited to, the following purposes:

(1) examination;

(2) audit;

(3) investigation;

(4) inspection;

(5) contract administration; or

(6) the making of copies, excerpts, or transcripts.

(c) The access required must be provided to the following officials and/or entities:

(1) The United States Department of Health and Human Services or its designee;

(2) The Comptroller General of the United States or its designee;

(3) Dental Program personnel from HHSC or its designee, including HHSC's independent auditor;

(4) The Office of Inspector General;

(5) The Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;

(6) Any independent verification and validation contractor or quality assurance contractor acting on behalf of HHSC;

(7) The Office of the State Auditor of Texas or its designee;

(8) A State or Federal law enforcement agency;

(9) A special or general investigating committee of the Texas Legislature or its designee; and

(10) Any other State or Federal entity identified by HHSC, or any other entity engaged by HHSC.

(d) Dental Contractor agrees to provide the access described wherever Dental Contractor maintains such books, records, and supporting documentation. Dental Contractor further agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described in this Section. Dental Contractor will require its Subcontractors to provide comparable access and accommodations.

(e) Upon request, the Dental Contractor must provide complete and unredacted originals or copies of the records and information described in this Section free of charge to HHSC and the entities described in subsection (c).

(f) In accordance with Texas Government Code § 533.012(e), any records and information submitted to HHSC or the Texas Attorney General's Office pursuant to Texas Government Code § 533.012(a)(1) are confidential and are not subject to disclosure under the Texas Public Information Act.

Section 9.03 Audits of Services, Deliverables and Inspections.

(a) Upon reasonable notice from HHSC, Dental Contractor will provide, and will cause its Subcontractors to provide, such investigators, auditors, reviewers, and inspectors as HHSC may from time to time designate, with access to:

(1) service locations, facilities, or installations;

(2) complete and unredacted originals or copies of records and information related to this Contract; and

(3) software.

Reasonable notice may include time-limited or immediate requests for information.

(b) The access described in this Section will be for the purpose of examining, inspecting, auditing, reviewing, or investigating:

(1) Dental Contractor's capacity to bear the risk of potential financial losses;

(2) The Services and Deliverables provided;

(3) A determination of the amounts payable under this Contract;

(4) A determination of the allowability of costs reported under this Contract;

(5) An examination of Subcontract terms and/or transactions;

(6) An assessment of financial results under this Contract;

(7) Detection of fraud, waste, or abuse;

(8) Other purposes HHSC deems necessary to perform its regulatory function and/or enforce the provisions of this Contract.

(c) Dental Contractor must provide, as part of the Services, any assistance that such investigators, auditors, reviewers, and inspectors reasonably may require to complete such investigations, audits, reviews, or inspections.

(d) If, as a result of an investigation, audit, inspection, or review of payments made to the Dental Contractor, HHSC discovers a payment error or overcharge, HHSC will notify the Dental Contractor of such error or overcharge. HHSC will be entitled to recover such funds as an offset to future payments to the Dental Contractor, or to collect such funds directly from the Dental Contractor. Dental Contractor must return funds owed to HHSC within 30days after receiving notice of the error or overcharge, or interest will accrue on the amount due. HHSC will assess any such interest at 12 per cent per annum, compounded daily. In the event that an audit reveals that errors in reporting by the Dental Contractor have resulted in errors in payments to the Dental Contractor or errors in the calculation of the Experience Rebate, the Dental Contractor will indemnify HHSC for any losses resulting from such errors, including the cost of the investigation, audit, inspection or review. If the interest rate stipulated hereunder is found by a court of competent jurisdiction to be outside the range deemed legal and enforceable, then the rate hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

Section 9.04 SAO Audit.

The Dental Contractor understands that acceptance of funds under this Contract acts as acceptance of the authority of the State Auditor's Office ("SAO"), or any successor agency, to conduct an investigation in connection with those funds. The Dental Contractor further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested at no cost. The Dental Contractor will ensure that this clause concerning the authority to audit funds and the requirement to cooperate is included in any Subcontract, and in any third party agreements described in **Section 4.08**.

Section 9.05 Response and Compliance with Findings.

(a) Dental Contractor must take action to ensure its or a Subcontractor's compliance, or correction of any finding of noncompliance, with any law, regulation, audit requirement, or generally accepted accounting principle relating to the Services and Deliverables or any other deficiency contained in any investigation, audit, review, or inspection conducted under this Article. This action will include Dental Contractor's delivery to HHSC, for HHSC'S approval, a Corrective Action Plan that addresses deficiencies identified in any investigation, audit, review, or inspection within 30 Days of the close of the investigation, audit, review, or inspection.

(b) Dental Contractor must bear the expense of compliance with any finding of noncompliance under this Section that is:

(1) Required by Texas or Federal law, regulation, rule, court order, or other audit requirement relating to Dental Contractor's business;

(2) Performed by Dental Contractor as part of the Scope of Work; or

(3) Necessary due to Dental Contractor's noncompliance with any law, regulation, rule, court order, or audit requirement imposed on Dental Contractor.

(c) As part of the Scope of Work, Dental Contractor must provide to HHSC upon request a copy of those portions of Dental Contractor's and its Subcontractors' internal audit reports relating to the Services and Deliverables provided to HHSC under this Contract.

Section 9.06 Notification of Legal and Other Proceedings, and Related Events.

The Dental Contractor must notify HHSC of all proceedings, actions, and events as specified in **Chapter 5 of the UMCM**.

Article 10. Terms and Conditions of Payment

Section 10.01 Calculation of Monthly Premium Payment.

(a) This is a risk-based contract. For each Program, HHSC will pay the Dental Contractor monthly Premium Payments set forth in the Dental Program Contract, based on the number of eligible enrolled Members. HHSC will calculate the monthly Premium Payments by multiplying the number of Members in each Rate Cell category by the Premium Rate for each Rate Cell. In consideration of the Monthly Premium Payments, the Dental Contractor agrees to provide the Services and Deliverables described in this Contract.

(b) The Dental Contractor must provide timely financial and statistical information necessary in the Premium Rate determination process. Encounter Data provided by Dental Contractor must conform to all HHSC requirements. Encounter Data containing non-compliant information, including, but not limited to, inaccurate Member identification numbers, inaccurate provider identification numbers, or diagnosis or procedures codes insufficient to adequately describe the diagnosis or procedure performed, will not be considered in the Dental Contractor's experience for rate-setting purposes.

(c) Information or data, including complete and accurate Encounter Data, as requested by HHSC for rate-setting purposes, must be provided to HHSC: (1) within 30 days of receipt of the letter from HHSC requesting the information or data; and (2) no later than March 31st of each year.

(d) The fixed monthly Premium Rate consists of the following components:

(1) An amount for the dental services performed during the month;

(2) An amount for administering the program, and

(3) An amount for the Dental Contractor's risk margin.

Premium Rates for each Program may vary by Dental Contractor. HHSC will employ or retain qualified actuaries to perform data analysis and calculate the Premium Rates for each rate period.

(e) Dental Contractor understands and expressly assumes the risks associated with the performance of the duties and responsibilities under this Contract, including the failure, termination or suspension of funding to HHSC, delays or denials of required approvals, and cost overruns not reasonably attributable to HHSC.

Section 10.02 Time and Manner of Payment.

(a) During the Contract Term and beginning after the Operational Start Date, HHSC will pay the monthly Premium Payments by the 10th Business Day of each month.

(b) The Dental Contractor must accept Premium Payments by direct deposit into the Dental Contractor's account.

(c) HHSC may adjust the monthly Premium Payment to the Dental Contractor in the case of an overpayment to the Dental Contractor, for Experience Rebate amounts due and unpaid (including any interest thereon), or if money damages (including any associated interest) are assessed in accordance with **Article 12**, "Remedies and Disputes."

(d) HHSC's payment of monthly Premium Payments is subject to availability of appropriations. If appropriations are not available to pay the full monthly Premium Payment, HHSC may:

(1) Equitably adjust the Premium Payments for all participating Dental Contractors, and reduce scope of service requirements as appropriate in accordance with **Article 8** "Amendments and Modifications," or

(2) Terminate the Contract in accordance with **Article 12** "Remedies and Disputes."

Section 10.03 Certification of Premium Rates.

HHSC will employ or retain a qualified actuary to certify the actuarial soundness of the Premium Rates, and all revisions or modifications thereto.

Section 10.04 Modification of Premium Rates.

The Parties expressly understand and agree that the agreed Premium Rates are subject to modification in accordance with **Article 8** "Amendments and Modifications," if changes in state or federal laws, rules, regulations, guidelines, policies, or court orders affect the rates or the actuarial soundness of the rates. HHSC will provide the Dental Contractor notice of a modification to the Premium Rates at least 60 days prior to the effective date of the change, unless HHSC determines that circumstances warrant a shorter notice period. If the Dental Contractor does not accept the rate change, either Party may terminate the Contract in accordance with **Article 12** "Remedies and Disputes."

Section 10.05 CHIP Premium Rates Structure.

(a) CHIP Rate Cells.

CHIP Premium Rates are defined on a per Member per month basis by the Rate Cells. CHIP Rate Cells are based on the Member's age group as follows:

(1) Under age one;

(2) Ages one through 5;

(3) Ages 6 through 14; and

(4) Ages 15 through 18.

These Rate Cells are subject to change after Rate Period 1.

(b) CHIP Premium Rates for Rate Period1.

The CHIP Premium Rates for Rate Period 1 will be included in the negotiated HHSC Dental Program Contract.

(c) CHIP Premium Rate development.

HHSC will establish base Premium Rates by analyzing Encounter Data and financial data. This analysis will include a review of historical enrollment and claims experience information; any changes to Medically Necessary Covered Dental Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information. HHSC may modify the base Premium Rates using diagnosis based risk adjusters to yield the final Premium Rates.

(d) Acuity Adjustment

HHSC may evaluate and implement an acuity adjustment methodology, or alternative reasonable methodology, that appropriately reimburses the Dental Contractor for acuity and cost differences that deviate from that of the community average, if HHSC in its sole discretion determines that such a methodology is reasonable and appropriate. The community average is a uniform rate for all Dental Contractor s in a Service Area and is determined by combining all the experience for all Dental Contractors in a Service Area to get an average rate for the Service Area.

(e) Value-Added Services.

Value-added Services will not be included in the rate-setting process.

(f) Case-by-case Services.

Case-by-case Services will not be included in the rate setting process.

Section 10.06 Medicaid Premium Rates Structure

(a) Medicaid Rate Cells.

Medicaid Premium Rates are defined on a per Member per month basis by the Rate Cells. Medicaid Rate Cells are:

(1) Under age one;

(2) Ages one through 5;

(3) Ages 6 through 14;

(4) Ages 15-18; and

(5) Ages 19 through 20.

(b) Medicaid Premium Rate development.

HHSC will establish base Premium Rates by analyzing historical Medicaid Encounter Data and financial data. This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information.

(c) Acuity adjustment.

HHSC may evaluate and implement an acuity adjustment methodology, or alternative reasonable methodology, that appropriately reimburses the Dental Contractor for acuity and cost differences that deviate from that of the community average, if HHSC in its sole discretion determines that such a methodology is reasonable and appropriate. The community average is a uniform rate for all Dental Contractors in a Service Area, and is determined by combining all the experience for all Dental Contractors in a Service Area to get an average rate for the Service Area.

(d) Value-Added Services.

Value-added Services will not be included in the rate-setting process.

(e) Case-by-case Services.

Case-by-case Services will not be included in the rate setting process

Section 10.07 Adjustments to Premium Payments

(a) Adjustment.

HHSC may adjust a payment made to the Dental Contractor for a Member if:

(1) A Member's eligibility status or program type is changed, corrected as a result of error, or is retroactively adjusted;

(2) The Member is enrolled into the Dental Contractor in error;

(3) The Member moves outside the United States;

(4) The Member dies before the first day of the month for which the payment was made; or

(5) The payment has been denied by the CMS in accordance with the requirements of 42 C.F.R. § 438.730.

(b) Appeal of adjustment.

The Dental Contractor may appeal the adjustment of premiums in the above circumstances using the HHSC dispute resolution process set forth in **Section 12.13**, ("Dispute Resolution").

Section 10.08 Experience Rebate

(a) Dental Contractor's duty to pay.

At the end of each FSR Reporting Period, the Dental Contractor must pay an Experience Rebate for the Program to HHSC as detailed in ATTACHMENT M, EXPERIENCE REBATE PROPOSAL SUBMISSION. The Net Income Before Taxes and total Revenues are as measured by the Financial-Statistical Report (FSR) as reviewed and confirmed by HHSC. The final amount used in the calculation of the percentage may be impacted by the Loss Carry Forward; see **Section 10.08 (c).**

With the exception of the Dual Demonstration, the percentages are calculated on a Consolidated Basis, and include the consolidated Net Income Before Taxes for all of the Dental Contractor's HHSC capitated managed care contracts, including any separate capitated managed care contracts with the Dental Contractor's parent or other affiliated legal entities.

(b) Net Income Before Taxes.

(1) The Dental Contractor must compute the Net Income Before Taxes in accordance with the HHSC **Chapter 5 and 6 of the UMCM** and applicable federal regulations. The Net Income Before Taxes will be confirmed by HHSC or its agent for the FSR Reporting Period relating to all Revenues and Allowable Expenses incurred pursuant to the Contract. HHSC reserves the right to modify the UMCM in accordance with **Section 8.05**, "Modification of the HHSC Uniform Managed Care Manual."

(2) For purposes of calculating Net Income Before Taxes, certain items are omitted from the calculation, as they are not Allowable Expenses; these include:

(i) the payment of an Experience Rebate;

(ii) any interest expense associated with late or underpayment of the Experience Rebate;

(iii) financial incentives;

(iv) financial disincentives, including without limitation any incentives described in **Section 2.6** of the RFP; and

(v) The liquidated damages, and any interest expense associated, as described in Attachment "C."

See **Chapter 6 of the UMCM.**

(3) Financial incentives are true net bonuses and will not be reduced by the potential increased Experience Rebate payments. Financial disincentives are true net disincentives and will not be offset in whole or in part by potential decreases in Experience Rebate payments.

(4) For FSR reporting purposes, financial incentives incurred must not be reported as an increase in Revenues or as an offset to costs, and any financial incentive award of such will not

increase reported income. Financial disincentives incurred must not be included as reported expenses, and must not reduce reported income. The reporting or recording of any of these incurred items will be done on a memo basis, which is below the income line, and will be listed as separate items.

(c) Carry forward of prior FSR Reporting Period losses.

(1) General.

Losses incurred on a Consolidated Basis by the Dental Contractor for a given FSR Reporting Period may be carried forward to the next FSR Reporting Period and applied as an offset against consolidated pre-tax net income for determination of any Experience Rebate due. These prior losses may be carried forward for up to two contiguous FSR Reporting Periods.

When a loss in a given FSR Reporting Period is carried forward and applied against profits either or both of the next two FSR Reporting Periods, the loss must first be applied against the first subsequent FSR Reporting Period. The profit in the first subsequent FSR Reporting Period is reduced to a zero pre-tax income; any additional loss then remaining unapplied may be carried forward to any profit in the next subsequent FSR Reporting Period. In this case, the revised income in the third FSR Reporting Period would be equal to the cumulative income of the three contiguous FSR Reporting Periods. The loss cannot be carried forward to the fourth FSR Reporting Period or beyond.

Losses incurred in the last or next-to-last FSR Reporting Period of a prior contiguous contract with HHSC may be carried forward up to two FSR Reporting Periods, into the first or potentially second FSR Reporting Period of this Contract, if the losses meet all other requirements of both the prior and current contracts.

(2) Basis of consolidation.

In order for a loss to be eligible for potential carryforward as an offset against future income, the Dental Contractor must have a negative Net Income Before Taxes for an FSR Reporting Period on a Consolidated Basis.

(d) Settlements for payment.

(1) There may be one or more Dental Contractor payment(s) of the State share of the Experience Rebate on income generated for a given FSR Reporting Period. The first scheduled payment (the "Primary Settlement") will equal 100 percent of the State share of the Experience Rebate as derived from the FSR, and will be paid on the same day the 90-day FSR Report is submitted to HHSC.

The "Primary Settlement," as utilized herein, refers strictly to what should be paid with the 90-day FSR, and does not refer to the first instance in which the Dental Contractor may tender a payment. For example, the Dental Contractor may submit a 90-day FSR indicating no Experience Rebate is due, but then submit a 334-day FSR with a higher income and a

corresponding Experience Rebate payment. In such case, this initial payment would be subsequent to the Primary Settlement.

(2) The next scheduled payment will be an adjustment to the Primary Settlement, if required, and will be paid on the same day that the 334-day FSR Report is submitted to HHSC, if the adjustment is a payment from the Dental Contractor to HHSC. **Section 10.08(e)** describes the interest expenses associated with any such payment after the Primary Settlement.

The Dental Contractor may make non-scheduled payments at any time to reduce the accumulation of interest under **Section 10.08(e).** For any nonscheduled payments prior to the 334-day FSR, the Dental Contractor is not required to submit a revised FSR, but is required to submit an Experience Rebate calculation form and an adjusted summary page of the FSR. The FSR summary page is labeled "Summary Income Statements (Dollars), All Coverage Groups Combined (FSR, Part I)."

(3) HHSC or its agent may audit or review the FSRs. If HHSC determines that corrections to the FSRs are required, based on an HHSC audit/review or other documentation acceptable to HHSC, then HHSC will make final adjustments. Any payment resulting from an audit or final adjustment will be due from the Dental Contractor within 30 days of the earlier of:

(i) The date of the management representation letter resulting from the audit; or

(ii) The date of any invoice issued by HHSC.

Payment within this 30-day timeframe will not relieve the Dental Contractor of any interest payment obligation that may exist under **Section 10.08(e**).

(4) In the event that any Experience Rebates and/or corresponding interest payments owed to the State are not paid by the required due dates, then HHSC may offset such amounts from any future Capitation Payments, or collect such sums directly from the Dental Contractor. HHSC may adjust the Experience Rebate if HHSC determines the Dental Contractor has paid amounts for goods or services that are not reasonable, necessary, allocable, and allowable in accordance with the HHSC UMCM Chapters 5 and 6 the Federal Acquisition Regulations (FAR), or other applicable federal or state regulations. HHSC has final authority in auditing and determining the amount of the Experience Rebate.

(e) Interest on Experience Rebate.

(1) Interest on any Experience Rebate owed to HHSC will be charged beginning 35 days after the due date of the Primary Settlement, as described in **Section 10.08(d)(1)**. Thus, any Experience Rebate due or paid on or after the Primary Settlement will accrue interest starting at 35 days after the due date for the 90-day FSR Report. For example, any Experience Rebate payment(s) made in conjunction with the 334-day FSR, or as a result of audit findings, will accrue interest back to 35 days after the due-date for submission of the 90-day FSR.

The Dental Contractor has the option of preparing an additional FSR based on 120 days of claims run-out (a "120- day FSR"). If a 120-day FSR, and an Experience Rebate payment

based on it, are received by HHSC before the interest commencement date above, then such a payment would be counted as part of the Primary Settlement.

(2) If an audit or adjustment determines a downward revision of income after an interest payment has previously been required for the same State Fiscal Year, then HHSC will recalculate the interest and, if necessary, issue a full or partial refund or credit to the Dental Contractor.

(3) Any interest obligations that are incurred pursuant to **Section 10.08** that are not timely paid will be subject to accumulation of interest as well, at the same rate as applicable to the underlying Experience Rebate.

(4) All interest assessed pursuant to **Section 10.08** will continue to accrue until such point as a payment is received by HHSC, at which point interest on the amount received will stop accruing. If a balance remains at that point that is subject to interest, then the balance will continue to accrue interest. If interim payments are made, then any interest that may be due will only be charged on amounts for the time period during which they remained unpaid.

By way of example only, if $100,000 is subject to interest commencing on a given day, and a payment is received for $75,000 45 days after the start of interest, then the $75,000 will be subject to 45 days of interest, and the $25,000 balance, along with any unpaid interest will continue to accrue interest until paid.

The accrual of interest as defined under **Section10.08(e)** will not stop during any period of dispute. If a dispute is resolved in the Dental Contractor's favor, then interest will only be assessed on the revised unpaid amount.

(5) If the Dental Contractor incurs an interest obligation pursuant to **Section 10.08 for an Experience Rebate payment**, HHSC will assess such interest at 12% per annum, compounded daily. If any interest rate stipulated hereunder is found by a court of competent jurisdiction to be outside the range deemed legal and enforceable, then in such specific case the rate hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

(6) Any interest expense incurred pursuant to **Section 10.08** is not an Allowable Expense for reporting purposes on the FSR.

Section 10.09 Federal Disallowance.

If the federal government recoups money from the state for expenses and/or costs that are deemed unallowable by the federal government, the state has the right to, in turn, recoup payments made to the Dental Contractor for these same expenses or costs, even if they had not been previously disallowed by the state and were incurred by the Dental Contractor, and any such expenses or costs would then be deemed unallowable by the state. If the state retroactively recoups money from the Dental Contractor due to a federal disallowance, the state will recoup the entire amount paid to the Dental Contractor for the federally disallowed expenses or costs, not just the federal portion.

Section 10.10 Payment by Members.

(a) The Dental Contractor, Network Providers, and Out-of-Network Providers are prohibited from billing or collecting any amount from a Member for Covered Services, except that CHIP Network Providers and Out-of-Network Providers may collect copayments authorized in the CHIP State Plan from CHIP Members for Covered Services.

(b) The Dental Contractor must inform Members of costs for non-covered services, and must require its Network Providers to:

(1) inform Members of costs for non-covered services prior to rendering such services; and

(2) obtain a signed Private Pay form from such Members.

Section 10.11 Restriction on Assignment of Fees.

During the Contract Term, Dental Contractor may not, directly or indirectly, assign to any third party any beneficial or legal interest of the Dental Contractor in or to any payments to be made by HHSC pursuant to this Contract. This restriction does not apply to fees paid to Subcontractors.

Section 10.12 Liability for Taxes.

HHSC is not responsible in any way for the payment of any Federal, state or local taxes related to or incurred in connection with the Dental Contractor's performance of this Contract. Dental Contractor must pay and discharge any and all such taxes, including any penalties and interest. In addition, HHSC is exempt from federal excise taxes, and will not pay any personal property taxes or income taxes levied on Dental Contractor or any taxes levied on employee wages.

Section 10.13 Liability for Employment-related Charges and Benefits.

Dental Contractor will perform work under this Contract as an independent contractor and not as agent or representative of HHSC. Dental Contractor is solely and exclusively liable for payment of all employment-related charges incurred in connection with the performance of this Contract, including but not limited to salaries, benefits, employment taxes, workers compensation benefits, unemployment insurance and benefits, and other insurance or fringe benefits for staff.

Section 10.14 No Additional Consideration.

(a) Dental Contractor will not be entitled to nor receive from HHSC any additional consideration, compensation, salary, wages, charges, fees, costs, or any other type of remuneration for Services and Deliverables provided under the Contract, except by properly authorized and executed Contract amendments.

(b) No other charges for tasks, functions, or activities that are incidental or ancillary to the delivery of the Services and Deliverables will be sought from HHSC or any other State

agency, nor will the failure of HHSC or any other party to pay for such incidental or ancillary services entitle the Dental Contractor to withhold Services and Deliverables due under the Agreement.

(c) Dental Contractor will not be entitled by virtue of the Contract to consideration in the form of overtime, health insurance benefits, retirement benefits, disability retirement benefits, sick leave, vacation time, paid holidays, or other paid leaves of absence of any type or kind whatsoever.

Section 10.15 Adjustment to Capitation in Consideration of the ACA Section 9010.

The following applies only to Dental Contractors that are covered entities under Section 9010 of the PPACA, and thus required to pay the Health Insurance Providers Fee ("HIP Fee") for United States health risks.

Beginning in calendar year 2014, the PPACA requires the Dental Contractor to pay the HIP Fee no later than September 30th (as applicable to each relevant year, the "HIP Fee Year") with respect to premiums paid to the Dental Contractor in the preceding calendar year (as applicable to each relevant year, the "HIP Data Year"), and continuing similarly in each successive year. In order to satisfy the requirement for actuarial soundness set forth in 42 C.F.R. § 438.4 with respect to amounts paid by HHSC under this Agreement, the parties agree that HHSC will make a retroactive adjustment to capitation to the Dental Contractor for the full amount of the HIP Fee allocable to this Agreement, as follows:

Amount and method of payment: For each HIP Fee Year, HHSC will make an adjustment to capitation to the Dental Contractor for that portion of the HIP Fee that is attributable to the Capitation Payments paid by HHSC to the Dental Contractor for risks in the applicable HIP Data Year under the Agreement, less any applicable exclusions and appropriate credit offsets. This capitation adjustment will be determined by HHSC and will include the following:

(1) The amount of the HIP Fee attributable to this Agreement;

(2) The federal income tax liability, if any, that the Dental Contractor incurs as a result of receiving HHSC's payment for the amount of the HIP Fee attributable to this Agreement; and

(3) Any Texas state premium tax attributable to the capitation adjustment.

The amount of the HIP Fee will not be determinable until after HHSC establishes the regular Capitation Rates for a rate period. HHSC therefore will perform an actuarial calculation to account for the HIP Fee within actuarially sound Capitation Rates each year and apply this Capitation Rate adjustment to the regular Capitation Rates already paid to the Dental Contractor.

The Dental Contractor's federal income tax rate will not be known prior to the end of the tax year. As a result, HHSC will make a tax rate assumption for purposes of developing the capitation adjustment. If the tax rate assumption later proves to be higher than the actual tax rate

for one or more Dental Contractors, HHSC may re-determine the capitation adjustment for those Dental Contractors using the lower tax rate and reconcile the capitation amount paid.

Documentation Requirements: HHSC will pay the Dental Contractor after it receives sufficient documentation, as determined by HHSC, detailing the Dental Contractor's Texas Medicaid and CHIP-specific liability for the HIP Fee. The Dental Contractor will provide documentation that includes the following:

(1) The preliminary and final versions of the IRS Form 8963;

(2) Texas Medicaid/CHIP-specific premiums included in the premiums reported on Form 8963; and

(3) The preliminary and final versions of the Fee statement provided by the IRS.

Payment by HHSC is intended to put the Dental Contractor in the same position as the Dental Contractor would have been had no HIP Fee been imposed upon the Dental Contractor.

This provision will survive the termination of the Agreement.

Article 11. Disclosure, Confidentiality, Privacy, and Security of Information.

Section 11.01 Confidentiality.

(a) The Dental Contractor and all Subcontractors, consultants, or agents must treat all information that is obtained through performance of the Services under the Contract, including information relating to applicants or Dental Members as Confidential Information to the extent that confidential treatment is provided under law and regulations. The Dental Contractor must protect Confidential Information from unauthorized disclosure or public release based on state or federal law or other legal agreement. For purposes of this Contract, the Dental Contractor will treat Agency Sensitive Information as Confidential Information. Although Agency Sensitive Information may not be subject to specific legal, regulatory or other external requirements, it is considered HHS sensitive and is not readily available to the public. Agency Sensitive Information could be subject to disclosure under the Texas Public Information Act, but the Dental Contractor should control disclosure due to sensitivity.

(b) The Dental Contractor is responsible for understanding the degree to which information obtained through performance of the Contract is confidential under State and Federal law, regulations, or administrative rules.

(c) The Dental Contractor and all Subcontractors, consultants, or agents under the Contract must not use any information obtained through performance of the Contract in any manner except as is necessary for the proper discharge of obligations and securing of rights under the Contract.

(d) The Dental Contractor must have a system in effect to protect all records and all other documents deemed confidential under the Contract maintained in connection with the activities under the Contract. Any disclosure or transfer of Confidential Information by the

Dental Contractor, including information required by the HHSC, must be in accordance with applicable law. If the Dental Contractor receives a request for information deemed confidential under the Contract, the Dental Contractor must immediately notify HHSC of such request, and must make reasonable efforts to protect the information from public disclosure.

(e) In addition to the requirements expressly stated in this section, the Dental Contractor must comply with any policy, rule, or reasonable requirement of HHSC that relates to the safeguarding or disclosure of information relating to Dental Members, the Dental Contractor's operations, or the Dental Contractor's performance of the Contract.

(f) In the event of the expiration of the Contract or termination of the Contract for any reason, all Confidential Information disclosed to and all copies thereof made by the Dental Contractor must be returned to HHSC or, at HHSC's option, erased or destroyed. The Dental Contractor must provide HHSC certificates evidencing such erasure or destruction.

(g) The obligations in this section shall not restrict any disclosure by the Dental Contractor pursuant to any applicable law, or by order of any court or government agency, provided that the Dental Contractor must give prompt notice to HHSC of such order.

(h) With the exception of confidential Dental Member information, information provided under the Contract by one Party (the "Furnishing Party") to another Party (the "Receiving Party") will not be considered Confidential Information if such data was:

(1) Already known to the Receiving Party without restrictions at the time of its disclosure by the Furnishing Party;

(2) Independently developed by the Receiving Party without reference to the Furnishing Party's Confidential Information;

(3) Rightfully obtained by the Receiving Party without restriction from a third party after its disclosure to a third party by the Furnishing Party;

(4) Publicly available other than through the fault or negligence of the Receiving Party; or

(5) Lawfully released without restriction to anyone.

Section 11.02 Disclosure of HHSC's Confidential Information.

(a) The Dental Contractor must report to HHSC any and all unauthorized disclosures or uses of HHSC's Confidential Information of which it or its Subcontractor(s), consultant(s), or agent(s) is aware or has knowledge in accordance with Section 11.08 of the Contract. The Dental Contractor acknowledges that any publication or disclosure of HHSC's Confidential Information to others may cause immediate and irreparable harm to HHSC and may constitute a violation of State or federal laws. If the Dental Contractor, its Subcontractor(s), consultant(s), or agent(s) should publish or disclose such Confidential Information to others without authorization, HHSC will immediately be entitled to injunctive relief or any other remedies to which it is entitled under law or equity. HHSC will have the right to recover

from the Dental Contractor all damages and liabilities caused by or arising from the Dental Contractor's, its Subcontractors', consultants', or agents' failure to protect HHSC's Confidential Information. The Dental Contractor must defend, with counsel approved by HHSC, indemnify and hold harmless HHSC from all damages, costs, liabilities, and expenses, including reasonable attorneys' fees and costs, caused by or arising from the Dental Contractor's or its Subcontractors', consultants' or agents' failure to protect HHSC's Confidential Information. HHSC will not unreasonably withhold approval of counsel selected by the Dental Contractor.

(b) The Dental Contractor must require its Subcontractors, consultants, and agents to comply with the terms of this provision.

Section 11.03 Member Records.

(a) HHSC may require the transfer of Dental Member Records, upon written notice to the Dental Contractor, to another entity, as consistent with federal and state laws and applicable releases. The Dental Contractor must comply with the requirements of state and federal laws regarding the transfer of Dental Member Records.

(b) The term "Dental Member Record" for this section means only those administrative, enrollment, case management, and other such records maintained by the Dental Contractor and is not intended to include patient records maintained by participating Providers.

Section 11.04 Requests for Public Information.

(a) HHSC will promptly notify the Dental Contractor of a request for disclosure of information filed in accordance with the Texas Public Information Act, Tex. Gov't. Code Chapter 552 of the, that consists of the Dental Contractor's confidential information, including information or data to which the Dental Contractor has a proprietary or commercial interest. HHSC will deliver a copy of the request for Public Information to the Dental Contractor.

(b) With respect to any information that is the subject of a request for disclosure, the Dental Contractor must demonstrate to the Texas Office of Attorney General the specific reasons why the requested information is confidential or otherwise excepted from required public disclosure under law. The Dental Contractor must provide HHSC with copies of all such communications.

(c) To the extent authorized under the Texas Public Information Act, HHSC agrees to safeguard from disclosure information received from the Dental Contractor that the Dental Contractor believes to be confidential information. The Dental Contractor must clearly mark such information as confidential information or provide written notice to HHSC that it considers the information confidential.

(d) The requirements of Subchapter J, Chapter 552, Government Code, may apply to this contract and the Dental Contractor agrees that this Contract can be terminated if the Dental Contractor knowingly or intentionally fails to comply with a requirement of that subchapter.

Section 11.05 Privileged Work Product.

(a) The Dental Contractor acknowledges that HHSC asserts that privileged work product may be prepared in anticipation of litigation and that the Dental Contractor is performing the Services with respect to privileged work product as an agent of HHSC, and that all matters related thereto are protected from disclosure by the Texas Rules of Civil Procedure, Texas Rules of Evidence, Federal Rules of Civil Procedure, or Federal Rules of Evidence.

(b) HHSC will notify the Dental Contractor of any privileged work product to which the Dental Contractor has or may have access. After the Dental Contractor is notified or otherwise becomes aware that such documents, data, database, or communications are privileged work product, only the Dental Contractor personnel, for whom such access is necessary for the purposes of providing the Services, may have access to privileged work product.

(c) If the Dental Contractor receives notice of any judicial or other proceeding seeking to obtain access to HHSC's privileged work product, the Dental Contractor must:

(1) Immediately notify HHSC; and

(2) Use all reasonable efforts to resist providing such access.

(d) If the Dental Contractor resists disclosure of HHSC's privileged work product in accordance with this Section, HHSC will, to the extent authorized under Civil Practices and Remedies Code or other applicable State law, have the right and duty to:

(1) Represent the Dental Contractor in such resistance;

(2) To retain counsel to represent the Dental Contractor; or

(3) To reimburse the Dental Contractor for reasonable attorneys' fees and expenses incurred in resisting such access.

(e) If a court of competent jurisdiction orders the Dental Contractor to produce documents, disclose data, or otherwise Breach the confidentiality obligations imposed in the Contract, or otherwise with respect to maintaining the confidentiality, proprietary nature, and secrecy of privileged work product, the Dental Contractor will not be liable for Breach of such obligation.

Section 11.06 Unauthorized Acts.

Each Party agrees to:

(1) Notify the other Party promptly of any unauthorized possession, use, or knowledge, or attempt thereof, by any person or entity that may become known to it, of any HHSC Confidential Information or any information identified by the Dental Contractor as confidential or proprietary;

(2) Promptly furnish to the other Party full details of the unauthorized possession, use, or knowledge, or attempt thereof, and use reasonable efforts to assist the other Party in

investigating or preventing the reoccurrence of any unauthorized possession, use, or knowledge, or attempt thereof, of Confidential Information;

(3) Cooperate with the other Party in any litigation and investigation against third Parties deemed necessary by such Party to protect its proprietary rights; and

(4) Promptly make reasonable efforts to prevent a reoccurrence of any such unauthorized possession, use, or knowledge such information.

Section 11.07 Legal Action.

Neither party may commence any legal action or proceeding in respect to any unauthorized possession, use, or knowledge, or attempt thereof by any person or entity of HHSC's Confidential Information or information identified by the Dental Contractor as confidential or proprietary, which action or proceeding identifies the other Party information without such Party's consent.

Section 11.08 Dental Contractor's Incident and Breach Notice, Reporting and Mitigation.

The Dental Contractor's obligation begins at Discovery of any unauthorized disclosure of Confidential Information or any privacy or security incident that may compromise Confidential Information (collectively "Incident") and continues until all effects of the Incident are resolved to HHSC's satisfaction, hereafter referred to as the "Incident Response Period".

For each Incident, the Dental Contractor must perform a risk analysis in accordance with HIPAA requirements to determine the probability of compromise of the Confidential Information.

Section 11.08.1 Notification to HHSC

(a) The Dental Contractor must notify HHSC within the timeframes set forth in subsection (c) below unless HHSC has agreed in writing to an alternate timeframe for notification.

(b) The Dental Contractor must require that its Subcontractors and Providers take the necessary steps to assure that the Dental Contractor can comply with all of the following Incident notice requirements.

(c) Incident Notice:

(1) Initial Notice.

Within 24 hours of Discovery of an Incident that the Dental Contractor's risk analysis has determined has more than a low probability of compromise, or when the Dental Contractor should have reasonably discovered such Incident, the Dental Contractor must preliminarily report on the occurrence of an Incident to the HHSC Privacy Officers via email at: privacy@HHSC.state.tx.us. This initial notice must, at a minimum, contain all information reasonably available to the Dental Contractor about the Incident, confirmation that the Dental Contractor has met any applicable one-hour Breach notification requirement for any Breach of

information obtained from a federal system of records in accordance with OMB Memorandum M-17-12, and provide a single point of contact for the Dental Contractors for HHSC communications both during and outside of business hours during the Incident Response Period.

(2) Formal Notice.

No later than three Business Days after Discovery of an Incident that the Dental Contractor's risk analysis has determined has more than a low probability of compromise, or when the Dental Contractor should have reasonably Discovered such Incident, the Dental Contractor must provide written formal notification to HHSC using the Potential Privacy/Security Incident Form which is available on the HHSC website. The formal notification must include all available information about the Incident, and the Dental Contractor's investigation of the Incident.

(3) Annual Notice.

For an Incident that the Dental Contractor's risk analysis has determined has a low probability of compromise or only involves unauthorized disclosure of a single individual's Confidential Information to a single unauthorized recipient, the Dental Contractor must provide notice to HHSC of such Incident no later than 60 Days after the end of the calendar year in which the Incident occurred.

No later than 60 Days after the end of each calendar year, the Dental Contractor must provide the HHS Privacy Office with a comprehensive list of all incidents involving HHSC confidential information that were reported to the US Office for Civil Rights in accordance with the obligations under HIPAA.

Section 11.08.2 Dental Contractor Investigation, Response and Mitigation.

(a) The Dental Contractor must fully investigate and mitigate, to the extent practicable, any Incident. At a minimum, the Dental Contractor must:

(1) Immediately commence a full and complete investigation;

(2) Cooperate fully with HHSC in its response to the Incident;

(3) Complete or participate in an initial risk analysis;

(4) Provide a final risk analysis

(5) Submit proposed corrective actions to HHSC for review and approval;

(6) Commit necessary and appropriate staff and resources to expeditiously respond;

(7) Report to HHSC as required by HHSC and all applicable federal and state laws for Incident response purposes and for purposes of HHSC's compliance with report and notification requirements, to the satisfaction of HHSC;

(8) Fully cooperate with HHSC to respond to inquiries and/or proceedings by federal and state authorities about the Incident;

(9) Fully cooperate with HHSC's efforts to seek appropriate injunctive relief or to otherwise prevent or curtail such Incidents;

(10) Recover, or assure destruction of, any Confidential Information impermissibly disclosed during or as a result of the Incident; and

(11) Provide HHSC with a final report on the Incident explaining the Incident's resolution.

Section 11.08.3 Breach Notification to Individuals and Reporting to Authorities.

(a) In addition to the notices required in Section 11.08.1, the Dental Contractor must provide Breach notification, in accordance with 45 C.F.R. §§ 164.400-414, or as specified by HHSC following an Incident.

(b) The Dental Contractor must assure that the time, manner and content of any Breach notification required by this Section meets all federal and state regulatory requirements. Breach notice letters must be in the Dental Contractor's name and on the Dental Contractor's letterhead and must contain contact information to obtain additional information, including the name and title of the Dental Contractor's representative, an email address and a toll-free telephone number.

(c) The Dental Contractor must provide HHSC with copies of all distributed communications related to the Breach notification.

(d) The Dental Contractor must demonstrate to the satisfaction of HHSC that any Breach notification required by applicable law was timely made. If there are delays outside of the Dental Contractor's control, the Dental Contractor must provide written documentation to HHSC of the reasons for the delay.

Section 11.09 Information Security and Privacy Requirements.

(a) Compliance

The Dental Contractor will comply with all applicable state and federal security and privacy requirements, as well as implement industry best practices, governing the creation, collection, access, use, storage, maintenance, disclosure, safeguarding and destruction of HHS data including Agency Sensitive and Confidential Information.

(b) Protection.

The Dental Contractor will implement, maintain, document, and use appropriate administrative, technical and physical security measures to protect all HHS Information Resources and data, including Agency Sensitive Information and Confidential Information.

(c) Reviews.

The Dental Contractor must comply with security and privacy controls compliance assessments, updates, and monitoring by HHS as required by state and federal law or at HHS' discretion. The security and privacy controls will be based on the National Institute of Standards and Technology (NIST) Special Publication 800-53 from the applicable state and federal

requirements. The HHS process is described in the Information Security Risk Assessment and Monitoring Procedures (IS-RAMP) that is published on the HHS Internet website.

(d) Workforce.

The Dental Contractor must ensure that its workforce, including Subcontractors, who are granted specified HHS authorized access to internal HHS Information Resources, comply with the HHS Acceptable Use Policy (AUP) and sign the Acceptable Use Agreement (AUA) prior to access, in accordance with 1 Tex. Admin. Code Chapter 202.22.

(e) Information Security and Privacy Officials.

The Dental Contractor must designate an Information Security Official and a Privacy Official who will be responsible for managing the security and privacy programs and requirements. The Dental Contractor will provide HHS the names, phone numbers and email addresses of these officials. The Security Official and Privacy Official roles may be performed by the same individual.

(f) Program.

The Dental Contractor must establish an information security and privacy program and maintain information security and privacy policies and standards that are updated at least annually with respect to the management or handling of HHS Information Resources or data. The program will:

(1) Comply with all applicable legal and regulatory requirements for Texas HHS data protection;

(2) Comply with HHS Information Security Office's published or provided policies, standards, and controls (IS-Policy, IS-AUP, AUA, IS-Web and Mobile Minimum Security Standard, IS-RAMP, ISSG/IS-Controls);

(3) Ensure the integrity, availability, and confidentiality by implementing technical, administrative and physical safeguards for HHS Agency Sensitive Information and Confidential Information;

(4) Protect against any anticipated threats or hazards to the security or integrity of such information;

(5) Protect and monitor against unauthorized access to or use of such information that could result in harm to the person that is the subject of such information both logically and physically;

(6) Routinely review, monitor, and remove unnecessary accounts that have access to HHS Agency Sensitive Information or Confidential Information;

(7) Coordinate with HHS to determine the HHS data types accessed, transmitted, stored, or maintained by the system and identify applicable state, federal and regulatory requirements;

(8) Document system accountability with an associated HHS Information Owner and, if provided by the Contractor, Information custodians;

(9) Encrypt the HHS Agency Sensitive Information and Confidential Information on end-user devices, on portable devices, in transit over public networks, and while stored in the cloud;

(10) FIPS 140-2 validated encryption will be used for federal protected data and access to HHS Confidential and Agency Sensitive Information will be controlled and monitored;

(11) Prohibit the use of free Cloud services with HHS Agency Sensitive or Confidential Information;

(12) Prohibit the performance of any work or the maintenance of any information relating or obtained pursuant to this Agreement to occur outside of the United States;

(13) Provide the workforce security and privacy training, conduct appropriate background checks, ensure individual accountability, and implement appropriate sanctions for non-compliance;

(14) Establish a secure method of assigning and selecting passwords, or use of unique identifier technologies, such as biometrics or token devices;

(15) Keep current on security update/patch releases and maintain up-to-date anti-virus/malware protection;

(16) Ensure security will be integrated into all phases including planning, development, and implementation and will include security testing and remediation of security vulnerabilities prior to production especially for online websites, applications and mobile applications;

(17) Establish standards and methods to securely return, destroy or dispose of HHS Agency Sensitive Information or Confidential Information;

(18) Provide documentation of information security and privacy policies/standards to HHS Information Security if requested;

(19) Ensure HHS websites provide the HHS privacy notice;

(20) Develop and implement methods that ensure security for all components, including:

(i) Environmental security;

(ii) Physical site security;

(iii) Computer hardware security;

(iv) Computer software security;

(v) Application security;

(vi) Data access and storage;

(vii) Client/user security;

(viii) Secure processes and procedures;

(ix) Telecommunications and network security; and

(x) General support systems (GSS) security.

Article 12. Remedies and Disputes

Section 12.01 Understanding and Expectations.

The remedies described in this Section are directed to Dental Contractor's timely and responsive performance of the Services and production of Deliverables, and the creation of a flexible and responsive relationship between the Parties. The Dental Contractor is expected to meet or exceed all HHSC objectives and standards, as set forth in the Contract. All areas of responsibility and all Contract requirements will be subject to performance evaluation by HHSC. Performance reviews may be conducted at the discretion of HHSC at any time and may relate to any responsibility or requirement. All responsibilities or requirements not fulfilled may be subject to remedies set forth in the Contract.

Section 12.02 Tailored Remedies.

(a) Understanding of the Parties.

Dental Contractor agrees and understands that HHSC may pursue tailored contractual remedies for noncompliance with the Contract. At any time and at its discretion, HHSC may impose or pursue one or more remedies for each item of noncompliance and will determine remedies on a case-by-case basis. HHSC's pursuit or non-pursuit of a tailored remedy does not constitute a waiver of any other remedy that HHSC may have at law or equity.

(b) Notice and opportunity to cure for non-material breach.

(1) HHSC will notify Dental Contractor in writing of specific areas of Dental Contractor performance that fail to meet performance expectations, standards, or schedules set forth in the Contract, but that, in the determination of HHSC, do not result in a material deficiency or delay in the implementation or operation of the Services.

(2) Dental Contractor will, within five Business Days, or another date approved by HHSC of receipt of written notice of a non-material deficiency, provide HHSC a written response that:

Explains the reasons for the deficiency, the Dental Contractor's plan to address or cure the deficiency, and the date and time by which the deficiency will be cured; or

If Dental Contractor disagrees with HHSC's findings, its reasons for disagreeing with HHSC's findings.

(3) Dental Contractor's proposed cure of a non-material deficiency is subject to the approval of HHSC. Dental Contractor's repeated commission of non-material deficiencies or repeated failure to resolve any such deficiencies may be regarded by

HHSC as a material deficiency and entitle HHSC to pursue any other remedy provided in the Contract or any other appropriate remedy HHSC may have at law or equity.

(c) Corrective Action Plan.

(1) At its option, HHSC may require Dental Contractor to submit to HHSC a written Corrective Action Plan to correct or resolve a material breach of the Contract, as determined by HHSC.

(2) The Corrective Action Plan must provide:

A detailed explanation of the reasons for the cited deficiency;

Dental Contractor's assessment or diagnosis of the cause; and

A specific proposal to cure or resolve the deficiency.

(3) The Corrective Action Plan must be submitted by the deadline set forth in HHSC's request for a Corrective Action Plan. The Corrective Action Plan is subject to approval by HHSC, which will not unreasonably be withheld.

(4) HHSC will notify Dental Contractor in writing of HHSC's final disposition of HHSC's concerns. If HHSC accepts Dental Contractor's proposed Corrective Action Plan, HHSC may:

Condition such approval on completion of tasks in the order or priority that HHSC may reasonably prescribe;

Disapprove portions of Dental Contractor's proposed Corrective Action Plan; or

Require additional or different corrective action(s).

Notwithstanding the submission and acceptance of a Corrective Action Plan, Dental Contractor remains responsible for achieving all written performance criteria.

(5) HHSC's acceptance of a Corrective Action Plan under this Section will not:

Excuse Dental Contractor's prior substandard performance;

Relieve Dental Contractor of its duty to comply with performance standards; or

Prohibit HHSC from assessing additional tailored remedies or pursuing other appropriate remedies for continued substandard performance.

(d) Administrative remedies.

(1) At its discretion, HHSC may impose one or more of the following remedies for each item of material noncompliance and will determine the scope and severity of the remedy on a case-by-case basis:

(i) Assess liquidated damages in accordance with "Liquidated Damages Matrix;"

(ii) Conduct accelerated monitoring of the Dental Contractor. Accelerated monitoring includes more frequent or more extensive monitoring by HHSC or its agent;

(iii) Decline to renew or extend the Contract;

(iv) Appoint temporary management under the circumstances described in 42 C.F.R. § 438.706;

(v) Initiate disenrollment of a Member or Members;

(vi) Suspend enrollment of Members;

(vii) Withhold or recoup payment to Dental Contractor;

(viii) Require forfeiture of all or part of the Dental Contractor's bond; or

(ix) Terminate the Contract in accordance with Section 12.03, ("Termination by HHSC").

(2) For purposes of the Contract, an item of material noncompliance means a specific action of Dental Contractor that:

(i) Violates a material provision of the Contract;

(ii) Fails to meet an agreed measure of performance; or

(iii) Represents a failure of Dental Contractor to be reasonably responsive to a reasonable request of HHSC for information, assistance, or support relating to the Services or Deliverables within the timeframe specified by HHSC.

(3) HHSC will provide notice to Dental Contractor of the imposition of an administrative remedy in accordance with this Section, with the exception of accelerated monitoring, which may be unannounced. HHSC may require Dental Contractor to file a written response in accordance with this Section.

(4) The Parties agree that a State or Federal statute, rule, regulation, or Federal guideline will prevail over the provisions of this Section unless the statute, rule, regulation, or guidelines can be read together with this Section to give effect to both.

(e) Damages.

(1) HHSC will be entitled to actual and/or consequential damages resulting from the Dental Contractor's failure to comply with any of the terms of the Contract. In some cases, the actual damage to HHSC or State of Texas as a result of Dental Contractor's failure to meet any aspect of the responsibilities of the Contract and/or to meet specific performance standards set forth in the Contract are difficult or impossible to determine with precise accuracy. Therefore, liquidated damages will be assessed in writing against and paid by the Dental Contractor in accordance with and for failure to meet any aspect of the responsibilities of the Contract and/or to meet the specific performance standards

identified by HHSC in Attachment F, "Deliverables/Liquidated Damages Matrix." Liquidated damages will be assessed if HHSC determines such failure is the fault of the Dental Contractor, including the Dental Contractor's Subcontractors and/or consultants, and is not materially caused or contributed to by HHSC or its agents. If at any time, HHSC determines the Dental Contractor has not met any aspect of the responsibilities of the Contract and/or the specific performance standards due to mitigating circumstances, HHSC reserves the right to waive all or part of the liquidated damages. All such waivers must be in writing, contain the reasons for the waiver, and be signed by the appropriate executive of HHSC.

(2) The liquidated damages prescribed in this Section are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of HHSC's projected financial loss and damage resulting from the Dental Contractor's nonperformance, including financial loss as a result of project delays. Accordingly, in the event Dental Contractor fails to perform in accordance with the Contract, HHSC may assess liquidated damages as provided in this Section.

(3) If Dental Contractor fails to perform any of the Services described in the Contract, HHSC may assess liquidated damages for each occurrence of a liquidated damages event, to the extent consistent with HHSC's tailored approach to remedies and Texas law.

(4) HHSC may elect to collect liquidated damages:

Through direct assessment and demand for payment delivered to Dental Contractor; or

By deduction of amounts assessed as liquidated damages as set-off against payments then due to Dental Contractor or that become due at any time after assessment of the liquidated damages. HHSC will make deductions until the full amount payable by the Dental Contractor is received by HHSC.

(f) Equitable Remedies.

(1) Dental Contractor acknowledges that, if Dental Contractor breaches, or attempts or threatens to breach its material obligation under the Contract, HHSC may be irreparably harmed. In such a circumstance, HHSC may proceed directly to court to pursue equitable remedies.

(2) If a court of competent jurisdiction finds that Dental Contractor breached, or attempted or threatened to breach any such obligations, Dental Contractor agrees that without any additional findings of irreparable injury or other conditions to injunctive relief, it will not oppose the entry of an appropriate order compelling performance by Dental Contractor and restraining it from any further breaches, or attempted or threatened breaches.

(g) Suspension of Contract.

(1) HHSC may suspend performance of all or any part of the Contract if:

(i) HHSC determines that Dental Contractor has committed a material breach of the Contract;

(ii) HHSC has reason to believe that Dental Contractor has committed, assisted in the commission of Fraud, Waste or, Abuse, malfeasance, misfeasance, or nonfeasance by any party concerning the Contract;

(iii) HHSC determines that the Dental Contractor knew, or should have known of Fraud, Waste or, Abuse, malfeasance, or nonfeasance by any party concerning the Contract, and the Dental Contractor failed to take appropriate action; or

(iv) HHSC determines that suspension of the Contract in whole or in part is in the best interests of the State of Texas or the HHSC Programs.

(2) HHSC will notify Dental Contractor in writing of its intention to suspend the Contract in whole or in part. Such notice will:

(i) Be delivered in writing to Dental Contractor;

(ii) Include a concise description of the facts or matter leading to HHSC's decision; and

(iii) Unless HHSC is suspending the contract for convenience, request a Corrective Action Plan from Dental Contractor or describe actions that Dental Contractor may take to avoid the contemplated suspension of the Contract.

Section 12.03 Termination by HHSC.

Prior to completion of the Contract Term, all or a part of this Contract may be terminated for any of the following reasons:

(a) Termination in the best interest of HHSC.

HHSC may terminate the Contract without cause at any time when, in its sole discretion, HHSC determines that termination is in the best interests of the State of Texas. HHSC will provide reasonable advance written notice of the termination, as it deems appropriate under the circumstances. The termination will be effective on the date specified in HHSC's notice of termination.

(b) Termination for cause.

Except as otherwise provided by the U.S. Bankruptcy Code, or any successor law, HHSC may terminate the Contract, in whole or in part, upon the following conditions:

(1) Assignment for the benefit of creditors, appointment of receiver, or inability to pay debts.

HHSC may terminate the Contract at any time if Dental Contractor:

(i) Makes an assignment for the benefit of its creditors;

(ii) Admits in writing its inability to pay its debts generally as they become due; or

(iii) Consents to the appointment of a receiver, trustee, or liquidator of Dental Contractor or of all or any part of its property.

(2) Failure to adhere to laws, rules, ordinances, or orders.

HHSC may terminate the Contract if a court of competent jurisdiction finds Dental Contractor failed to adhere to any laws, ordinances, rules, regulations or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of Dental Contractor's duties under the Contract. HHSC will provide at least 30 Days advance written notice of such termination.

(3) Breach of confidentiality.

HHSC may terminate the Contract at any time if Dental Contractor breaches confidentiality laws with respect to the Services and Deliverables provided under the Contract.

(4) Failure to maintain adequate personnel or resources.

HHSC may terminate the Contract if, after providing notice and an opportunity to correct, HHSC determines that Dental Contractor has failed to supply personnel or resources and such failure results in Dental Contractor's inability to fulfill its duties under the Contract. HHSC will provide at least 30 Days advance written notice of such termination.

(5) Termination for gifts and gratuities.

(i) HHSC may terminate the Contract at any time following the determination by a competent judicial or quasi-judicial authority and Dental Contractor's exhaustion of all legal remedies that Dental Contractor, its employees, agents or representatives have either offered or given anything of value to an officer or employee of HHSC or the State of Texas in violation of state law.

(ii) Dental Contractor must include a similar provision in each of its Subcontracts and must enforce this provision against a Subcontractor who has offered or given anything of value to any of the persons or entities described in this Section, whether or not the offer or gift was in Dental Contractor's behalf.

(iii) Termination of a Subcontract by Dental Contractor pursuant to this provision will not be a cause for termination of the Contract unless:

(a) Dental Contractor fails to replace such terminated Subcontractor within a reasonable time; and

(b) Such failure constitutes cause, as described in this subsection 12.03(b).

(iv) For purposes of this Section, a "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment, and charitable contributions. The term does not include contributions to holders of public office or candidates for public office that are paid and reported in accordance with State or Federal law.

(6) Termination for non-appropriation of funds.

Notwithstanding any other provision of the Contract, if funds for the continued fulfillment of the Contract by HHSC are at any time not forthcoming or are insufficient, through failure of any entity to appropriate funds or otherwise, then HHSC will have the right to terminate the Contract at no additional cost and with no penalty whatsoever by giving prior written notice documenting the lack of funding. HHSC will provide at least 30 Days advance written notice of such termination. HHSC will use reasonable efforts to ensure appropriated funds are available.

(7) Judgment and execution.

(i) HHSC may terminate the Contract at any time if judgment for the payment of money in excess of $500,000.00 that is not covered by insurance, is rendered by any court or governmental body against Dental Contractor, and Dental Contractor does not:

(a) Discharge the judgment or provide for its discharge in accordance with the terms of the judgment;

(b) Procure a stay of execution of the judgment within 30 days from the date of entry thereof; or

(c) Perfect an appeal of such judgment and cause the execution of such judgment to be stayed during the appeal, providing such financial reserves as may be required under generally accepted accounting principles.

(ii) If a writ or warrant of attachment or any similar process is issued by any court against all or any material portion of the property of Dental Contractor, and such writ or warrant of attachment or any similar process is not released or bonded within 30days after its entry, HHSC may terminate the Contract in accordance with this Section.

(8) Termination for Dental Contractor's material breach of the Contract. HHSC will have the right to terminate the Contract in whole or in part if HHSC determines, at its sole discretion, that Dental Contractor has materially breached the Contract

(9) Termination for Criminal Conviction.

HHSC will have the right to terminate the Contract in whole or in part, or require the replacement of a Material Subcontractor, if the Dental Contractor or a Material Subcontractor is convicted of a criminal offense in a state or federal court:

(i) Related to the delivery of an item or service;

(ii) Related to the neglect or abuse of patients in connection with the delivery of an item or service;

(iii) Consisting of a felony related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct, or

(iv) Resulting in a penalty or fine in the amount of $500,000 or more in a state or federal administrative proceeding.

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(c) Pre-termination Process

The following process will apply when HHSC terminates the Contract for any reason set forth in Section 12.03(b), "Termination for Cause," other than Subpart 6, "Termination for Non-appropriation of Funds."

In accordance with 42 C.F.R. § 438.710, before terminating the Contract, HHSC will provide the Dental Contractor with 30 Days advance written notice of its intent to terminate. The pre-termination notice will include the following information: the reason for the termination; the proposed effective date of the termination; and the time and place of the pre-termination hearing. During the pre-termination hearing, the Dental Contractor may present written information explaining why HHSC should not terminate the Contract. After the pre-termination hearing, the State Medicaid Director will provide the Dental Contractor with a written notice of HHSC's final decision affirming or reversing the proposed termination of the Contract and the effective date of termination if applicable.

HHSC's final decision to terminate the Contract is binding and is not subject to review by the State Office of Administrative Hearings under Chapter 2260, Texas Government Code.

The pre-termination process described herein will not limit or otherwise reduce the Dental Contractor's rights and the Parties' responsibilities under Section 12.13, "Dispute Resolution."

Section 12.04 Termination by Dental Contractor.

(a) Failure to pay.

Dental Contractor may terminate the Contract if HHSC fails to pay the Dental Contractor undisputed charges when due as required under the Contract. Retaining premium, recoupment, sanctions, or penalties that are allowed under the Contract or that result from the Dental Contractor's failure to perform or the Dental Contractor's default under the terms of the Contract is not cause for termination. Termination for failure to pay does not release HHSC from the obligation to pay undisputed charges for services provided prior to the termination date.

If HHSC fails to pay undisputed charges when due, then the Dental Contractor may submit a notice of intent to terminate for failure to pay in accordance with the requirements of Section 12.04(e). If HHSC pays all undisputed amounts then due within 30 Days after receiving the notice of intent to terminate, the Dental Contractor cannot proceed with termination of the Contract under this Section.

(b) Change to HHSC Uniform Managed Care Manual.

Dental Contractor may terminate this agreement if the Parties are unable to resolve a dispute concerning a material and substantive change to the HHSC UMCM, a change that materially and substantively alters the Dental Contractor's ability to fulfill its obligations under the Contract.

Dental Contractor must submit a notice of intent to terminate due to a material and substantive change in the HHSC UMCM no later than 30 days after the effective date of the policy change. HHSC will not enforce the policy change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(c) Change to Premium Rate.

If HHSC proposes an initial Capitation Rate or a modification to the Premium Rate that is unacceptable to the Dental Contractor, the Dental Contractor may terminate the Contract. Dental Contractor must submit a written notice of intent to terminate due to a change in the Premium Rate no later than 30 Days after HHSC's notice of the proposed change. HHSC will not enforce the rate change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(d) Expiration of Contract.

If Dental Contractor rejects, or intends to reject, an amendment extending the term of the Contract, Dental Contractor is subject to the requirements of Section 12.04(e).

(e) Notice of intent to terminate or to allow the Contract to expire.

If the Dental Contractor intends to terminate the Contract pursuant to this Section, or intends to allow the Contract to expire, Dental Contractor must give HHSC at least 90 Days written notice of intent to terminate, or intent to allow the Contract to expire. The termination date will be calculated as the last day of the month following 90 Days from the date the notice of intent is received by HHSC.

In the event the Dental Contractor fails to comply with this notice requirement, the Contract shall be extended under the same terms, conditions, and rates, for the period of time necessary to satisfy this notice requirement.

Section 12.05 Termination by Mutual Agreement.

The Contract may be terminated by mutual written agreement of the Parties.

Section 12.06 Effective Date of Termination

Except as otherwise provided in the Contract, termination will be effective as of the date specified in the notice of termination. The Turnover Phase obligations of Dental Contractor will continue to apply after the effective date of the Contract termination.

Section 12.07 Extension of Termination Effective Date.

The Parties may extend the effective date of termination one or more times by mutual written agreement.

Section 12.08 Payment and Other Provisions at Contract Termination.

(a) In the event of termination pursuant to this Article, HHSC will pay the Premium Payment for Services and Deliverables rendered through the effective date of termination. All pertinent provisions of the Contract will form the basis of settlement.

(b) Dental Contractor must provide HHSC all reasonable access to records, facilities, and documentation as is required to efficiently and expeditiously close out the Services and Deliverables provided under the Contract.

(c) Dental Contractor must prepare a Turnover Plan, which is acceptable to and approved by HHSC. The Turnover Plan will be implemented during the time period between receipt of notice and the termination date.

Section 12.09 Modification of Contract in the Event of Remedies.

HHSC may propose a modification of this Contract in response to the imposition of a remedy under this Article. Any modifications under this Section must be reasonable, limited to the matters causing the exercise of a remedy, in writing, and executed in accordance with Article 8. Dental Contractor must negotiate such proposed modifications in good faith.

Section 12.10 Turnover Assistance.

Upon receipt of notice of termination of the Contract by HHSC or by the Dental Contractor, Dental Contractor will provide any Turnover assistance reasonably necessary to enable HHSC to effectively close out the Contract and move the work to another vendor or to perform the work itself.

During the Turnover Phase, Dental Contractor must continue performing under the Contract, including rendering all Contracted services, until such time HHSC determines that the Dental Contractor has completed all requirements in accordance with the Turnover Plan.

Section 12.11 Rights upon Termination or Expiration of Contract.

In the event that the Contract is terminated for any reason, or upon its expiration, HHSC will, at HHSC's discretion, retain ownership of any and all associated work products, Deliverables or documentation in whatever form that they exist.

Section 12.12 Dental Contractor Responsibility for Associated Costs.

If HHSC terminates the Contract for Cause, the Dental Contractor will be responsible to HHSC for all reasonable costs incurred by HHSC, the State of Texas, or any of its administrative agencies to replace the Dental Contractor. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation that is reasonably attributable to Dental Contractor's failure to perform any Service in accordance with the terms of the Contract.

Section 12.13 Dispute Resolution.

(a) General Contract of the Parties.

The Parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the Parties employ all reasonable and informal means to resolve any dispute under the Contract. The Parties express their mutual commitment to using all

reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this Section.

(b) Duty to negotiate in good faith.

Any dispute that in the judgment of any Party to the Contract may materially or substantially affect the performance of any Party will be reduced to writing and delivered to the other Party. The Parties shall then negotiate in good faith and use every reasonable effort to resolve such dispute and the Parties must not resort to any formal proceedings unless they have reasonably determined that a negotiated resolution is not possible. The resolution of any dispute disposed of by Contract between the Parties shall be reduced to writing and delivered to all Parties within 10 Business Days.

(c) Claims for breach of Contract.

(1) General requirement. Dental Contractor's claim for breach of the Contract will be resolved in accordance with the dispute resolution process established by HHSC in accordance with Chapter 2260, Texas Government Code.

(2) Negotiation of claims. The Parties expressly agree that the Dental Contractor's claim for breach of this Contract that the Parties cannot resolve in the ordinary course of business or through the use of all reasonable and informal means will be submitted to the negotiation process provided in Chapter 2260, Subchapter B, Texas Government Code.

To initiate the process, Dental Contractor must submit written notice to HHSC that specifically states that Dental Contractor invokes the provisions of Chapter 2260, Subchapter B, Texas Government Code. The notice must comply with the requirements of Title 1 Chapter 392, Subchapter B of the Texas Administrative Code.

The Parties expressly agree that the Dental Contractor's compliance with Chapter 2260, Subchapter B, Texas Government Code, will be a condition precedent to the filing of a contested case proceeding under Chapter 2260, Subchapter C, of the Texas Government Code.

(3) Contested case proceedings. The contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be Dental Contractor's sole and exclusive process for seeking a remedy for any and all alleged breaches of contract by HHSC, if the Parties are unable to resolve their disputes under subsection(c)(2) of this section.

The Parties expressly agree that compliance with the contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be a condition precedent to seeking consent to sue from the Texas Legislature under Chapter 107, Civil Practices & Remedies Code. Neither the execution of this Contract by HHSC nor any other conduct of any representative of HHSC relating to this Contract must be considered a waiver of HHSC's sovereign immunity to suit.

(4) HHSC rules. The submission, processing, and resolution of Dental Contractor's claim is governed by the rules adopted by HHSC pursuant to Chapter 2260, Texas

Government Code, found Title 1 Chapter 392, Subchapter B of the Texas Administrative Code.

(5) Dental Contractor's duty to perform. Neither the occurrence of an event constituting an alleged breach of contract nor the pending status of any claim for breach of contract is grounds for the suspension of performance, in whole or in part, by Dental Contractor of any duty or obligation with respect to the performance of the Contract. Any changes to the Contract as a result of a dispute resolution will be implemented in accordance with Article 8 ("Amendments and Modifications").

Section 12.14 Liability of Dental Contractor.

(a) Dental Contractor bears all risk of loss or damage due to:

(1) Defects in products, Services or Deliverables;

(2) Unfitness or obsolescence of products, Services or Deliverables; or

(3) The negligence or intentional misconduct of Dental Contractor or its employees, agents, Subcontractors, or representatives.

(b) Dental Contractor must, at the Dental Contractor's own expense, defend with counsel approved by HHSC, indemnify, and hold harmless HHSC and State employees, officers, directors, contractors, and agents from and against any losses, liabilities, damages, penalties, costs, fees, including, without limitation, reasonable attorneys' fees, and expenses from any claim or action for property damage, bodily injury or death, to the extent caused by or arising from the negligence or intentional misconduct of the Dental Contractor and its employees, officers, agents, or Subcontractors. HHSC will not unreasonably withhold approval of counsel selected by Dental Contractor.

(c) Dental Contractor will not be liable to HHSC for any loss, damages, or liabilities attributable to or arising from the failure of HHSC or any state agency to perform a service or activity in connection with this Contract.

Article 13. Assurances and Certifications

Section 13.01 Proposal Certifications.

Dental Contractor acknowledges its continuing obligation to comply with the requirements of the certifications contained in its Proposal and will immediately notify HHSC of any changes in circumstances affecting the certifications.

Section 13.02 Conflicts of Interest.

(a) Representation.

Dental Contractor agrees to comply with applicable state and federal laws, including 41 U.S.C. § 423, rules, and regulations regarding conflicts of interest in the performance of its duties under this Contract. Dental Contractor warrants that it has no interest and will not acquire

any direct or indirect interest that would conflict in any manner or degree with its performance under this Contract.

(b) General duty regarding conflicts of interest.

Dental Contractor will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain. Dental Contractor will operate with complete independence and objectivity without actual, potential, or apparent conflict of interest with respect to the activities conducted under this Contract.

Section 13.03 Organizational Conflicts of Interest.

(a) Definition.

An organizational conflict of interest is a set of facts or circumstances, a relationship, or other situation under which the Dental Contractor or a Subcontractor has past, present, or currently planned personal or financial activities or interests that either directly or indirectly:

(1) Impairs or diminishes the Dental Contractor's or Subcontractor's ability to render impartial or objective assistance or advice to HHSC; or

(2) Provides the Dental Contractor or Subcontractor an unfair competitive advantage in future HHSC procurements, excluding the award of this Contract.

(b) Warranty.

Except as otherwise disclosed and approved by HHSC prior to the Effective Date of the Contract, Dental Contractor warrants that, as of the Effective Date and to the best of its knowledge and belief, there are no relevant facts or circumstances that could give rise to an organizational conflict of interest affecting this Contract. Dental Contractor affirms that it has neither given, nor intends to give, at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant, or any employee, or representative of same, at any time during the procurement process, or in connection with the procurement process, except as allowed under relevant state and federal law.

(c) Continuing duty to disclose.

(1) Dental Contractor agrees that, if after the Effective Date, Dental Contractor discovers or is made aware of an organizational conflict of interest, Dental Contractor will immediately and fully disclose such interest in writing to the HHSC project manager. In addition, Dental Contractor must promptly disclose any relationship that might be perceived or represented as a conflict after its discovery by Dental Contractor or by HHSC as a potential conflict. HHSC reserves the right to make a final determination regarding the existence of conflicts of interest, and Dental Contractor agrees to abide by HHSC's decision.

(2) The disclosure will include a description of the actions that Dental Contractor has taken or proposes to take to avoid or mitigate such conflicts.

(d) Remedy.

If HHSC determines that an organizational conflict of interest exists, HHSC may, at its discretion, terminate the Contract pursuant to Subsection 12.03(b)(9). If HHSC determines that Dental Contractor was aware of an organizational conflict of interest before the award of this Contract and did not disclose the conflict to the contracting officer, such nondisclosure will be considered a material breach of the Contract. Furthermore, such breach may be submitted to the Office of the Attorney General, Texas Ethics Commission, or appropriate State or Federal law enforcement officials for further action.

(e) Flow down obligation.

Dental Contractor must include the provisions of this Section in all Subcontracts for work to be performed similar to the service provided by Dental Contractor, and the terms "Contract," "Dental Contractor," and "project manager" modified appropriately to preserve the State's rights.

Section 13.04 HHSC Personnel Recruitment Prohibition.

Dental Contractor has not retained or promised to retain any person or company or utilized or promised to utilize a consultant that participated in HHSC's development of specific criteria of the RFP or who participated in the selection of the Dental Contractor for this Contract.

Unless authorized in writing by HHSC, Dental Contractor will not recruit or employ any HHSC personnel who have worked on projects relating to the subject matter of this Contract, or who have had any influence on decisions affecting the subject matter of this Contract, for two years following the completion of this Contract.

Section 13.05 Anti-kickback Provision.

Dental Contractor certifies that it will comply with the Anti-Kickback Act of 1986, 41 U.S.C. §§ 51-58 and Federal Acquisition Regulation 52.203-7, to the extent applicable.

Section 13.06 Debt or Back Taxes Owed to State of Texas.

In accordance with Section 403.055 of the Texas Government Code, Dental Contractor agrees that any payments due to Dental Contractor under the Contract will be first applied toward any debt or back taxes Dental Contractor owes the State of Texas. Dental Contractor further agrees that payments will be so applied until such debts and back taxes are paid in full.

Section 13.07 Outstanding Debts and Judgments.

Dental Contractor certifies that it is not presently indebted to the State of Texas, and that Dental Contractor is not subject to an outstanding judgment in a suit by State of Texas against Dental Contractor for collection of the balance. For purposes of this Section, an indebtedness is any sum of money that is past due and owed to the State of Texas and is not currently under dispute. A false statement regarding Dental Contractor's status will be treated as a material breach of this Contract and may be grounds for termination at the option of HHSC.

Article 14. Representations and Warranties

Section 14.01 Authorization.

(a) The execution, delivery and performance of this Contract has been duly authorized by Dental Contractor and no additional approval, authorization or consent of any governmental or regulatory agency is required to be obtained in order for Dental Contractor to enter into this Contract and perform its obligations under this Contract.

(b) Dental Contractor has obtained, or will obtain by the deadlines set forth in this Contract, all licenses, certifications, permits, and authorizations necessary to perform the Services under this Contract and currently is in good standing with all regulatory agencies that regulate any or all aspects of Dental Contractor's performance of this Contract. Dental Contractor will maintain all required certifications, licenses, permits, and authorizations during the term of this Contract.

Section 14.02 Ability to Perform.

Dental Contractor warrants that it has the financial resources to fund the capital expenditures required under the Contract without advances by HHSC or assignment of any payments by HHSC to a financing source.

Section 14.03 Minimum Net Worth.

The Dental Contractor has and will maintain throughout the life of this Contract, minimum net worth that complies with standards adopted by TDI. Minimum net worth means the excess total admitted assets over total liabilities, excluding liability for subordinated debt issued in compliance with Chapter 843 of the Texas Insurance Code.

Section 14.04 Insurer Solvency.

(a) The Dental Contractor must be and remain in full compliance with all applicable state and federal solvency requirements, including those set forth in 42 C.F.R. § 438.116, for basic-service indemnity insurance providers or DMOs, including but not limited to, all reserve requirements, net worth standards, debt-to-equity ratios, or other debt limitations. Provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI. In the event the Dental Contractor fails to maintain such compliance, HHSC, without limiting any other rights it may have by law or under the Contract, may terminate the Contract.

(b) If the Dental Contractor becomes aware of any impending changes to its financial or business structure that could adversely impact its compliance with the requirements of the Contract or its ability to pay its debts as they come due, the Dental Contractor must notify HHSC immediately in writing.

(c) The Dental Contractor must have a plan and take appropriate measures to ensure adequate provision against the risk of insolvency as required by TDI. Such provision must be adequate to provide for the following in the event of insolvency:

(1) Payments to unaffiliated dental providers and affiliated dental providers whose Contracts do not contain Member "hold harmless" clauses acceptable to the TDI;

(2) Continuation of Medically Necessary Covered Dental Services for the duration of the Contract Term for which a premium has been paid for a Member;

(3) Provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI and the Contract.

Should TDI determine that there is an immediate risk of insolvency or the Dental Contractor is unable to provide Medically Necessary Covered Dental Services to its Members, HHSC, without limiting any other rights it may have by law, or under the Contract, may terminate the Contract.

Section 14.05 Workmanship and Performance.

(a) All Services and Deliverables provided under this Contract will be provided in a manner consistent with the standards of quality and integrity as outlined in the Contract.

(b) All Services and Deliverables must meet or exceed the required levels of performance specified in or pursuant to this Contract.

(c) Dental Contractor will perform the Services and provide the Deliverables in a workmanlike manner, in accordance with best practices and high professional standards used in well-managed operations performing services similar to the Services described in this Contract.

Section 14.06 Warranty of Deliverables.

Dental Contractor warrants that Deliverables developed and delivered under this Contract will meet in all material respects the specifications as described in the Contract during the period following its acceptance by HHSC, through the term of the Contract, including any subsequently negotiated by Dental Contractor and HHSC. Dental Contractor will promptly repair or replace any such Deliverables not in compliance with this warranty at no charge to HHSC.

Section 14.07 Compliance with Contract.

Dental Contractor will not take any action substantially or materially inconsistent with any of the terms and conditions set forth in this Contract without the express written approval of HHSC.

Section 14.08 Technology Access.

All technological solutions offered by the Dental Contractor must comply with the requirements of Texas Government Code § 531.0162. This includes providing technological solutions that meet federal accessibility standards for persons with disabilities, as applicable.

Section 14.09 Electronic & Information Resources Accessibility Standards.

(a) Applicability.

The following Electronic and Information Resources (EIR) requirements apply to the Contract because the Dental Contractor performs services that include EIR that: (i) HHSC employees are required or permitted to access; or (ii) members of the public are required or permitted to access. This Section does not apply to incidental uses of EIR in the performance of a Contract, unless the Parties agree that the EIR will become property of the State or will be used by the HHSC's clients or recipients after completion of the Contract. Nothing in this section is intended to prescribe the use of particular designs or technologies or to prevent the use of alternative technologies, provided they result in substantially equivalent or greater access to and use of a Product.

(b) Definitions.

For purposes of this Section:

Accessibility Standards means the Electronic and Information Resources Accessibility Standards and the Web Site Accessibility Standards/Specifications.

Electronic and Information Resources means information resources, including information resources technologies, and any equipment or interconnected system of equipment that is used in the creation, conversion, duplication, or delivery of data or information. The term includes, but is not limited to, telephones and other telecommunications products, information kiosks, transaction machines, Internet websites, multimedia resources, and office equipment, including copy machines and fax machines.

Electronic and Information Resources Accessibility Standards means the accessibility standards for electronic and information resources contained in 1 Tex. Admin. Code Chapter 213.

Web Site Accessibility Standards/ Specifications means standards contained in 1 Tex. Admin. Code Chapter 206.

Product means information resources technology that is, or is related to, EIR.

(c) Accessibility Requirements.

Under Texas Government Code Chapter 2054, Subchapter M, and implementing rules of the Texas Department of Information Resources, HHSC must procure Products that comply with the Accessibility Standards when such Products are available in the commercial marketplace or when such Products are developed in response to a procurement solicitation. Accordingly, Dental Contractor must provide electronic and information resources and associated Product documentation and technical support that comply with the Accessibility Standards.

(d) Evaluation, Testing, and Monitoring.

(1) HHSC may review, test, evaluate and monitor Dental Contractor's Products and associated documentation and technical support for compliance with the Accessibility Standards. Review, testing, evaluation and monitoring may be conducted before and after the award of a contract. Testing and monitoring may include user acceptance testing.

Neither the review, testing, including acceptance testing, evaluation or monitoring of any Product, nor the absence of such review, testing, evaluation or monitoring, will result in a waiver of the State's right to contest the Dental Contractor's assertion of compliance with the Accessibility Standards.

(2) Dental Contractor agrees to cooperate fully and provide HHSC and its representatives' timely access to Products, records, and other items and information needed to conduct such review, evaluation, testing and monitoring.

(e) Representations and Warranties.

(1) Dental Contractor represents and warrants that: (i) as of the Effective Date of the Contract, the Products and associated documentation and technical support comply with the Accessibility Standards as they exist at the time of entering the Contract, unless and to the extent the Parties otherwise expressly agree in writing; and (ii) if the Products will be in the custody of the state or an HHS Agency's client or recipient after the Contract expiration or termination, the Products will continue to comply with such Accessibility Standards after the expiration or termination of the Contract Term, unless HHSC and/or its clients or recipients, as applicable, use the Products in a manner that renders it noncompliant.

(2) In the event Dental Contractor should have known, becomes aware, or is notified that the Product and associated documentation and technical support do not comply with the Accessibility Standards, Dental Contractor represents and warrants that it will, in a timely manner and at no cost to HHSC, perform all necessary steps to satisfy the Accessibility Standards, including but not limited to remediation, replacement, and upgrading of the Product, or providing a suitable substitute.

(3) Dental Contractor acknowledges and agrees that these representations and warranties are essential inducements on which HHSC relies in awarding this Contract.

(4) Dental Contractor's representations and warranties under this subsection will HHSC the termination or expiration of the Contract and will remain in full force and effect throughout the useful life of the Product.

(f) Remedies.

(1) Pursuant to Texas Government Code Sec. 2054.465, neither Dental Contractor nor any other person has cause of action against HHSC for a claim of a failure to comply with Texas Government Code Chapter 2054, Subchapter M, and rules of the Department of Information Resources.

(2) In the event of a breach of Dental Contractor's representations and warranties, Dental Contractor will be liable for direct, consequential, indirect, special, or liquidated damages and any other remedies to which HHSC may be entitled under this Contract and other applicable law. This remedy is cumulative of any and all other remedies to which HHSC may be entitled under this Contract and other applicable law.

Article 15. Intellectual Property

Section 15.01 Infringement and Misappropriation.

(a) Dental Contractor warrants that all Deliverables provided by Dental Contractor will not infringe or misappropriate any right of, and will be free of any claim of, any third person or entity based on copyright, patent, trade secret, or other intellectual property rights.

(b) Dental Contractor will, at its expense, defend with counsel approved by HHSC, indemnify, and hold harmless HHSC, its employees, officers, directors, contractors, and agents from and against any losses, liabilities, damages, penalties, costs, and fees from any claim or action against HHSC that is based on a claim of breach of the warranty set forth in the preceding paragraph. HHSC will promptly notify Dental Contractor in writing of the claim, provide Dental Contractor a copy of all information received by HHSC with respect to the claim, and cooperate with Dental Contractor in defending or settling the claim. HHSC will not unreasonably withhold, delay or condition approval of counsel selected by the Dental Contractor.

(c) In case the Deliverables, or any one or part thereof, is in such action held to constitute an infringement or misappropriation, or the use thereof is enjoined or restricted or if a proceeding appears to Dental Contractor to be likely to be brought, Dental Contractor will, at its own expense, either:

(1) Procure for HHSC the right to continue using the Deliverables; or

(2) Modify or replace the Deliverables to comply with the Specifications and to not violate any intellectual property rights.

If neither of the alternatives set forth in (1) or (2) above are available to the Dental Contractor on commercially reasonable terms, Dental Contractor may require that HHSC return the allegedly infringing Deliverable(s) in which case Dental Contractor will refund all amounts paid for all such Deliverables.

Section 15.02 Exceptions.

Dental Contractor is not responsible for any claimed breaches of the warranties set forth in Section 14.06 to the extent caused by:

(a) Modifications made to the item in question by anyone other than Dental Contractor or its Subcontractors, or modifications made by HHSC or its contractors working at Dental Contractor's direction or in accordance with the specifications; or

(b) The combination, operation, or use of the item with other items if Dental Contractor did not supply or approve for use with the item; or

(c) HHSC's failure to use any new or corrected versions of the item made available by Dental Contractor.

Section 15.03 Ownership and Licenses

(a) Definitions.

For purposes of this Section 15.03, the following terms have the meanings set forth below:

Custom Software means any software developed by the Dental Contractor: for HHSC; in connection with the Contract; and with funds received from HHSC. The term does not include Dental Contractor Proprietary Software or Third Party Software.

Dental Contractor Proprietary Software means software: (i) developed by the Dental Contractor prior to the Effective Date of the Contract, or (ii) software developed by the Dental Contractor after the Effective Date of the Contract that is not developed: for HHSC; in connection with the Contract; and with funds received from HHSC.

Third Party Software means software that is: developed for general commercial use; available to the public; or not developed for HHSC. Third Party Software includes without limitation: commercial off-the-shelf software; operating system software; and application software, tools, and utilities.

(b) Deliverables.

The Parties agree that any Deliverable, including without limitation the Custom Software, will be the exclusive property of HHSC.

(c) Ownership rights

(1) HHSC will own all right, title, and interest in and to its Confidential Information and the Deliverables provided by the Dental Contractor, including without limitation the Custom Software and associated documentation. For purposes of this Section 15.03, the Deliverables will not include Dental Contractor Proprietary Software or Third Party Software. Dental Contractor will take all actions necessary and transfer ownership of the Deliverables to HHSC, including, without limitation, the Custom Software and associated documentation prior to Contract termination.

(2) Dental Contractor will furnish such Deliverables, upon request of HHSC, in accordance with applicable State law. All Deliverables, in whole and in part, will be deemed works made for hire of HHSC for all purposes of copyright law, and copyright will belong solely to HHSC. To the extent that any such Deliverable does not qualify as a work for hire under applicable law, and to the extent that the Deliverable includes materials subject to copyright, patent, trade secret, or other proprietary right protection, Dental Contractor agrees to assign, and hereby assigns, all right, title, and interest in and to Deliverables, including without limitation all copyrights, inventions, patents, trade secrets, and other proprietary rights therein, including renewals thereof, to HHSC.

(3) Dental Contractor will, at the expense of HHSC, assist HHSC or its nominees to obtain copyrights, trademarks, or patents for all such Deliverables in the United States and any other countries. Dental Contractor agrees to execute all papers and to give all facts known to it necessary to secure United States or foreign country copyrights and

patents, and to transfer or cause to transfer to HHSC all the right, title, and interest in and to such Deliverables. Dental Contractor also agrees not to assert any moral rights under applicable copyright law with regard to such Deliverables.

(d) License Rights.

HHSC will have a royalty-free and non-exclusive license to access the Dental Contractor Proprietary Software and associated documentation during the term of the Contract. HHSC will also have ownership and unlimited rights to use, disclose, duplicate, or publish all information and data developed, derived, documented, or furnished by Dental Contractor under or resulting from the Contract. Such data will include all results, technical information, and materials developed for or obtained by HHSC from Dental Contractor in the performance of the Services hereunder, including but not limited to all reports, surveys, plans, charts, recordings, video or sound, pictures, drawings, analyses, graphic representations, computer printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the Services performed as a result of the Contract.

(e) Proprietary Notices.

Dental Contractor will reproduce and include HHSC's copyright and other proprietary notices and product identifications provided by Dental Contractor on such copies, in whole or in part, or on any form of the Deliverables.

(f) State and Federal Governments.

In accordance with 45 C.F.R. § 95.617, all appropriate State and Federal agencies will have a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, translate, or otherwise use, and to authorize others to use for Federal Government purposes all materials, the Custom Software and modifications thereof, and associated documentation designed, developed, or installed with federal financial participation under the Contract, including but not limited to those materials covered by copyright, all software source and object code, instructions, files, and documentation.

Article 16. Liability

Section 16.01 Property Damage.

(a) Dental Contractor will protect HHSC's real and personal property from damage arising from Dental Contractor's, its agent's, employees' and Subcontractors' performance of the Contract, and Dental Contractor will be responsible for any loss, destruction, or damage to HHSC's property that results from or is caused by Dental Contractor's, its agents', employees' or Subcontractors' negligent or wrongful acts or omissions. Upon the loss of, destruction of, or damage to any property of HHSC, Dental Contractor will notify the HHSC Project Manager thereof and subject to direction from the Project Manager or her or his designee, will take all reasonable steps to protect that property from further damage.

(b) Dental Contractor agrees to observe and encourage its employees and agents to observe safety measures and proper operating procedures at HHSC sites at all times.

(c) Dental Contractor will distribute a policy statement to all of its employees and agents that directs the employee or agent to promptly report to HHSC or to Dental Contractor any special defect or unsafe condition encountered while on HHSC premises. Dental Contractor will promptly report to HHSC any special defect or an unsafe condition it encounters or otherwise learns about.

Section 16.02 Risk of Loss.

During the period Deliverables are in transit and in possession of Dental Contractor, its carriers or HHSC prior to being accepted by HHSC, Dental Contractor will bear the risk of loss or damage thereto, unless such loss or damage is caused by the negligence or intentional misconduct of HHSC. After HHSC accepts a Deliverable, the risk of loss or damage to the Deliverable will be borne by HHSC, except loss or damage attributable to the negligence or intentional misconduct of Dental Contractor's agents, employees or Subcontractors.

Section 16.03 Limitation of HHSC's Liability

HHSC WILL NOT BE LIABLE FOR ANY INCIDENTAL, INDIRECT, SPECIAL, OR CONSEQUENTIAL DAMAGES UNDER CONTRACT, TORT INCLUDING NEGLIGENCE, OR OTHER LEGAL THEORY. THIS WILL APPLY REGARDLESS OF THE CAUSE OF ACTION AND EVEN IF HHSC HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

HHSC'S LIABILITY TO THE DENTAL CONTRACTOR UNDER THE CONTRACT WILL NOT EXCEED THE TOTAL CHARGES TO BE PAID BY HHSC TO THE DENTAL CONTRACTOR UNDER THE CONTRACT

Article 17. Insurance and Bonding

Section 17.01 Insurance Coverage.

(a) Statutory and General Coverage.

Dental Contractor will maintain, at Dental Contractor's own expense, during the Term of the Contract and until final acceptance of all Services and Deliverables, the following insurance coverage. Dental Contractor will provide HHSC with proof of the following insurance coverage on or before the Contract Effective Date:

(1) Business Automobile Liability Insurance for all owned, non-owned, and hired vehicles, for bodily injury and property damage;

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

(3) If Dental Contractor's current Comprehensive General Liability insurance coverage does not meet the above stated requirements, Dental Contractor will obtain

Umbrella Liability insurance to compensate for the difference in the coverage amounts. If Umbrella Liability insurance is provided it must follow the form of the primary coverage.

(b) Professional Liability Coverage.

(c) Dental Contractor must maintain at its own expense, or cause its Network Providers to maintain, during the Term of the Contract and until final acceptance of all Services and Deliverables, the following insurance coverage:

(1) Professional Liability Insurance for each Network Provider of $100,000.00 per occurrence and $300,000.00 in the aggregate. Dental Contractor must provide proof of such coverage upon request to HHSC.

(2) An Excess Professional Liability (Errors and Omissions) Insurance Policy for the greater of $3,000,000.00 or an amount, rounded to the nearest $100,000.00 that represents the number of Dental Members enrolled in the Dental Contractor in the first month of the applicable Contract Year multiplied by $150.00, not to exceed $10,000,000.00. Dental Contractor will provide HHSC with proof of this insurance coverage on or before the Contract Effective Date.

(d) General Requirements for All Insurance Coverage.

(1) Except as provided herein, all exceptions to the Contract's insurance requirements must be approved in writing by HHSC.

The Dental Contractor is prohibited from requiring a Network Provider to obtain the insurance coverage described in Section 17.01 if the Dental Provider or Network Provider qualifies as a state governmental unit or municipality under the Texas Tort Claims Act, and is required to comply with, and subject to, the provisions of the Texas Tort Claims Act.

(2) Dental Contractor or the Network Provider is responsible for any and all deductibles stated in the policies.

(3) Insurance coverage will be issued by insurance companies authorized by applicable law to conduct business in the State of Texas, and

(4) Insurance coverage must name HHSC as an additional insured, with the exception of Professional Liability insurance maintained by Providers. Insurance coverage must name HHSC as a loss payee, with the exception of Professional Liability insurance maintained by Providers and Business Automobile Liability insurance.

(5) Insurance coverage kept by the Dental Contractor must be maintained in full force at all times during the Term of the Contract, and until HHSC's final acceptance of all Services and Deliverables. Failure to maintain such insurance coverage will constitute a material breach of this contract.

(6) With the exception of Professional Liability Insurance maintained by Providers, the insurance policies described in this Section must have an extended reporting period of two years. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, the Contract Effective Date.

(7) With the exception of Professional Liability Insurance maintained by Providers, the insurance policies described in this Section must provide that prior written notice to be given to HHSC at least 30 Days before coverage is reduced below minimum HHSC contractual requirements, canceled, or non-renewed. Dental Contractor must submit a new coverage binder to HHSC to ensure no break in coverage. Each policy must include the following provision: "It is a condition of this policy that the company must furnish written notice to HHSC's designated contact at least 30 Days in advance of any reduction in cancellation, or non-renewal of this policy."

(8) The Parties expressly understand and agree that any insurance coverages and limits furnished by Dental Contractor will in no way expand or limit Dental Contractor's liabilities and responsibilities specified within the Contract documents or by applicable law.

(9) Dental Contractor expressly understands and agrees that any insurance maintained by HHSC will apply in excess of and not contribute to insurance provided by Dental Contractor under this contract.

(10) If Dental Contractor or its Providers, desire additional coverage, higher limits of liability, or other modifications for its own protection, Dental Contractor or its Providers will be responsible for the acquisition and cost of such additional protection. Such additional protection will not be an Allowable Expense under this Contract.

(11) Dental Contractor will require all insurers to waive their rights of subrogation against HHSC.

(e) Proof of Insurance Coverage.

(1) Except as provided in Section 17.01(d)(2), Dental Contractor must furnish HHSC original Certificates of Insurance evidencing the required insurance coverage on or before the Effective Date of the Contract. If insurance coverage is renewed during the term of the Contract, the Dental Contractor must furnish HHSC renewal certificates of insurance, or such similar evidence within five Business Days of renewal. Dental Contractor will submit evidence of insurance prior to Contract award. The failure of HHSC to obtain such evidence from Dental Contractor before permitting Dental Contractor to commence work will not be deemed to be a waiver by HHSC and Dental Contractor will remain under continuing obligation to maintain and provide proof of the insurance coverage.

(2) The insurance specified above will be carried until all Services and Deliverables required under the terms of the Contract are satisfactorily completed. Failure to carry or keep such insurance in force will constitute a violation of the Contract.

Section 17.02 Performance Bond.

Beginning on the Effective Date of the Contract, and each year thereafter, the Dental Contractor must obtain a performance bond with a one year term. The performance bond must be renewable, and renewal must occur no later than the first day of each subsequent State Fiscal Year. The performance bond must continue to be in effect for one year following the expiration

of the final renewal period or the date the contract terminates. Dental Contractor must obtain and maintain the annual performance bonds in the form prescribed by HHSC and approved by TDI, naming HHSC as Obligee, and securing Dental Contractor's faithful performance of the terms and conditions of this Contract. The annual performance bond(s) must be issued in the amount of $100,000.00. Performance bonds must be issued by a surety licensed by TDI, and specify cash payment as the sole remedy. Dental Contractor must deliver the initial performance bond to HHSC prior to or on the Effective Date of the Contract, and each renewal prior to the first day of the State Fiscal Year. Prior performance bonds received for a specific SFY will be released upon completion of the audit of the 334-Day FSR for the corresponding SFY.

Section 17.03 TDI Fidelity Bond.

The Dental Contractor will secure and maintain throughout the life of the Contract a fidelity bond as required by the Texas Department of Insurance. The Dental Contractor must promptly provide HHSC with copies of the bond and any amendments or renewals thereto.

Texas Health & Human Services Commission

Dental Services Scope of Work

DENTAL SERVICES SCOPE OF WORK

2.1 DENTAL PROGRAM SCOPE

The specifics of the Scope of Work (SOW) for the Dental Program are set forth below, and as appropriately referenced, in any Exhibits to **ATTACHMENT E, HHSC SOLICITATION NO. HHS0002879**, which are incorporated by reference into this Contract.

2.2 TRANSITION PHASE SCOPE

This Section presents the SOW for the Transition Phase of the Contract, which includes all activities the Dental Contractor is required to perform between the Effective Date and the Operational Start Date of a Contract resulting from award through procurement or an assignment and assumption due to termination, expiration, merger, or acquisition.

2.2.1 INTRODUCTION

The Transition Phase includes a timeline for Readiness Review, which must be completed to HHSC's satisfaction prior to the Dental Contractor's Operational Start Date. Readiness Review includes but is not limited to the following areas, which are further explained in Section 2:

- Administration of Key Dental Contractor Personnel
- Organizational Readiness Review
- Financial Readiness Review
- System Testing and Transfer of Data
- System Readiness Review
- Demonstration and Assessment of System Readiness
- Operations Readiness
- Assurance of System and Operational Readiness

Upon the identification by the Dental Contractor or HHSC of any deficiencies during or as a result of Readiness Review, Dental Contractor will correct the deficiencies within 10 Days of identification and written notification to the Parties or provide a Corrective Action Plan or risk mitigation plan as directed by HHSC if the deficiency requires more than 10 Days to correct.

HHSC may, at its discretion, postpone the Dental Contractor's Operational Start Date, or assess contractual remedies, including termination of the Contract, if the Dental Contractor fails to timely correct all Readiness Review deficiencies within a reasonable cure period determined by HHSC.

2.2.2 TRANSITION PHASE READINESS REVIEW DURATION

Dental Contractor must meet the Readiness Review requirements established by HHSC no later than 90 Days prior to the Operational Start Date.

2.2.3 TRANSITION PHASE SCHEDULE AND TASKS

The Dental Contractor has overall responsibility for the timely and successful completion of each of the Transition Phase tasks. The Dental Contractor is responsible for clearly specifying and requesting information needed from HHSC, other HHSC contractors, and Providers in a manner that does not delay the schedule or work to be performed. The Dental Contractor agrees to provide all materials and access required to complete the Readiness Review by the dates established by HHSC and if applicable, HHSC's Readiness Review contractor.

2.2.4 TRANSITION PHASE PLANNING

HHSC and the Dental Contractor will work together during the Transition Phase to:

1. Define reporting standards;
2. Establish communication protocols between HHSC and the Dental Contractor;
3. Establish contacts with other HHSC contractors;
4. Establish a schedule for key activities and milestones; and
5. Clarify expectations for the content and format of the Contract Deliverables.

The Dental Contractor must update the Transition Plan provided with its Proposal no later than 30 Days after the Effective Date, then provide monthly implementation progress reports through the sixth month of Dental Contractor Program operations.

In the case of the assignment and assumption of a Contract due to termination, expiration, merger, or acquisition, the incoming or transitioning Dental Contractor must provide a Transition Plan no later than 30 Days after the Dental Contractor notifies HHSC, or upon notification from HHSC of the termination, expiration, merger, or acquisition. The exiting Dental Contractor must comply with the requirements as described in **Section 2.8**,

The Transition Plan must include:

1. Specific staffing patterns by function for all operations, including enrollment, information systems, member services, quality improvement, claims management, case management, and provider and recipient training;
2. Specific time frames for demonstrating preparedness for implementation before the Operational Start Date; and
3. Other elements identified by HHSC.

The Dental Contractor's Transition Plan must include a detailed description of the process it will use to ensure continued authorization of dental services. HHSC will provide a file identifying the Dental Members to the Dental Contractor for this purpose. The Dental Contractor's Transition Plan must identify a designated Dental Contractor staff member responsible for the facilitation and oversight of this process. These requirements are further described in **Section 2.3.32**.

2.2.5 ADMINISTRATION AND KEY DENTAL CONTRACTOR PERSONNEL

No later than the Effective Date, the Dental Contractor must:

1. Designate and identify Key Personnel that meet the requirements of **ATTACHMENT A HHSC DENTAL CONTRACT TERMS AND CONDITIONS**;
2. Supply HHSC with current résumés of each Key Personnel and the percent of allocated time for each Key Personnel that is dedicated to the Contract;
3. Report on any organizational information that has changed since the Dental Contractor's Proposal, such as updated job descriptions and organizational charts, including Management Information System (MIS) job descriptions and an MIS staff organizational chart, if applicable; and
4. Provide the organizational chart and oversight criteria for each Material Subcontractors, including the percentage of time each Material Subcontractor dedicate to the Dental Contractor.

During the Transition Phase, the Dental Contractor must notify HHSC no later than five Days following a change in the Key Personnel or Material Subcontractors.

In the case of Contract termination or expiration, the Dental Contractor must provide HHSC with the Key Dental Contractor Personnel who will facilitate ongoing activities and requirements described in the Turnover Plan. In the case of merger or acquisition, the Dental Contractor must provide HHSC with the Key Dental Contractor Personnel who will facilitate ongoing activities and requirements described in the Transition Plan. The Dental Contractor will also provide HHSC with the Material Subcontractor's functions and responsibilities as identified in **Chapter 5 of the UMCM**.

2.2.6 ORGANIZATIONAL AND FINANCIAL READINESS REVIEW

During the Readiness Review, the Dental Contractor must update the organizational and financial information submitted in its Proposal. **Section 7** of **ATTACHMENT E, HHSC SOLICITATION NO. HHS0002879,** contains a list of financial statements, corporate background and experience information, and Material Subcontractor information that the Dental Contractor must update for Readiness Review.

During the Readiness Review, HHSC may request from the Dental Contractor certain operating procedures and updates to documentation to support the provision of Services. The Dental Contractor must provide assurance of the Dental Contractor's understanding of its responsibilities and the Dental Contractor's capability to assume the functions required under the Contract, based in part on the Dental Contractor's assurances of operational readiness, information contained in its Proposal, and in Transition Phase documentation submitted by the Dental Contractor.

At HHSC's election, the Dental Contractor is required to provide a Corrective Action Plan (CAP) in response to any Readiness Review deficiency no later than 10 Days after the discovery of any such deficiency by HHSC or the Dental Contractor. If the Dental

Contractor documents to HHSC's satisfaction that the deficiency has been corrected within 10 Days of such deficiency notification, a CAP may not be required.

2.2.6.1 RESPONSIBILITIES IN THE EVENT OF A FEDERAL EMERGENCY MANAGEMENT AGENCY OR GOVERNOR-DECLARED DISASTER, OR OTHER EMERGENCIES

In the event of a Federal Emergency Management Agency (FEMA) or State of Texas Governor-declared disaster, or other emergencies that are internal, man-made, or natural, the Dental Contractor must ensure the care of Members in compliance with the Dental Contractor's continuity of Member care emergency response plan (COMCER plan), particularly the care of Members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if Covered Services are disrupted or interrupted. Requirements for the COMCER plan and other disaster-related requirements are described in **Section 16.1.13 of the UMCM.**

The Dental Contractor must have a COMCER plan based on a risk assessment using an "all hazards" approach to respond. An "all hazards" approach focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal emergencies, man-made emergency, or natural disasters. As part of the plan, the Dental Contractor must describe the method to ensure that Members are able to see Out-of-Network providers if Members have a permanent address in FEMA or State of Texas Governor-declared disaster areas, or areas in which internal, man-made, or natural disasters have occurred, and are unable to access Covered Services from Network Providers.

The Dental Contractor must also describe the method it will use to ensure that prior authorizations are extended and transferred without burden to new Providers if directed by HHSC, and the method by which the Dental Contractor will identify the location of Members who have been displaced. Annually, the Dental Contractor must conduct exercises carrying out the plan's provisions, evaluate its performance and make necessary updates.

Additionally, the Dental Contractor must maintain a continuity of operations business plan which includes a collection of resources, actions, procedures, and information that is developed, tested, and held in readiness for use to continue operations in the event of a major disruption of operations due to a FEMA or State of Texas Governor-declared disaster, or other emergencies that are internal, man-made, or natural.

The continuity of operations business plan must address emergency financial needs, essential functions for Member services, critical personnel, and how to return to normal operations as quickly as possible.

During a FEMA or State of Texas Governor-declared disaster, or other emergency that is internal, man-made, or natural, the Dental Contractor is required to report to HHSC daily

or at an interval determined by HHSC, when requested, on the status of Members and issues regarding Member access to Covered Services.

When directed by HHSC, by authority of waivers available through the CHIP State Plan, the Dental Contractor must be able to require Network Providers to waive all CHIP cost-sharing requirements for children of families living in FEMA or State of Texas Governor-declared disaster areas or areas in which internal, man-made, or natural disasters have occurred, at the time of the disaster event.

The Dental Contractor claims system must have the capability to waive edits or allow override of edits by at least ZIP code and county for specific date ranges. The Dental Contractor claims system must have the capability to waive edits or allow override of edits by at least ZIP code and county for specific date ranges. The Dental Contractor must have a COMCER plan based on a risk assessment using an "all hazards" approach to respond. An "all hazards" approach focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal emergencies, man-made emergency, or natural disasters. As part of the plan, the Dental Contractor must describe the method to ensure that Members are able to see Out-of-Network providers if Members have a permanent address in FEMA or State of Texas Governor-declared disaster areas, or areas in which internal, man-made, or natural disasters have occurred, and are unable to access Covered Services from Network Providers.

2.2.6.2 EMPLOYEE BONUS AND/OR INCENTIVE PAYMENT PLAN

If the Dental Contractor intends to include Employee Bonus or Incentive Payments as allowable administrative expenses, the Dental Contractor must furnish a written Employee Bonus and/or Incentive Payments Plan to HHSC. The written plan must include a description of the Dental Contractor's criteria for establishing bonus and/or incentive payments, the methodology to calculate bonus and/or incentive payments, and the timing of bonus and/or incentive payments. The Bonus and/or Incentive Payment Plan and description must be submitted during the Transition Phase, no later than 30 days after the Effective Date of the Contract. If the Dental Contractor substantively revises the Employee Bonus and/or Incentive Payment Plan during the Operations Phase, the Dental Contractor must submit the revised plan to HHSC at least 30 days in advance of its effective date.

HHSC reserves the right to disallow all or part of a plan that it deems inappropriate. Any such payments are subject to audit and must conform with the **Chapter 6.1 of the UMCM**.

2.2.6.3 SYSTEM TESTING AND TRANSFER OF DATA

The Dental Contractor must have hardware, software, network, and communications systems with the capability and capacity to handle and operate a MIS and all subsystems identified in **Section 2.3.29** within the continental United States.

During this Readiness Review task, the Dental Contractor must accept into its system all necessary data files and information available from HHSC or its contractors. The Dental Contractor must install and test all hardware, software, and telecommunications required to support the Contract. The Dental Contractor must define and test modifications to the Dental Contractor's systems required to support the business functions of the Contract.

The Dental Contractor must produce data extracts and receive all electronic data transfers and transmissions. The Dental Contractor must demonstrate the ability to produce a dental services 837D encounter file during the Readiness Review.

If any errors or deficiencies are evident, the Dental Contractor must implement HHSC-approved resolution procedures to address problems identified. The Dental Contractor must provide HHSC, or a designated vendor, with test data files for systems and interface testing for all external interfaces, this includes testing of the required telephone lines for Providers and Dental Members and any necessary connections to the HHSC Enrollment Broker (EB). The EB will provide test Enrollment Files to new Dental Contractor that do not have previous HHSC Enrollment Files. The Dental Contractor must demonstrate its system capabilities and adherence to the resulting Contract specifications during Readiness Review.

2.2.6.3.1 SYSTEM READINESS REVIEW

During the system Readiness Review, the Dental Contractor must assure HHSC that systems services will not be disrupted or interrupted during the Operations Phase of the Contract. The Dental Contractor must coordinate with HHSC and its contractors to ensure the business and systems continuity for the processing of all dental claims and data as required under the Contract.

The Dental Contractor must submit to HHSC descriptions of interface and data and process flow for each key business process described in **Section 2.3.29** for system-wide functions. The extent to which the claim processing is automated, as required in **Section 2.3.29.4**, will be assessed.

If the Dental Contractor is a current State of Texas vendor, all existing and unresolved projects and systems issues related to hardware, software, claims processing, network, and communications systems must be cured no later than 90 Days prior to the Effective Date of the Contract. Uncured issues present after the Effective Date of the Contract will cause the Dental Contractor to fail Readiness Review.

The Dental Contractor must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. The Dental Contractor must develop and submit for HHSC review and approval the following information no later than 120 Days prior to the Operational Start Date:

1. Joint Interface Plan;
2. Security Plan;
3. Disaster Recovery Plan;
4. Business Continuity Plan;

5. Risk Management Plan; and
6. Systems Quality Assurance Plan.

2.2.6.3.1.1 DEMONSTRATION AND ASSESSMENT OF SYSTEM READINESS

The Dental Contractor must provide documentation on systems and facility security and provide evidence or demonstrate that it is compliant with HIPAA. The Dental Contractor must provide HHSC with a summary of all recent external audit reports, including findings and corrective actions, relating to the Dental Contractor's proposed systems, including any Statement on Standards for Attestation Engagements No. 16 audits that have been conducted in the past three years. The Dental Contractor must promptly make additional information on the detail of such system audits available to HHSC upon request.

In addition, HHSC will provide to the Dental Contractor a test plan that will outline the activities that need to be performed by the Dental Contractor during Readiness Review, and the Dental Contractor must demonstrate system readiness. The Dental Contractor must execute system readiness test cycles to include all external data interfaces, including those with the Dental Contractor's Material Subcontractors.

HHSC may independently test whether the Dental Contractor's MIS has the capacity to administer the requirements of this Contract. This Readiness Review of a Dental Contractor's MIS may include, but is not limited to, a desk review or an onsite review. HHSC may request from the Dental Contractor additional documentation to support the provision of Medically Necessary Covered Dental Services. Based in part on the Dental Contractor's demonstration of systems readiness, information contained in its Proposal, additional documentation submitted by the Dental Contractor, and any review conducted by HHSC or its contractors, HHSC will assess the Dental Contractor's understanding of its responsibilities and the Dental Contractor's capability to assume the MIS functions required under the Contract.

2.2.6.4 OPERATIONS READINESS

The Dental Contractor must clearly define and document the policies and procedures that will be followed to support day-to-day business activities related to the provision of Medically Necessary Covered Dental Services, including coordination with Subcontractors. The Dental Contractor must clearly document all policies and procedures to produce the Contract Deliverables. The Dental Contractor will be responsible for developing and documenting its approach to quality assurance. HHSC will conduct operation Readiness Reviews during the time period between the Contract Effective Date and the Operational Date, as well as biannually to ensure the Dental Contractors are in compliance with the Contract.

The Dental Contractor must reimburse HHSC for all travel costs incurred by HHSC for onsite Readiness Reviews. For purposes of this section, "travel costs" include HHSC approved airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC in connection with the onsite reviews. Reimbursement by the Dental Contractor will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the Dental Contractor. The Dental Contractor may

not require a Social Security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement. During operations Readiness Review, the Dental Contractor must perform the following activities and submit Deliverables on a schedule specified by HHSC:

1. Develop, or revise existing operations procedures and associated documentation to support the Dental Contractor's proposed approach to conducting operations activities in compliance with the SOW. If the Dental Contractor is an incumbent HHSC Dental Contractor, a Dental Contractor currently providing Texas Medicaid and CHIP dental services, such revisions must reflect the guidance and direction given to the Dental Contractor by HHSC to date, provided such is applicable to the SOW;
2. Submit a comprehensive plan for Network adequacy that includes a list of all contracted and credentialed Providers in a format approved by HHSC. The list must include the Provider types identified in Tex. Gov't Code § 533.005(a)(21)(B)(i), (ii), and (iv). The plan must include a description of additional contracting and credentialing activities scheduled to be completed before the Operational Start Date;
3. Implement a Dental Member services staff training curriculum and a Provider training curriculum, and provide documentation demonstrating compliance with training requirements, such as enrollment or attendance rosters dated and signed by each attendee or other written evidence of the training. Training must meet the requirements of 1 Tex. Admin. Code § 353.105, and include privacy, Member advocacy, Internal Dental Contractor Member Appeal process, HHSC State Fair Hearing process, Medically Necessary Covered Dental Services, Value-added Services (VAS), medical necessity, Dental Member harm identification, issue escalation, prohibitions related to restraint, and community resource navigation;
4. Prepare a coordination plan documenting how the Dental Contractor will coordinate its business activities with those activities performed by HHSC or its contractors, and if any, Material Subcontractors. The coordination plan must include identification of coordinated activities and protocols for the Transition Phase;
5. Submit to HHSC the draft Dental Member handbook, draft Provider manual, draft Provider directory, and draft Dental Member identification card for HHSC's review and approval. The materials must meet the requirements specified in **Section 2.3.20** and include the Critical Elements defined in the **UMCM.** The Dental Contractor must submit a final Dental Member handbook and Provider directory incorporating changes required by HHSC prior to the Operational Start Date;
6. Submit to HHSC the Dental Contractor's proposed Dental Member Complaint and Internal Dental Contractor Appeal processes;
7. Provide sufficient copies of the final Provider directory to HHSC in sufficient time to meet the enrollment schedule;
8. Demonstrate toll-free telephone systems and reporting capabilities for the Dental Member services hotline and the Provider hotline;

9. Submit a written Fraud, Waste, and Abuse (FWA) compliance plan to HHSC for approval no later than 30 Days after the Contract's Effective Date. **Section 2.3.31.1** provides the requirements of the plan.
10. Ensure that, if this function is subcontracted to another entity, the Subcontractor also meets all the requirements in this section and the FWA requirements stated in **Section 2.3.31.1.** Submit model Provider Contracts to HHSC for review during Readiness Review. HHSC may reject or require changes to any model Provider Contract that does not comply with HHSC requirements for these Provider Contracts;
11. Fully inform all Providers about the claim submission process and claim data requirements at least 30 Days prior to the Operational Start Date and as a provision within the Dental Contractor's Provider Contract and the Provider manual described in subsection 5 above;
12. Develop and implement a network access assurance program to continually improve Network access and quality. Under this program, the Dental Contractor must provide enhanced payments to qualified Providers. During Readiness Review, the Dental Contractor must submit a written description of its proposed network access assurance program to HHSC, and must receive HHSC's written approval before implementing the program;
13. Develop a privacy notice, commonly referred to as Notice of Privacy Practice (NOPP), as required by HIPAA, including 45 C.F.R. § 164.520. The Dental Contractor must provide HHSC with a copy of its privacy notice during Readiness Review for HHSC approval;
14. Submit a Cultural Competency plan to HHSC for approval. The plan must align with the federal and state standards as described in **Chapter 11 of the UMCM**. The Cultural Competency plan must detail how the Dental Contractor implements each component of the related federal and state standards for such plans. The Dental Contractor must describe how its implementation of these standards impact implementation of the principal standard, which is to "Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."

Note to Dental Contractors. The above services and Chapter reference in Number 14 may not have been incorporated into the UMCM at the time this Contract was awarded. In the event they have not been, such services will be as part of the current HHSC UMCM change process. The Contract will be amended appropriately at that time.

HHSC may require the Dental Contractor to resubmit one or more of the above items if the Dental Contractor begins providing a new service or benefit, or implements a Major Systems change after the Effective Date.

2.2.6.5 ASSURANCE OF SYSTEM AND OPERATIONAL READINESS

In addition to successfully providing the Deliverables described in **Section 2.2.4**, the Dental Contractor must assure HHSC that all processes, MIS, and staffed functions are ready and able to successfully assume responsibilities for operations prior to the Operational Start Date, including hiring and training of the Key Personnel, Member services staff, Provider services staff, and MIS staff. The Dental Contractor must also assure HHSC that the MIS system and interfaces are in place and functioning properly; communications procedures are in place; Provider manuals have been distributed; and Provider training sessions have occurred according to the HHSC approved schedule.

HHSC may terminate the Contract, postpone the Operational Start Date, or assess other contractual remedies if the Dental Contractor fails to timely correct all Transition Phase deficiencies within a reasonable cure period, as determined by HHSC.

2.2.6.6 MEMBER ENROLLMENT DURING TRANSITION

During the Transition period, HHSC will notify potential and current Dental Members of their option to choose a Dental Contractor for the Operations Phase. HHSC will notify current Dental Members about Dental Contractor options starting six months prior to the Operational Start Date. Beginning three months prior to Operational Start Date, HHSC will provide a prospective member file to each Dental Contractor.

The Dental Contractor must:

1. Load the prospective eligibility file, receive daily updates of the prospective eligibility file, and process eligibility changes sent by HHSC;
2. Create a file that will include all pertinent dental and clinical data associated with Dental Members who transition away from their Dental Contractor; and
3. Coordinate with HHSC to determine the appropriate file layouts and timelines for transfers between the Dental Contractor and HHSC.

The Dental Contractor is required to mitigate risk associated with not being prepared for the Operations Phase in coordination with HHSC, with consideration of the following high-level processes:

1. HHSC will identify key events (Readiness Review milestones) based on a project work plan that each Dental Contractor must achieve by a specified time;
2. To ensure that each Dental Contractor is on track to meet these Readiness Review milestones, HHSC will conduct weekly Readiness Review webinars;
3. If a Dental Contractor consistently fails to meet the established Readiness Review milestones, it will be identified as high risk and targeted for increased technical assistance;
4. HHSC will conduct an abbreviated systems and operations Readiness Review six months prior to the Operational Start Date and will tentatively assess a Dental Contractor as "Go" or "No-Go" based on established and published criterion;
5. The "No-Go" determination will be made only in those instances where a Dental Contractor cannot become fully operational by the Operational Start Date, as

determined by HHSC. In that case, the Dental Contractor will not be listed as an option for Dental Members selecting a Dental Contractor during initial Dental Member notification;

6. Upon a Dental Contractor's remediation of the issues identified by HHSC to HHSC's satisfaction, the Dental Contractor status will change to "Go" and become an option;
7. Final Readiness Review will occur 90 Days prior to go live, and if at this point a Dental Contractor is identified as a "No-Go" then Dental Members will be notified that the Dental Contractor is no longer available as an option and another Dental Contractor must be selected. If a Dental Member does not select a Dental Contractor, then HHSC will default a Dental Member into a plan.
8. When the Dental Contractor is able to demonstrate readiness to HHSC, then it will be restored as an option and HHSC will apply the default enrollment criteria specified by HHSC.

2.2.7 TEXAS DEPARTMENT OF INSURANCE AND CENTERS FOR MEDICARE AND MEDICAID SERVICES LICENSURE, CERTIFICATION, OR APPROVAL

The Dental Contractor must receive Texas Department of Insurance (TDI) licensure, certification, or approval as a dental maintenance organization or an indemnity insurer in all counties in the State no later than 60 Days after the Contract's Effective Date. HHSC may terminate the Contract at no additional cost to HHSC and with no penalty for the Dental Contractor's failure to provide HHSC with the required TDI certification or approval.

2.2.8 CONTINUITY OF CARE AND OUT-OF-NETWORK PROVIDERS

During the Transition Phase, HHSC will require current Dental Contractor to provide any new Dental Contractor with files identifying Dental Members with prior authorizations for dental services as instructed by HHSC. The Dental Contractor must describe the process it will use to ensure continuation of these services in its Transition Plan, as noted in **Section 2.2.4**. The Dental Contractor must ensure that Providers are educated about and trained regarding the process for continuing these services prior to the Operational Start Date.

The Dental Contractor must ensure that each Dental Member has access to a second opinion regarding the use of any Covered Service. A Dental Member must be allowed access to a second opinion from a Network Provider or Out-of-Network provider if a Network Provider is not available, at no cost to the Dental Member, in accordance with 42 C.F.R. §438.206(b)(3). The Dental Contractor may use single case agreements with Out-of-Network providers to facilitate a Dental Member's access to a second opinion. The Dental Contractor is not required to include Dental Members seeking a second opinion as part of its "Out-of-Network Utilization Reporting" requirements under **Chapter 5 of the UMCM.**

2.2.9 CONTINUING TRANSITION OBLIGATIONS

The Dental Contractor must work with HHSC, Providers, and Dental Members to promptly identify and resolve problems identified after the Operational Start Date and to communicate to HHSC, Providers, and Dental Members, as applicable, the steps the Dental Contractor is taking to resolve the problems.

2.3 OPERATIONS PHASE SCOPE

This section describes SOW requirements for the Operations Phase of the Contract which begins on the Operational Start Date. HHSC has additional requirements in **ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS** and the **UMCM.** The Respondent is responsible for all requirements set forth in **ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS** and the **UMCM,** which is incorporated by reference into the Contract. HHSC may modify these documents as it deems necessary.

2.3.1 GENERAL SCOPE OF WORK

The Dental Contractor must provide Medically Necessary Covered Dental Services to Dental Members enrolled with the Dental Contractor on or after the Operational Start Date.

The Dental Contractor must comply, to the satisfaction of HHSC, with all Contract requirements and all applicable provisions of state and federal laws, rules, regulations, and all state plan or waiver agreements with CMS.

2.3.2 OPERATIONAL PHASE READINESS, OPERATIONAL, AND TARGETED REVIEWS

HHSC may conduct desk or onsite reviews related as part of its Contract performance. HHSC may also require Contractors to submit detailed policies and procedure that document day-to-day business activities related to Contract requirements for HHSC review and approval.

The Dental Contractor may be subject to additional Readiness Reviews if it makes changes deemed by HHSC to require such Readiness Reviews. Changes made during the Operational Phase that may lead to additional Readiness Reviews include, but are not limited to:

1. Location change;
2. Processing system changes, including changes in Material Subcontractors performing MIS or claims Processing Functions;
3. Carve-ins of new membership; and
4. Carve-ins of new Services.

HHSC will determine whether the proposed changes will require a desk review or an onsite review.

HHSC will determine whether the proposed changes require a desk review and/or an onsite review. The Dental Contractor must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent for onsite reviews conducted as part of Readiness Review or HHSC's normal Contract monitoring efforts. For purposes of this section, "authorized reimbursable travel costs" may include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite reviews. Reimbursement by the Dental Contractor will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the Dental Contractor. The Dental Contractor may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

Unless the Dental Contractor receives HHSC approval for a one-time exception in writing, the Dental Contractor must provide HHSC with secure access rights as an authorized guest user to all Member and Provider access points, including but not limited to its Member and Provider portals and call center services, for remote monitoring capability. To qualify for an exception to this requirement, the Dental Contractor must demonstrate to HHSC the required functionality for Member and Provider portals via WebEx or onsite reviews. Portal demonstrations must be conducted in the Dental Contractor or the Subcontractor's production environment or an environment that mirrors the production environment functionality.

The Dental Contractor must develop and submit a risk management plan and contingency plan, as required by the UMCM, to ensure risks and issues are effectively monitored and managed as to limit impact to business operations.

The Dental Contractor must document and report resolution of system or service related issues to HHSC, including the length of time from discovery to resolution, severity level, and provide corrective measures and a root cause analysis to prevent future problems from occurring.

For MIS Changes Only: The Dental Contractor must provide HHSC updates to the Dental Contractor's organizational chart and descriptions of MIS responsibilities at least 30 Days prior to the effective date of an MIS change. The Dental Contractor must provide an up-to-date official point of contact to HHSC for MIS issues on an ongoing basis. The Dental Contractor or its designee must be able to demonstrate, upon HHSC's request, sufficient oversight of each Material Subcontractor based on Dental Contractor's assessed risk of Material Subcontractor's performance.

Major Systems Changes are subject to HHSC desk review and onsite review of the Dental Contractor's facilities, as necessary, to test readiness and functionality prior to implementation. Prior to HHSC approval of the Major Systems Change, the Dental Contractor may not implement any changes to its operating systems.

The Dental Contractor must provide HHSC updates to the Dental Contractor's organizational chart relating to MIS and the description of MIS responsibilities at least 30 Days prior to the effective date of the change. The Dental Contractor must provide HHSC official points of contact, on an on-going basis, for MIS issues.

During the Operational Phase, HHSC may conduct any Systems Readiness Reviews described in **Section 2.3.2;** or elsewhere in the Contract to validate the Dental Contractor's ability to meet the MIS requirements. The System Readiness Review may include a desk review or onsite review and must be conducted for the following events:

1. A new Dental Contractor is brought into the Dental Program;
2. An existing Dental Contractor changes location; or
3. An existing Dental Contractor changes its processing system, including changes in Material Subcontractors performing MIS or claims processing functions.

Refer to **Section 2.2** for additional information regarding Readiness Reviews and **Section 4.08(c) of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS** for information regarding Readiness Reviews of the Dental Contractor's Material Subcontractors.

2.3.3 HHSC PERFORMANCE REVIEW AND EVALUATION

In accordance with **Section 12.01 of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**, HHSC, at its discretion, will review, evaluate and assess the development and implementation of the Dental Contractor's policies and procedures related to the timely and appropriate delivery of Services and Deliverables as required under the Contract. Reviews, evaluations, and assessments may include the following:

1. Dental Contractor's reviews of its own policies and procedures, and ensuing corrective actions taken, including demonstration by the Dental Contractor that the corrective action(s) or intervention(s) included in the Corrective Action Plan (CAP) have been completed or implemented using a method approved or provided by HHSC;
2. Dental Contractor internal policies;
3. Dental Contractor internal procedures;
4. Dental Contractor workflows;
5. Dental Contractor use of prior authorizations;
6. Dental Contractor utilization review process;
7. Assessment of the Dental Contractor service planning package;
8. The potential for underutilization of services; assessments; delivery of services; and
9. Case notes.

Upon notice and at no charge to HHSC, the Dental Contractor and its Subcontractors must cooperate with HHSC and provide any assistance required to complete the review, evaluation, or assessment including prompt and adequate access to related documents, internal systems containing Dental Member information and records, and appropriate staff, as well as, utilization management documentation, case notes, and service locations or facilities that are related to the scope of services provided under the Contract.

HHSC may monitor the Dental Contractor to confirm the Dental Contractor is using prior authorization and Utilization Review processes that ensure appropriate utilization and prevent overutilization or underutilization of services. A Dental Contractor providing dental services must also comply with the terms of **Section 2.3.25**.

2.3.4 MEDICALLY NECESSARY COVERED DENTAL SERVICES

The Dental Contractor is responsible for authorizing, arranging, coordinating, and providing Medically Necessary Covered Dental Services in accordance with the requirements of this Contract. The Dental Contractor must provide Medically Necessary Covered Dental Services to all Dental Members beginning on the Member's date of enrollment regardless of pre-existing conditions, prior diagnosis, receipt of any prior dental health care services, or for any other reason, subject to the HHSC-prescribed benefit limitations. The Dental Contractor must not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any Dental Member.

The Dental Contractor must not practice discriminatory selection or encourage segregation among the total group of eligible Dental Members by excluding, seeking to exclude, or otherwise discriminating against any group or class of individuals.

1) Dental Contractor is responsible for providing all Medically Necessary Covered Dental Services available to clients of the Fee-for-Service (FFS) program to the Dental Contractor's eligible Medicaid members, in no less than the amount, duration, and scope as is available through FFS, as reflected in the state plan under Title XIX of the Social Security Act Medical Assistance Program and detailed in the Texas Medicaid Provider Procedures Manual (TMPPM) as **ATTACHMENT H, TEXAS MEDICAID PROVIDER PROCEDURES MANUAL**, and as required by 42 C.F.R. subpart B of Part 441 for Members under the age of 21, and in accordance with 42 C.F.R. § 438.210, with the exception of Non-capitated Services explained in **Section 2.5.1.5**. Dental Contractor must provide the services described in the most recent TMPPM and any updates thereto. The Dental Contractor is responsible for educating Dental members about the availability of Non-capitated Services and referring Dental members to and helping coordinate care for Non-capitated Services.

ATTACHMENT G, CHIP MEDICALLY NECESSARY COVERED DENTAL SERVICES, includes a comprehensive list of Medically Necessary Covered Dental Services for CHIP members, including preventive, diagnostic, restorative, endodontic, periodontal, prosthodontic, and oral and maxillofacial surgery.

The Dental Contractor is responsible for paying for or reimbursing for all Medically Necessary Covered Dental Services provided to CHIP members, up to maximum benefit amounts.

Dental Members who receive Medically Necessary Covered Dental Services are not responsible for paying the costs of such services, other than any authorized cost-sharing

under CHIP, unless the Dental Member has exhausted his or her applicable maximum benefit limits.

Certain dental services are benefits of CHIP but are excluded from the Covered Dental Services provided by the Dental Contractor. The Dental Contractor is not responsible for coverage of or payment for these "Non-capitated Services," which are described more fully in **Section 2.5.1.5.** The Dental Contractor is responsible for educating CHIP Dental members about the availability of these Non-capitated Services and referring CHIP Dental members to and helping coordinate care for these Non-capitated Services.

Medically Necessary Covered Dental Services for Medicaid and CHIP Dental Members are subject to change due to changes in federal and state law; changes in the Medicaid or CHIP state plan; changes in Medicaid or CHIP policy; and changes in dental practice, protocols, or technology.

In the development of medical necessity determinations, the Dental Contractor must adopt practice guidelines that:

1. Are based on valid and reliable clinical evidence or a consensus of oral health care professionals in the particular field;
2. Consider the needs of the Dental Contractor's Members;
3. Do not conflict in part or in whole with state or federal policy;
4. Are adopted in consultation with contracting oral health care professionals;
5. Are reviewed and updated periodically as appropriate or as requested by HHSC; and
6. Are shared with Providers in the Dental Contractor Network as a means of transparency.

2.3.5 VALUE-ADDED SERVICES

The Dental Contractor may propose additional services for coverage which are Value-added Services (VAS). VAS may be actual dental services, benefits, or positive incentives that HHSC determines will promote oral health, healthy lifestyles, health literacy, service access, and improved oral health outcomes among Dental Members. If approved by HHSC, VAS may also include transportation. A VAS must not be Medicaid or CHIP benefits covered under the Contract. Best practice approaches to delivering Medically Necessary Covered Dental Services are not considered VAS.

The Dental Contractor must offer VAS to all Dental Members; but may distinguish among an identified group or category of Dental Members. VAS do not need to be consistent between Medicaid and CHIP.

Any VAS that the Dental Contractor elects to provide must be provided at no additional cost to HHSC. The costs of VAS are not reportable as Allowable Costs on the Financial Statistical Report (FSR) for either dental or administrative expenses and are not factored into the rate-setting process. In addition, the Dental Contractor must not pass on the cost of the VAS to Dental Members or Providers. HHSC may collect data on VAS costs in the FSR or elsewhere, for informational purposes.

The Dental Contractor may offer discounts on non-covered benefits to Dental Members as VAS, provided that the Dental Contractor complies with Tex. Ins. Code § 1451.2065. The Dental Contractor must ensure that Providers do not charge Members for any other cost-sharing for a VAS, including copayments or deductibles.

The Dental Contractor must specify the conditions and parameters regarding the delivery of each VAS and must clearly describe any limitations or conditions specific to each VAS in the Dental Member handbook. The Dental Contractor must also include a disclaimer in its Marketing Materials and Provider directory indicating that restrictions and limitations may apply to VAS.

The Dental Contractor's proposed VAS must be approved by HHSC prior to implementation. The Dental Contractor must use HHSC's template for submitting proposed VAS. See **Chapter 4 of the UMCM**.

Dental Contractor will be given the opportunity to add, enhance, delete, or reduce VAS once per State Fiscal Year (SFY), with changes to be effective September 1. HHSC may allow additional modifications to VAS if Medically Necessary Covered Dental Services are amended by HHSC during a SFY. The Dental Contractor must submit requests to add, enhance, delete, or reduce a VAS to HHSC by April 1 of each SFY to be effective the following September 1.

Once requests are approved, the Dental Contractor must not reduce or delete any VAS until September 1. When the Dental Contractor requests deletion or reduction of a VAS, the Dental Contractor must include information regarding the processes by which the Dental Contractor will notify Dental Members and revise Member Materials and Marketing Materials. See **Chapter 4 of the UMCM**.

A Dental Contractor's request to add a VAS must at least:

1. Define and describe the proposed VAS;
2. Identify the category or group of Dental Members eligible to receive the VAS, if it is a type of service that is not appropriate for all Dental Members;
3. Describe any limitations or restrictions that apply to the VAS;
4. Identify the Providers or entities responsible for providing the VAS;
5. Describe how the Dental Contractor will identify the VAS in its financial statistical report (FSR), as applicable;
6. Propose how and when the Dental Contractor will notify Providers and Dental Members about the availability of such VAS;
7. Describe the process by which a Dental Member may obtain or access the VAS, including any action required by the Dental Member, as appropriate;
8. Include a statement that the Dental Contractor will provide such VAS for at least 12 months following HHSC approval; and
9. Describe how the Dental Contractor will identify the VAS in administrative data (e.g., Encounter Data), and in Encounters, FSRs, and in any other reports to HHSC.

A Dental Contractor must not include a VAS in any material distributed to Dental Members or prospective members until the Dental Contractor obtains HHSC's approval. If a VAS is deleted, the Dental Contractor must notify each Dental Member, at a minimum of 30 Days

prior to discontinuing the VAS that the service will no longer be available as a VAS through the Dental Contractor. The Dental Contractor must also revise all materials distributed to prospective members to reflect the change in VAS. These materials are subject to review and approval by HHSC as outlined in **Section 2.3.20.3**.

2.3.6 CASE-BY-CASE SERVICES

The Dental Contractor may offer additional benefits that are outside the capitation rate and scope of Medically Necessary Covered Dental Services to individual Dental Members on a case-by-case basis, based on medical necessity, cost-effectiveness, the wishes of the Dental Member or Dental Member's Legally Authorized Representative (LAR), and the potential for improved dental health status of the Dental Member. In compliance with **Section 9.01** of **ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**, The Dental Contractor does not have to receive HHSC approval for Case-by-case Services and does not have to provide such services to all Dental Contractor Members. Contractor must maintain documentation of authorized case-by-case services that includes the reasons for the approval, at a minimum this documentation must include the reason for providing the service. Case-by-case services authorized by the Dental Contractor are not considered in the rate-setting process, are provided by the Dental Contractor at no cost to HHSC, the Dental Member, or Provider, and must be appropriately reported in the Dental Contractor's FSR.

2.3.7 COORDINATION OF NON-CAPITATED SERVICES

The Dental Contractor is not responsible for coverage or payment of Non-capitated Services, including Emergency Dental Services provided to CHIP members in a Hospital or ambulatory surgical center setting. These Non-capitated Services are part of the medical benefit provided by CHIP. The CHIP medical benefit provides limited emergency dental coverage for dislocated jaw, traumatic damage to teeth, and removal of cysts; treatment of oral abscess of tooth or gum origin; treatment and devices for craniofacial anomalies; and drugs. The CHIP medical benefit also provides coverage for hospital, physician, and related medical services (e.g. anesthesia) associated with dental care in these settings.

Under Medicaid, Emergency Dental Services in a Hospital or ambulatory surgical setting are also Non-capitated Services provided as part of the medical benefit paid by traditional Medicaid FFS or Medicaid medical managed care. Medicaid medical benefits provide for coverage of some dental related services, including but not limited to, dislocated jaw, traumatic damage to teeth and supporting structures, removal of cysts, treatment of oral abscess of tooth or gum origin, treatment and devices for correction of craniofacial anomalies, and drugs. The Medicaid medical benefit also provides for hospital, physician, and related medical services (e.g. anesthesia and facility fees) associated with dental care in these settings.

The Dental Contractor must educate Dental Members regarding the availability of Non-capitated Services and appropriate referrals for Dental Members to obtain or access these services. The Dental Contractor must inform Providers that bills for all Non-capitated

Services must be submitted to the appropriate CHIP or Medicaid Dental Contractor s or HHSC's Claims Administrator.

2.3.7.1 NONEMERGENCY MEDICAL TRANSPORTATION SERVICES AND MEDICAID DENTAL SERVICES

Members may use NEMT Services to access Medically Necessary Covered Dental Services if they have no other available means of transportation. A Member's managed care organization is responsible for arranging and coordinating NEMT Services. The Dental Contractor must inform all Members of the availability of NEMT Services and advise them to contact their managed care organizations to request the services. Once contacted by a Member, the managed care organization may need supporting documentation from the Dental Contractor to approve the requested NEMT Services. The Dental Contractor must be responsive to these requests from the managed care organization and in a timely manner that does not delay the Member's ability to access Medically Necessary Covered Dental Services.

2.3.8 ACCESS TO CARE

All Medically Necessary Covered Dental Services must be available to Dental Members on a timely basis, in accordance with appropriate dental guidelines, and consistent with generally accepted practice parameters, and the requirements in the Contract. The Dental Contractor must ensure that all Dental Members have access to a choice of Providers for all Medically Necessary Covered Dental Services. If the Dental Contractor is unable to meet this standard, the Dental Contractor must request an exception from HHSC.

The Dental Contractor must comply with the applicable access requirements established by TDI under 28 Tex. Admin. Code § 3.9208 and § 11.1607 for all Dental Contractor operating in Texas, except as otherwise required by the Contract. Where conflicts exist between TDI access requirements and the Contract, the shortest mileage and timeframe requirements will apply.

Providers must retain the authority to control the number of Dental Members they accept into their practice. The Dental Contractor cannot require a Provider to maintain an Open or closed panel.

The Dental Contractor must ensure that Providers offer office hours to Dental Members that are at least equal to those offered to members of the Dental Contractor's commercial lines of business, or to Fee-for-Service participants. The Dental Contractor must ensure all Providers' locations are accessible to Dental Members.

A Dental Contractor must provide the Medically Necessary Covered Dental Services outlined in Attachment G, "Medicaid Medically Necessary Covered Services". If the Medically Necessary Covered Dental Services are not available through Network

Providers, the Dental Contractor must, upon the request of a Provider or Dental Member, the Dental Contractor must provide a referral to an Out-of-Network (OON) provider if Medically Necessary Covered Dental Services are not available through the Provider, within the timeframes noted in **Section 2.3.8.1**. The Dental Contractor must fully reimburse the OON provider in accordance with the OON methodology for Medicaid as defined by HHSC, and for CHIP, at the usual and customary rate defined by TDI in 28 Tex. Admin. Code § 11.506. A Medicaid or CHIP Dental Contractor is not responsible for payment for unauthorized non-emergency services provided to a Member by Out-of-Network Providers, except when that provider is an Indian Health Care Provider (IHCP) enrolled as a Federally Qualified Health Center (FQHC), as provided in **Section 2.3.33**

The Dental Contractor must not require the Dental Member to pay for any Medically Necessary Covered Dental Services by Providers except HHSC-specified copayments for CHIP Dental Members, where applicable.

2.3.8.1 APPOINTMENT ACCESSIBILITY

Through its Network composition and management, the Dental Contractor must ensure that the following standards for appointment accessibility are met. The standards are measured from the date of presentation or request, whichever occurs first:

1. Urgent care, including urgent specialty care, must be provided within 24 hours.
2. Therapeutic and diagnostic care must be provided within 14 Days.
3. Main Dentists must make referrals for specialty care on a timely basis, based on the urgency of the Dental Member's oral health condition, but no later than 30 Days.
4. Preventive dental must be provided within 14 Days. Services should be offered to CHIP members in accordance with the American Academy of Pediatric Dentistry (AAPD) periodicity schedule, and to Medicaid members who are 6 months through 20 years of age, with dental checkups occurring at 6-month (180-day) intervals, and thereafter, in accordance with the AAPD periodicity schedule.
5. Non-urgent specialty care must be provided within 60 Days of authorization.

2.3.8.2 ACCESS TO NETWORK PROVIDERS

The Dental Contractor's Network must have dental Providers in sufficient numbers, and with sufficient capacity, to provide timely access in accordance with the appointment accessibility standards in **Section 2.3.8.1**, "Appointment Accessibility" and in **Chapter 5.28.1, Access to Network Providers Performance Standards and Specifications of the UMCM**.

Counties will be designated as Metro, Micro, or Rural and as defined in **ATTACHMENT N, Access Standards Map**. The county designation is based on population and density parameters. Dental Members' residences in eligibility files with HHSC will be used to assess distance and travel times. The Dental Contractor must ensure that access is consistent with 1 Tex. Admin. Code § 353.411.

HHSC will track Dental Contractor performance. HHSC will use the Dental Contractor Provider Files to run geo-mapping reports which will measure provider choice, distance and travel time from the Dental Member to the Provider. HHSC will compile the reports based on each Dental Contractor's Network. HHSC will share identified deficiencies with the Dental Contractor.

2.3.8.3 DENTIST ACCESS

2.3.8.3.1 MAIN DENTISTS

The Dental Contractor's Network must comply with the accessibility standards set forth in 1 Tex. Admin. Code § 353.411 and in **Chapter 5.28.1 Access to Network Providers Performance Standards and Specifications UMCM**. At a minimum the Dental Contractor must ensure that Members have access to a Main Dentist with an Open Panel.

2.3.8.3.2 SPECIALISTS

The Dental Contractor must ensure that Dental Members have access to a Pediatric dentist, Orthodontist, endodontist, periodontist, and oral surgeon. Dental Contractors must make best efforts to include orthodontists who provide cleft/craniofacial services in their Networks.

2.3.8.4 EXCEPTION PROCESS

HHSC will consider requests for exceptions to the access standards for all provider types under limited circumstances (e.g. if no appropriate provider types are located within the distance standard). Each exception request must be supported by information and documentation specified by HHSC Managed Care Compliance and Operations Network Adequacy. Exceptions may be granted on a case-by-case basis for an area that does not meet the performance standards as outlined in **Chapter 5, "Access to Network Providers Performance Standards and Specifications." of the UMCM.** Exceptions may be granted only for a specific amount of time at HHSC's discretion. The Dental Contractor must establish, through applicable supporting documentation, a normal pattern for securing Health Care Services or that the Dental Contractor is providing care of a higher skill level or specialty that the level available within the Service Area.

2.3.8.5 MONITORING ACCESS

The Dental Contractor must verify that Medically Necessary Covered Dental Services furnished by Network Providers are available and accessible to Members in compliance with the standards described in Sections **2.3.8.1,** "Appointment Accessibility," and Section **2.3.8.2**, "Access to Network Providers."

The Dental Contractor must design, develop, and implement a Provider Directory verification survey to verify that the provider information maintained by the Dental

Contractor is correct and in alignment with the provider information maintained by the HHSC Administrative Services Contractor.

The survey must be conducted annually each fiscal year. At a minimum, survey must include verification of provider directory critical elements in accordance with **Chapter 5 of the UMCM.**

The Dental Contractors may conduct the survey through its online Provider Portal, telephone calls, onsite visits, email, or other method that collects and verifies information. The Dental Contractor must conduct a statistically valid random sample (95 percent confidence level with a margin of error +/- 5% percent) of Network Main Dentists and specialists. The Dental Contractor must collect, analyze, and submit survey results and supporting documentation as specified in **Chapter 5 of the UMCM**.

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

2.3.9 MAIN DENTISTS

The Dental Contractor must develop a Network of Main Dentists consisting of general dentists, pediatric dentists, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs), that will provide preventive care and refer Dental Members to specialty care as needed.

The Dental Contractor must require Main Dentists to provide Dental Members with diagnostic and preventive services in accordance with the AAPD recommendations - see http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf. The Dental Contractor must make best efforts to ensure that Main Dentists follow these dental periodicity requirements. These best efforts include, but are not limited to, Provider education, Provider profiling, monitoring, and feedback activities.

The Dental Contractor must require Main Dentists to assess the dental needs of Dental Members for referral to specialty care providers and provide referrals as needed. The Dental Contractor must ensure that Main Dentists assess Members' needs for referrals and make such referrals. The Dental Contractor must have provisions in place that ensure referrals to specialists are processed within 72 hours after receiving the referral from the Provider. The Dental Contractor must require Main Dentists to coordinate the Dental Members' care with specialty care providers after each referral. The Dental Contractor must address specialty care in its Provider education activities, and review Provider referral patterns.

The Dental Contractor must assist the Dental Member in selecting a Main Dentist within 30 Days of enrollment with the Dental Contractor. If the Member has not selected a Main Dentist within 30 Days of enrollment, the Dental Contractor must assign the Member to a Main Dentist. This automated assignment is done using an automated algorithm approved by HHSC that considers:

1. The Dental Member's established history with a Main Dentist, as demonstrated by Encounter history with the Provider in the preceding year, if available;
2. The geographic proximity of the Dental Member's home address to the Main Dentist;
3. Whether the Provider serves as the Main Dentist to other children in the Dental Member's household who are enrolled in Medicaid or CHIP;
4. Limitations on default assignment, such as restrictions on age and capacity by the Main Dentist; and
5. Other criteria as approved by HHSC.

The Dental Contractor must allow Main Dentists to request a Dental Member to be reassigned to another Main Dentists for any of the following reasons:

1. The Dental Member is not included in the Main Dentist's scope of practice;
2. The Dental Member is noncompliant with dental advice;
3. The Dental Member consistently displays unacceptable office decorum; or
4. The Dental Member's and Main Dentist's relationship is not mutually agreeable.

Through its Provider Contracts, the Dental Contractor must require that Dental Members have 24 hours a day, 7 days a week access to Main Dentists. Through its Provider Contracts, the Dental Contractor must require such access with the following acceptable and unacceptable telephone coverage for Dental Members to contact Main Dentists after normal business hours. Normal business hours are at the discretion of each individual Main Dentist.

Acceptable coverage after normal business hours includes all of the following:

1. The office telephone is answered after normal business hours by an answering service, which meets the language requirements of each of the Prevalent Languages and can contact the Main Dentist or another designated dental Provider in emergency situations. The answering service, Main Dentist, or his or her designee must be able to provide the Dental Member instructions on accessing Emergency Dental Services. For calls regarding non-emergent conditions received by an answering service, the Main Dentist or his or her designee must respond within four hours after normal business operations resume;
2. The office telephone is answered after normal business hours by a recording in the language of each of the Prevalent Languages, directing the Member to call another number to reach the Main Dentist or another dental Provider designated by the Main Dentist. Someone must be available to answer the designated Provider's telephone. Another recording is not acceptable; and,
3. The office telephone is transferred after normal business hours to another location where someone will answer the telephone and be able to contact the Main Dentist or another dental Provider, who can return the call within four hours.

Unacceptable after normal business hours coverage:

1. The office telephone is only answered during office hours;
2. The office telephone is answered after normal business hours by a recording that tells Members to leave a message;

3. The office telephone is answered after normal business hours by a recording that directs Members to go to an Emergency room for any services needed; and
4. Returning calls received after normal business hours more than four hours after normal business hours resume.

The Dental Contractor is encouraged to include in its Network Providers who offer dental care services during evening and weekend hours.

2.3.9.3 MAIN DENTIST NOTIFICATIONS

The Dental Contractor must furnish each Main Dentist with a current list of enrolled Dental Members assigned to that Provider no later than five Business Days after the Dental Contractor receives the Enrollment File from the EB each month. The Dental Contractor may offer and provide such enrollment information in alternative formats when such format is acceptable to the Main Dentist.

2.3.9.4 INDIAN HEALTH CARE PROVIDERS

The Dental Contractor must demonstrate a sufficient number of Indian Health Care Providers (IHCP) are participating in its Provider Network to ensure that Indian Members who are eligible to receive services have timely access to services available from a Network IHCP. The Dental Contractor must allow an Indian Member to designate a Network IHCP as a Main Dental Home Provider, as long as that provider has capacity to provide the services. The Dental Contractor must allow an Indian Member to receive Covered Services from an Out-of-Network (OON) IHCP from whom the Indian Member is otherwise eligible to receive such services.

If the Dental Contractor cannot ensure timely access to Covered Services because of few or no Network IHCPs, the Dental Contractor will be considered as compliant with this Contract in accordance with 42 C.F.R. §438.14(b)(1), and §457.1209 if Indian Members are allowed to access IHCPs out-of-state or if the circumstance is deemed good cause for disenrollment from managed care in accordance with 42 C.F.R.§438.56(c) and §457.1212. The Dental Contractor must permit an OON IHCP to refer an Indian Member to a Network Provider.

The Dental Contractor must pay for Covered Services provided by an IHCP to an Indian Member, regardless of whether the IHCP is a Network Provider. The Dental Contractor must (1) pay the IHCP an agreed to negotiated rate, or (2) in the absence of a negotiated rate, pay a rate not less than the level and amount that would be paid to a Network Provider that is not an IHCP; and (3) make payment to all IHCPs in its Network in a timely manner as required for payments to practitioners in individual or group practices under 42 C.F.R. §447.45 and §447.46.

If an IHCP is not enrolled in Medicaid as an FQHC and regardless of whether an IHCP is a Network Provider, the IHCP must be paid the applicable encounter rate published annually in the Federal Register by the Indian Health Service, or, in the absence of a published encounter rate, the amount the IHCP would be paid if services were provided

under the State Plan in Medicaid FFS. If a n IHCP is enrolled in Medicaid as an FQHC, the IHCP must be reimbursed as described in Section 8.1.15.

2.3.9.5 PROVIDER NETWORK

The Dental Contractor must maintain a Network with Open Panels sufficient to provide all Dental Members with access to the full range of Medically Necessary Covered Dental Services required under the Contract. The Dental Contractor must ensure its Providers and Subcontractors meet all state and federal eligibility criteria, reporting requirements, and any other applicable rules or regulations, as amended, which relate to the Contract.

The Network must be responsive to the linguistic, cultural, and other unique needs of any minority, or physically, intellectually, or cognitively disabled individuals, or other special population served by the Dental Contractor, including the capacity to communicate with Dental Members in languages other than English, when necessary, as well as, with those who are blind, deaf-blind, deaf, or hearing impaired.

The Dental Contractor's initial base of Providers may consist primarily of Providers currently participating in Medicaid or CHIP. The Dental Contractor must also recruit other Providers, particularly in Medically Underserved Areas. The Dental Contractor must seek qualified Providers currently serving Dental Members to participate in its Network. Dental Contractor utilizing OON providers to render services to their Dental Members must not exceed the utilization standards established in 1 Tex. Admin. Code § 353.4.

In addition, if applicable, the Dental Contractor's Network must include a sufficient number of Indian Health Care Providers to ensure that eligible Dental Members enrolled with the Dental Contractor have timely access to services.

HHSC may modify this requirement for Medicaid Dental Contractors that demonstrate good cause for noncompliance, as set forth in 1 Tex. Admin. Code § 353.4(e)(3).

A Provider must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D.

Dental Contractor is prohibited from employing, contracting with, or entering into a Provider agreement with Providers whose license is expired or cancelled who are excluded, suspended, or terminated from participation in the Texas Medicaid and CHIP programs.

2.3.10 PROVIDER CONTRACT REQUIREMENTS

The Dental Contractor must enter into written Provider Contracts with properly credentialed Providers. The Dental Contractor's contract with Providers must be in writing, must be in compliance with applicable federal and state laws and regulations, and must include the minimum requirements specified in **Chapter 8 of the UMCM**. The Dental Contractor must give each Provider a copy of its executed contract within 45 Days of execution.

If licensure or certification is required to provide a Covered Dental Service, the Provider Contract must ensure that a Provider is licensed or certified in the State of Texas, except

as provided in **Section 2.3.17**. The Provider Contract must ensure that all Providers comply with all state and federal laws governing the provision of Medically Necessary Covered Dental Services. The Dental Contractor must not contract with Providers who are under sanction or exclusion from Medicaid or CHIP.

The Dental Contractor is prohibited from requiring a Provider or Provider group to enter into an exclusive contracting arrangement with the Dental Contractor as a condition for participation in its Network.

2.3.11 FIRST DENTAL HOME SERVICES FOR MEDICAID MEMBERS

The First Dental Home is a package of dental services aimed at improving the oral health of children 6-35 months of age. Its purpose is to provide simple, consistent messages that promote the importance of oral health to parents and caregivers of very young children and to keep children free from oral disease. The First Dental Home visit can be initiated as early as 6 months of age and must include, but is not limited to, the following:

1. Comprehensive oral examination;
2. Oral hygiene instruction with primary caregiver;
3. Dental prophylaxis, if appropriate;
4. Topical fluoride varnish application when teeth are present;
5. Caries risk assessment; and
6. Dental anticipatory guidance.

To provide First Dental Home services, Providers must have the appropriate certification from HHSC Texas Health Steps. The Dental Contractor must ensure Providers of First Dental Home Services apply for the First Dental Home certification through Texas Health Steps after completing the continuing education course. Training for certification to provide First Dental Home services is available as a free continuing education course on the Texas Health Steps website at www.txhealthsteps.com. Dental Contractor is responsible for verifying that Providers who submit claims for First Dental Home services have the appropriate certification from HHSC Texas Health Steps. The Dental Contractor must consult the MASTER Provider File issued weekly by Claims Administrator or check in the Online Provider Lookup (OPL) to confirm.

2.3.12 PROVIDER CREDENTIALING AND RE-CREDENTIALING

Dental Contractor must utilize the Texas Association of Health Plans' (TAHP) contracted Credentialing Verification Organization (CVO) as part of its credentialing and recredentialing process regardless of membership in the TAHP. The CVO is responsible for receiving completed applications, attestations, and primary source verification documents. The Dental Contractor retains the sole responsibility for credentialing the Provider.

At least once every three years, the Dental Contractor must review and approve the credentials of all participating Providers. The Dental Contractor may subcontract with another entity to which it delegates credentialing activities, if the delegated credentialing

is maintained in accordance with the National Committee for Quality Assurance delegated credentialing requirements and HHSC defined requirements.

At a minimum, the scope and structure of a Dental Contractor's credentialing and re-credentialing processes must be consistent with recognized Dental Contractor industry standards and relevant state and federal regulations including 28 Tex. Admin. Code §§ 11.1402(c) and 11.1902, relating to provider credentialing and notice. For the Medicaid Program, Dental Contractor must also comply with 42 C.F.R. §§ 438.12 and 438.214. The re-credentialing process must take into consideration Provider performance data including Member Complaints and Appeals, quality of care, and Utilization Management.

The Dental Contractor must complete the credentialing process for a new provider, and its claims system must be able to recognize the provider as a Provider no later than 90 Days after receipt of a complete application.

If an application does not include required information, the Dental Contractor must notify the Provider in writing of all missing information no later than 5 Business Days after receipt. If the provider responds with the missing information within 10 Days of receipt of the written notice, the Dental Contractor must complete the process within 90 Days from receipt of the original application. If the provider responds with the missing information after more than 10 Days of receipt of the written notice, the Dental Contractor has 90 Days to complete the credentialing process from the date of receipt of the completed application.

The Dental Contractor must not discriminate for the participation, reimbursement, or indemnification of any provider 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. If the Dental Contractor declines to include individual or groups of providers in its Network, it must give the affected providers written notice of the reasons for its decision. The Dental Contractor may not require providers to participate in the Dental Contractor's other lines of business in order to participate in the Dental Program. Credentialing documentation must be submitted to HHSC upon request.

2.3.12.3 EXPEDITED CREDENTIALING PROCESS

The Dental Contractor must establish and implement an expedited credentialing process, as required by Tex. Gov't Code § 533.0064, that allows applicant providers to provide services to Members on a provisional basis for the following provider types:

1. Dentists; and
2. Dental specialists, including dentists and physicians providing dental specialty care.

The Dental Contractor must allow providers to qualify for expedited credentialing if the provider:

1. Is a member of an established dental care provider group that has a current contract in place with a Dental Contractor;
2. Is a Medicaid enrolled provider;

3. Agrees to comply with the terms of the contract between the Dental Contractor and the dental care provider group, and
4. Timely submits all documentation and information required by the Dental Contractor, as necessary, for the Dental Contractor to begin the credentialing process.

Additionally, if a provider qualifies for expedited credentialing, the Dental Contractor's claims system must be able to process claims from the provider as if the provider was a Network Provider no later than 30 Days after receipt of a complete application, even if the Dental Contractor has not yet completed the credentialing process.

2.3.12.4 BOARD CERTIFICATION STATUS

The Dental Contractor must maintain a policy with respect to pediatric dentists and specialty providers that encourages participation of board-eligible and board-certified Providers in the Network. The Dental Contractor must make information on the percentage of board-eligible and board-certified pediatric dentists, and specialty Providers by specialty in the Network available to HHSC upon request.

2.3.13 PROVIDER RELATIONS INCLUDING MANUAL, MATERIALS, AND TRAINING

The Dental Contractor must maintain a provider relations presence in Texas. If the provider relations presence is a named provider relations specialist, upon a change of that specialist, the Dental Contractor must notify impacted Providers within ten Days of the change. Notification must be in writing, either through email, or in the Provider portal. The notification must include the new provider relations specialist's name, phone number, and email address.

The Dental Contractor must designate a dedicated provider relations email address or telephone number for Provider relations issues requiring additional follow up or escalation. The Dental Contractor must provide an email response or returned phone call to the Provider within three Business Days to all inquiries received; an auto-generated or pre-recorded response acknowledging the inquiry does not meet this requirement.

2.3.13.3 PROVIDER MANUAL

The Dental Contractor must prepare and issue a Provider manual to all existing Providers. For newly contracted Providers, the Dental Contractor must issue copies of the Provider manual within five Business Days from inclusion of the Provider into the Network. The Provider manual must contain the critical elements defined in **Chapter 3 of the UMCM**. The Dental Contractor must update the Provider manual in accordance with any changes made to the critical elements in **Chapter 3 of the UMCM** and provide the updated manual to Providers within 30 Days of such changes.

HHSC must review and approve any substantive revisions to the Provider Manual before the Dental Contractor publishes or distributes it to Providers.

2.3.13.4 PROVIDER MATERIALS

Provider Materials must comply with state and federal laws, rules and regulations, governing the Dental Program. **Chapters 4 and 8 of the UMCM** set forth material and submission requirements. HHSC may require discontinuation or correction of any Provider Materials, including those previously approved by HHSC.

2.3.13.5 PROVIDER TRAINING

The Dental Contractor must provide training to all Providers and their staff regarding the requirements of the Contract and any requirements related to meeting the special needs of the population of the Dental Program. The Dental Contractor's training must be completed within 30 Days of the date the Provider completes contracting and credentialing. The Dental Contractor must maintain and make available upon request the attendance rosters, dated and signed by each attendee, or other written evidence of training of each Provider and his or her staff.

The Dental Contractor must establish ongoing Provider training that includes the following issues:

1. Medically Necessary Covered Dental Services and the Provider's responsibilities for providing and coordinating these services;
    a. Special emphasis must be placed on areas that vary from commercial coverage rules, prior authorization (PA) processes, and claims processing expectations, and
    b. The processes for making referrals and coordination with Non-capitated Services.
2. Relevant requirements of the Contract;
3. The Dental Contractor's quality assurance and performance improvement (QAPI) program and the Provider's role in such a program;
4. The Dental Contractor's policies and procedures regarding referrals by Main Dentists, especially regarding Network and OON referrals;
5. Member cost-sharing obligations, for CHIP members only, limitations on Medically Necessary Covered Dental Services, VAS, and prohibitions on balance-billing Dental Members for Medically Necessary Covered Dental Services;
6. Cultural Competency training based on federal and state requirements;
7. Texas Health Steps (THSteps) dental benefits and the necessity of documentation of services qualifying for reimbursement;
8. NEMT Services available to Dental Members and how Members may request NEMT Services to access Medically Necessary Covered Dental Services;
9. The importance of updating contact information to ensure accurate Provider directories and the online Provider lookup;
10. Information about the Dental Contractor's process for acceleration of THSteps dental services for Farmworker Child(ren) enrolled in Medicaid;
11. Missed appointment referrals and assistance provided by the Texas Health Steps Outreach and Informing Unit for Medicaid members;

12. HHSC policies related to Dental Contractor retaliation against providers;
13. Dental Contractor and HHSC Complaint and Appeal processes;
14. Claims processing and policies specific to the Dental Contractor including:
    a. Claims procedures as described in **Chapter 2 of the UMCM**;
    b. Recoupments; and
    c. Dental Member rights and responsibilities, primary coverage requirements and under what circumstances a Dental Member may be responsible for some fees; and
15. Education about responsibility to report FWA, including how and where to make reports.
16. For general and pediatric dentists, First Dental Home certification requirements, including the training and application processes.

When developing Provider training materials, the Dental Contractor must consult with major stakeholders, such as trade associations and provider groups.

2.3.14 PROVIDER HOTLINE

The Dental Contractor must operate a toll-free telephone line for Provider inquiries during normal business hours which are, for the purposes of this section, from 8 a.m. to 5 p.m. local time throughout the state, Monday through Friday, excluding State-approved holidays. The State-approved holiday schedule is updated annually and can be found on the Texas State Auditor's Office website under Holiday Schedule. The Provider hotline must be staffed with personnel who are knowledgeable about the Dental Program, Medically Necessary Covered Dental Services, and Non-capitated Services.

The Dental Contractor must ensure that, during non-business hours, the Provider hotline is answered by an automated system with the capability to provide callers with operating hours information and instructions on how to verify enrollment for a Dental Member with an urgent condition.

The Dental Contractor must ensure the Provider hotline has an automated response option in which the dental Providers may enter a child's unique Dental Member ID number and receive the following information:

1. Verification of a child's membership in Medicaid or CHIP;
2. The child's eligibility for the current month; and
3. The status of a child's dental benefit, and if the child is in CHIP, any amounts drawn against HHSC's specified annual CHIP benefit cap.

This information must also be available through a fax-back capability.

The Dental Contractor must ensure the Provider hotline staff has the ability to:

1. Search for enrollment information by a variety of fields;
2. Confirm the year-to-date status of a child's CHIP dental benefit, including any amounts that have been drawn against the dental benefit cap;

3. Accurately answer questions about the dental claims process and confirm the status of a pending claim; and
4. Accurately answer questions about enrollment as a dental Provider and facilitate the enrollment process.

The Dental Contractor must ensure that the Provider hotline meets each of the following minimum performance requirements:

1. No more than 7 percent of the calls are abandoned; and
2. No more than 2 minutes average hold time.

The Dental Contractor must conduct ongoing call quality assurance to ensure these standards are met. The Provider hotline may serve multiple Programs if the hotline staff is knowledgeable about each Program. The Dental Contractor may include the Dental Program in its existing Member Services hotline, if the hotline staff is knowledgeable about the Dental Program, as well as, the Dental Contractor's other contracted dental services.

The Dental Contractor must monitor its performance regarding Provider hotline standards and submit performance reports summarizing call center performance for the hotline as indicated in **Chapter 5 of the UMCM**. If the Dental Contractor's hotline serves multiple managed care programs, the Dental Contractor must have the capability to report call center performance for each program, including reporting the Medicaid and CHIP call center performance separately.

If HHSC determines that it is necessary to conduct onsite monitoring of the Dental Contractor's hotline functions, the Dental Contractor must reimburse HHSC for all travel costs incurred by HHSC relating to such monitoring. For purposes of this section, "travel costs" may include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC in connection with the onsite monitoring. Reimbursement by the Dental Contractor will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the Dental Contractor. The Dental Contractor must not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

2.3.15 PROVIDER REIMBURSEMENT

The Dental Contractor must pay for all Medically Necessary Covered Dental Services provided to Dental Members. The Provider Contract must include a complete description of the payment methodology or amount, as described in **Chapter 8 of the UMCM**. The Dental Contractor must define in its Provider Contract if it is using the Texas Medicaid Fee Schedule or another source for reimbursement purposes.

The Provider Contracts must require Providers to comply with the requirements of Tex. Gov't Code § 531.024161, regarding reimbursement of claims based on orders or referrals by supervising providers.

The Dental Contractor must ensure claims payment is timely and accurate as described in **Section 2.3.29.4** and **Chapter 2 of the UMCM**. The Dental Contractor must require tax

identification numbers from all participating providers. The Dental Contractor is required to do back-up withholding from all payments to Providers who fail to give tax identification numbers or who give incorrect numbers.

Provider payments must comply with all applicable state and federal laws, rules, and regulations, including the following sections of the Patient Protection and Affordable Care Act:

1. 42 U.S.C. § 1396a(a)(80), "Prohibition on Payments to Institutions or Entities Located Outside of the United States"; and
2. 42 U.S.C. § 1396b-1, "Payment Adjustment for Health Care-Acquired Conditions."

The Dental Contractor must comply with registration requirements in Tex. Ins. Code § 1458.051 and with reimbursement and fee schedule requirements in Tex. Ins. Code §§ 1451.451 and 1458.101–102.

As required by Tex. Gov't Code § 533.005(a)(25), the Dental Contractor must not implement significant, non-negotiated, across-the-board Provider reimbursement rate reductions unless:

1. It receives HHSC's prior approval; or
2. The reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by HHSC.

For purposes of this requirement, an across-the-board rate reduction is a reduction that applies to all similarly-situated providers or types of providers. The Dental Contractor must submit a written request for an across-the-board rate reduction to the State Medicaid Director and provide a copy to HHSC Managed Care Compliance & Operations division, if the reduction is not based on a change in the Medicaid fee schedule or cost containment initiative implemented by HHSC.

The Dental Contractor must submit the request at least 90 Days prior to the planned effective date of the reduction. If HHSC does not issue a written statement of disapproval within 45 Days of receipt, then the Dental Contractor may move forward with the reduction on the planned effective date. Further, the Dental Contractor must give Providers at least 30 Days' written notice of changes to the Dental Contractor's fee schedule, excluding changes derived from changes to the Medicaid fee schedule, before implementing the change. If the Dental Contractor fee schedule is derived from the Medicaid fee schedule, the Dental Contractor must implement fee schedule changes no later than 30 Days after the Medicaid fee schedule change, and any retroactive claim adjustments must be completed within 60 Days after HHSC retroactively adjusts the Medicaid fee schedule.

2.3.15.1 PROVIDER PREVENTABLE CONDITIONS

"Provider-preventable condition" has the same meaning as "provider-preventable condition" provided in 42 C.F.R. 447.26 and includes the following events: the wrong surgical or other invasive procedure performed on a Dental Member; surgical or other invasive procedure performed on the wrong tooth; or surgical or other invasive procedure

performed on the wrong patient. For purposes of this term, most dental procedures, other than preventative procedures, will be considered "invasive."

The Dental Contractor must not pay for Provider-preventable conditions. The Dental Contractor must ensure its Provider Contracts contain language requiring Providers to report to the Dental Contractor the following events: the wrong surgical or other invasive procedure performed on a Dental Member; surgical or other invasive procedure performed on the wrong tooth; or surgical or other invasive procedure performed on the wrong patient. The Dental Contractor must also submit quarterly reports of Provider-preventable conditions to the HHSC health plan monitoring team and the HHSC Dental Director.

This section is effective September 1, 2020.

2.3.15.2 PROVIDER OVERPAYMENTS

The Dental Contractor must have a mechanism in place through which Providers report overpayments. The Dental Contractor must inform Providers of this mechanism. The mechanism must allow Providers to include a reason for the overpayment. The Dental Contractor must ensure that the Provider submit overpayments within 60 Days from identification. For purposes of this section, "identification" refers to when the person has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment.

2.3.16 TERMINATION OF DENTAL CONTRACTOR PROVIDER CONTRACTS

The Dental Contractor must notify HHSC five Days prior to Dental Contractor termination of the following Dental Contractor Provider Contracts:

1. A Main Dentist contract that impacts more than one percent of its Members; or
2. Any Provider contract that impacts more than five percent of its Network for a provider type by Dental Reporting Region and Dental Contractor program.

Additionally, the Dental Contractor must give written notice of termination of a Provider to each Dental Member who receives his or her primary dental care, or who is seen on a regular basis by, the Provider as follows:

1. For a Provider disenrolled from Medicaid by HHSC, the Dental Contractor must provide notice to affected Dental Members within five Days following disenrollment;
2. For involuntary terminations of a Provider (terminations initiated by the Dental Contractor), the Dental Contractor must provide notice to the Dental Member of the termination of the Provider once the Dental Contractor has made a final decision to terminate the Provider, but in no event later than 15 Days after the Dental Contractor issues notice of termination to the Provider;

3. For voluntary terminations of a Provider (terminations initiated by the Provider), the Dental Contractor, to the extent practicable, must provide notice to the Dental Member of the termination of the Provider, but in no event less than at least 30 Days before the effective date of the termination.

In the event that the Provider sends untimely notice of termination to the Dental Contractor making it impossible for the Dental Contractor to send Dental Members notice within the required timeframe, the Dental Contractor must provide notice as soon as practical, but no more than 15 Days after the Dental Contractor receives notification to terminate from the Provider.

The Dental Contractor must send notice of termination of a Provider to:

1. All Dental Members in a Main Dentist's panel; and
2. All Dental Members who have had one visit within the past three months, or two or more visits with the Provider in the past 12 months.

2.3.17 OUT-OF-STATE PROVIDERS

The Dental Contractor may enroll out-of-state providers in its Network, in accordance with 1 Tex. Admin. Code § 352.17. To participate in Medicaid, the provider must be enrolled with HHSC as a Medicaid provider. The Dental Contractor may enroll out-of-state diagnostic laboratories in its Medicaid and CHIP Networks under the circumstances described in Texas Government Code § 531.066.

2.3.18 PROVIDER ADVISORY GROUPS

The Dental Contractor must establish and conduct quarterly meetings with Providers. The Dental Contractor must maintain a record of provider advisory group meetings, including agendas and minutes, for the time period established in **Section 9.01 of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**.

2.3.19 PROVIDER PROTECTION PLAN

In accordance with the requirements of Tex. Gov't Code § 533.0055, the requirements of HHSC's provider protection plan are listed below, and the Dental Contractor must comply with the following:

1. Provide responses to authorization requests within three Business Days of routine requests;
2. Provide for timely and accurate claims adjudication and proper claims payment in accordance with **Chapter 2 of the UMCM**;
3. Include Provider training and education on the requirements for claims submission and appeals, including the Dental Contractor's policies and procedures. See also **Section 2.3.13**;
4. Ensure Member access to care, in accordance with **Section 2.3.8**;
5. Ensure prompt credentialing, as required by **Section 2.3.12**;

6. Ensure compliance with state and federal standards regarding PAs, as described in **Sections 2.3.24** and **Section 2.3.25**;
7. Provide 30 Days notice to Providers before implementing changes to policies and procedures affecting the PA process. However, in the case of suspected FWA by a single Provider, the Dental Contractor may implement changes to policies and procedures affecting the PA process without the required notice period;
8. Include other measures developed by HHSC or a provider protection plan workgroup, or measures developed by the Dental Contractor and approved by HHSC; and
9. The Dental Contractor must participate in HHSC's provider protection plan work group, which will develop recommendations and proposed timelines for other components of the provider protection plan.

2.3.20 MEMBER SERVICES

The Dental Contractor must maintain a Member services department with a sufficient number of staff to assist Dental Members and Dental Members' family members, guardians, or LAR in obtaining Medically Necessary Covered Dental Services for Dental Members including meeting Member services hotline requirements and Linguistic Access capabilities. The Dental Contractor must maintain employment standards and requirements for Member services department staff.

2.3.20.3 MEMBER MATERIALS

The Dental Contractor must design, print, and distribute Dental Member identification (ID) cards and a Dental Member handbook to Dental Members. Within five Business Days following the receipt of an Enrollment File from the EB, the Dental Contractor must mail a Dental Member ID card and a Dental Member handbook to the Case Head or Account Name for each new Dental Member. When the Case Head or Account Name is associated with two or more new Dental Members, the Dental Contractor is only required to send one Dental Member handbook. The Dental Contractor is responsible for mailing materials only to those Dental Members for whom valid address data are contained in the Enrollment File.

All Member Materials must be at or below a 6th grade reading level as measured by the appropriate score on the Flesch-Kincaid Readability Test. Member Materials must be written and distributed in English, Spanish, and Prevalent Languages identified by HHSC. HHSC will provide the Dental Contractor with reasonable notice when a non-English language is spoken by ten percent of the managed care eligible population. All Member Materials must be available in a format accessible to the visually impaired, which may include large print, Braille, compact disc, or other electronic format. Member Materials must comply with the requirements set forth in the **UMCM**, including required critical elements and marketing policies and procedures.

Written materials must also be made available in alternative formats upon request of the Dental Member at no cost. Written materials must include taglines in the Prevalent Languages in the Dental Reporting Region, as well as large print, explaining the

availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone numbers of the Dental Contractor's Member service unit. Large print means printed in a font size no smaller than 18 point. All written materials for Dental Members and potential members must use a font size no smaller than 12 point. All written materials for potential members and Dental Members must also include a large print tagline and information on how to request Auxiliary Aids and Services, including the provision of materials in alternative formats. Auxiliary Aids and Services must be made available upon request of the Dental Member at no cost.

The Dental Contractor's Member Materials and other communications cannot contain discretionary clauses, as described in Section 1271.057(b) of the Texas Insurance Code.

The Dental Contractor must submit Member Materials to HHSC for approval prior to publication or distribution, including revisions to previously approved Member Materials. If HHSC has not responded to the Dental Contractor's request for review within 15 Business Days, the Dental Contractor may use the submitted materials provided the Dental Contractor first notifies HHSC of its intended use. HHSC may, at any time, require discontinuation, revision, or correction of any Member Materials, including those previously approved by HHSC.

2.3.20.4 MEMBER IDENTIFICATION CARDS

All Dental Member ID cards must include all the critical elements identified in **Chapter 3 of the UMCM**. The Dental Contractor must reissue the Dental Member ID card within seven Days at no charge for any reason that results in a change to the information disclosed on the Dental Member ID card.

2.3.20.5 MEMBER HANDBOOK

The Member handbook must meet the Member Materials requirements specified by **Section 2.3.20.3** above and must include critical elements in **Chapter 3 of the UMCM**.

The Dental Contractor must produce and distribute a revised Dental Member handbook, or an insert informing Dental Members of changes to Medically Necessary Covered Dental Services upon HHSC notification and at least 30 Days prior to the effective date of such change in Medically Necessary Covered Dental Services. In addition to modifying the Member Materials for new Dental Members, the Dental Contractor must notify all existing Dental Members of changes to the Medically Necessary Covered Dental Services. If HHSC notifies the Dental Contractor that the change in Covered Services is significant, the Dental Contractor must notify existing Members through a written notice, such as a mailed letter or electronic mail, within the same timeframe or within a timeframe approved by HHSC. If multiple members reside within a single household, the Dental Contractor shall send only one written notice pursuant to this section. If HHSC notifies the Dental Contractor that the change in Medically Necessary Covered Dental Services is not significant, the Dental Contractor must notify existing Dental Members through any method of communication within the same timeframe or within a timeframe approved by HHSC.

2.3.20.6 PROVIDER DIRECTORY

The Dental Contractor must have a process in place to compare the information in the master provider file provided by the HHSC Administrative Services Contractor with the Dental Contractor's Provider directory. When the Dental Contractors identifies a discrepancy, the Dental Contractor must assist the Provider through the process of updating inaccurate information with the HHSC Administrative Services Contractor. Dental Contractors must contact Providers monthly until the information on the master provider file reflects the Dental Contractor Provider Verification survey in Section **2.3.8.5** or other data sources provided to the Dental Contractors by HHSC or identified by the Dental Contractor. The Dental Contractor must include in its Provider Contract that the Provider will update its information with the HHSC Administrative Services Contractor in a timely fashion or immediately upon request by the Dental Contractor.

The Dental Contractor must develop separate Provider Directories for the Medicaid and CHIP Programs. Provider Directories must be available in hard copy, and the directories must be submitted to the HHSC Administrative Services Contractor. The Provider Directory for each Dental Contractor Program, including substantive revisions, must be approved by HHSC before publication and distribution. Substantive revisions are revisions to the information required by **Chapter 3 of the UMCM** (with the exception of information contained in actual the Provider listings and indices) and any additional information that the Dental Contractor adds to the directory at its discretion.

For each Program, HHSC may divide the State into more than one area for the purpose of publishing the Provider Directories. HHSC will establish weight limits for the Provider Directories, which may vary by area. HHSC will require Dental Contractors that exceed the weight limits to compensate HHSC for postage fees in excess of the weight limits.

As described in Section 7, "Transition Phase Requirements," during the Readiness Review, the Dental Contractor must develop and submit to HHSC the draft Provider Directory templates for approval and must submit the final Provider Directories incorporating changes required by HHSC prior to the Operational Start Date. Such draft and final Provider Directories must be submitted according to the Readiness Review deadlines established by HHSC.

The Provider Directory must comply with HHSC's marketing policies and procedures, as set forth in Chapter **4 of the UMCM**.

The Provider Directories for each Program must, at a minimum, meet the Member Materials requirements specified by Section **2.3.20.1** above and must include the required elements identified in **Chapter 3 of the UMCM**. The Provider Directory must include only Network Providers credentialed by the Dental Contractor in accordance with Section **2.3.23.2.5**, "Provider Credentialing and Re-credentialing." If the Dental Contractor contracts with limited Provider Networks, the Provider Directory must comply with the

requirements of 28 Tex. Admin. Code §11.1600(b)(11), relating to the disclosure and notice of limited Provider Networks.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3, requires the State to submit oral health provider data on a quarterly basis to the CMS' contractor, currently the Health Resources and Services Administration (HRSA). HRSA uploads the data to the Insure Kids Now (IKN) website and persons enrolled in Medicaid and CHIP may access this information using a provider lookup tool. The intent of this CHIPRA provision is to provide persons enrolled in Medicaid and CHIP access to oral health provider information across the nation. To align with the intent of this oral health provision in CHIPRA, the Dental Contractor must provide HHSC with an electronic version of an updated Provider Directory on a quarterly basis and to Members upon request.

2.3.20.6.1 HARD COPY PROVIDER DIRECTORY

The hard copy Provider directory must contain the required information included in **Chapter 3 of the UMCM**.

The Dental Contractor must update hardbound copies of the Provider Directory in accordance with 42 C.F.R. § 438.10 or as directed by HHSC. The Dental Contractor must make such updates available to existing Members upon request.

The Dental Contractor must develop separate Provider Directories for Medicaid and CHIP. The Dental Contractor must send the most recent Provider directory, including any updates, to Dental Members upon request in accordance with Texas Gov't Code § 533.0063. The Dental Contractor must, at least annually, offer the Provider Directory to Dental Members in writing or by verbal offer through its Dental Member outreach efforts and education materials.

2.3.20.6.2 ONLINE PROVIDER DIRECTORY

The Dental Contractor must have an online Provider directory to provide an electronic Provider look-up search of its Provider Network. The Dental Contractor must have procedures for systematically updating the Provider Network database that must include predictable scheduled algorithms. The online Provider directory must be updated at least on a weekly basis to reflect its most current Network.

The online Provider directory must contain the required information included in **Chapter 3 of the UMCM**.

The Dental Contractor must maintain a mobile optimized site for the online Provider directory that meets the requirements pertaining to the Dental Contractor's website as described in **Section 2.3.21**. The site must minimize download and wait time and must not use tools or techniques that require significant memory, disk resources, or special intervention. HHSC, where cost effective to HHSC and less burdensome to the Dental Members, requires the development of mobile device applications in addition to the use of

tools that take advantage of efficient data access methods, reduce server load, and consume less bandwidth.

Upon request, the Dental Contractor must send Dental Members, via email, an electronic version of the Provider directory for the mailing region in which they reside. The Dental Contractor must inform Dental Members that the Provider directory is available in paper form, without charge, upon the Dental Member's request, and provide it within five Business Days of the request. **Exhibit "M"** to **ATTACHMENT E, HHSC SOLICITATION NO. HHS0002879, Dental Reporting Regions Map**, contains the map detailing the mailing regions referenced above.

2.3.20.7 MEMBER SERVICES HOTLINE

The Dental Contractor must operate a toll-free hotline that Dental Members can call 24 hours a day, seven days a week (Member services hotline). The Member services hotline must be staffed with personnel designated solely to the Texas Dental Program. This staff must be properly trained, competent, and knowledgeable about the Dental Program and Medically Necessary Covered Dental Services including Non-capitated Services.

The Member services hotline must have staff available during normal business hours, which for the purposes of this section are Business Days between the hours of 8:00 a.m. to 5:00 p.m. local time excluding State-approved holidays.

The Dental Contractor must ensure that during non-business hours, the Member services hotline is answered by an automated system with the capability to provide callers with operating hours and instructions on what to do in case of emergency. All recordings must be in English, Spanish, and other Prevalent Languages. A voice mailbox must be available during non-business hours for callers to leave messages. The Dental Contractor's Member services hotline staff must return Dental Members' calls received by the automated system on the next working day during normal business hours. If the Member services hotline does not have a voice-activated menu system, the Dental Contractor must have a menu system that will accommodate Dental Members who cannot access the system through other physical means.

The Dental Contractor must ensure that its Member services hotline staff treat all callers with dignity and respect the callers' need for privacy. All of the Dental Contractor's Member services hotline staff must be:

1. Able to answer non-clinical questions pertaining to the role of the Main Dental Home, such as referrals or the process for receiving authorization for procedures or services;
2. Able to give information about Providers in a particular area;
3. Knowledgeable about FWA and the requirements to report any conduct that if substantiated may constitute FWA in the Dental Program;
4. Trained regarding the federal and state Cultural Competency standards;
5. Trained to assist a Dental Member or a Dental Member's authorized representative, guardian, or LAR with scheduling an appointment with a Provider during the Provider's hours of operation and within the Dental Member's availability, in

accordance with **Section 2.3.8.2**. Member services hotline staff must offer Dental Members the opportunity to participate in a facilitated three-way call between the Member or the Member's authorized representative, guardian, or LAR and a Provider's office to schedule an appointment. If a Dental Member does not want to participate in a three-way call, the Dental Contractor must document refusal and offer a list of Providers;

6. Knowledgeable about the Dental Program and Medically Necessary Covered Dental Services limitations, including limitations on procedures and annual CHIP benefit cap, and any VAS and oral health education initiatives as described in **Section 2.3.20.8** offered by the Dental Contractor;
7. For CHIP Members, be able to confirm the year-to-date status of the member's dental benefit, including any amounts that have been drawn against the annual benefit cap for a specific member, and be able to give correct cost-sharing information relating to premiums, co-pays, or deductibles, as applicable; See **Chapter 6 of the UMCM**.
8. Able to answer non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services; and
9. Able to answer non-clinical questions pertaining to accessing Non-capitated Services.

Hotline services must meet Cultural Competency requirements and must appropriately handle calls from callers who speak Prevalent Languages, including Spanish, as well as calls from individuals who are deaf or hard-of-hearing. To meet these requirements, the Dental Contractor must employ bilingual Spanish-speaking Member services representatives and must secure the services of other contractors as necessary. The Dental Contractor must provide such oral interpretation services to all hotline callers free of charge.

The Dental Contractor must process all incoming Dental Member telephone inquiries in a timely and responsive manner. The Dental Contractor must not impose maximum call duration limits and must allow calls to be of sufficient length to ensure adequate information is provided to the Dental Member. The Dental Contractor must ensure that the hotline meets the following minimum performance requirements for the Dental Program:

1. At least 80 percent of toll-free line calls must be answered within 30 seconds measured from the time the call is placed in queue after selecting an option.
2. No more than 7 percent of the calls are abandoned; and
3. No more than 2 minutes average hold time.

The Dental Contractor must conduct ongoing quality assurance monitoring to ensure these standards are met. The Dental Contractor may include the Dental Program in its existing Member services hotline, if the hotline staff is knowledgeable about the Dental Program, as well as the Dental Contractor's other contracted dental services.

The Dental Contractor must submit performance reports summarizing its call center performance for its Member services hotline as indicated in **Chapter 5 of the UMCM**. If

the Dental Contractor's Hotline serves multiple managed care programs, the Dental Contractor must have the capability to report call center performance by program, as well as reporting Medicaid and CHIP call center performance separately.

If HHSC determines that it is necessary to conduct onsite monitoring of the Dental Contractor's hotline functions, the Dental Contractor must reimburse HHSC for all travel costs incurred by HHSC relating to such monitoring. For purposes of this section, "travel costs" may include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC in connection with the onsite monitoring. Reimbursement by the Dental Contractor will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the Dental Contractor. The Dental Contractor may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

2.3.20.8 MEMBER EDUCATION

The Dental Contractor must develop and implement health education initiatives that educate Dental Members, their authorized representative, LAR, or guardian, as appropriate, about:

1. How the Dental Program operates, including the role of the Main Dental Home;
2. Medically Necessary Covered Dental Services, CHIP member cost-sharing obligations and limitations, and any VAS offered by the Dental Contractor;
3. The value of dental exams and preventive care; and
4. How to obtain Medically Necessary Covered Dental Services.

The Dental Contractor must provide a range of oral health promotion and wellness information and activities for Dental Members in formats that meet the needs of all Dental Members. The Dental Contractor must propose, implement, and assess innovative Dental Member education strategies for wellness care, as well as general health promotion and prevention. The Dental Contractor must conduct wellness promotion programs to improve the oral health status of its Dental Members. The Dental Contractor may cooperatively conduct oral health education classes for all enrolled Dental Members with one or more Dental Contractors also contracting with HHSC. The Dental Contractor must work with its Providers to integrate health education, wellness, and prevention training into the care of each Dental Member.

In accordance with Tex. Health & Safety Code § 48.052(c), Dental Contractor may employ or contract with certified Community Health Workers or "promotors" to conduct outreach and Dental Member education activities.

2.3.20.9 CULTURAL COMPETENCY PLAN

The Dental Contractor must have a comprehensive written Cultural Competency plan ("CC plan") describing how the Dental Contractor will ensure culturally competent services and provide Linguistic Access and Disability-related Access. The CC plan must be developed

in adherence to the federal and state Cultural Competency standards. The CC plan must adhere to the following:

1. Title VI of the Civil Rights Act guidelines and the provision of Auxiliary Aids and Services, in compliance with the Americans with Disabilities Act;
2. Title III, Department of Justice Regulation 28 C.F.R. § 36.303, 42 C.F.R. § 438.206 (c)(2); and
3. 1 Tex. Admin. Code § 353.411.
4. **Chapter 16 of the UMCM**

The CC plan must describe how the individuals and systems within the Dental Contractor's organization will effectively provide services to Dental Members, caregivers, and Providers of all cultures, races, ethnic backgrounds, languages, communications needs, disabilities, and religions, as well as those with disabilities, in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each. Additionally, it must describe how the Dental Contractor will implement each component of the federal and state standards.

During the Operations Phase, the Dental Contractor must submit modifications and amendments to its CC plan to HHSC no later than 30 Days prior to implementation. Its CC plan must also be made available to the Dental Contractor's Providers. HHSC may require the Dental Contractor to update its CC plan to incorporate new or amended requirements based on HHSC guidance. In that event, the Dental Contractor has 60 Days to submit its updated CC plan to HHSC.

2.3.20.10 COMPETENT INTERPRETER SERVICES

The Dental Contractor must arrange and pay for Competent Interpreter services, including written, spoken, and sign language interpretation, for Dental Members to ensure effective communication regarding treatment, medical and dental history, or health condition. The Dental Contractor must maintain policies and procedures outlining the manner in which Dental Members and their Providers can access Competent Interpreter services including written, spoken, and sign language interpretation, when the Dental Member is in his or her Provider's office.

2.3.20.11 MEMBER SERVICE EMAIL ADDRESS

The Dental Contractor must have a secure email address through which a Dental Member may contact the Dental Contractor to receive assistance with identifying Providers and scheduling an appointment for the Dental Member or accessing services. The Dental Contractor must, within one Business Day, acknowledge the Dental Member's request with an email response informing the Dental Member that by communicating via email the Dental Member consents to receive information through the same means. Member services staff must provide the Dental Member the requested information within three Business Days following the receipt of the email.

2.3.20.12 MEMBER ELIGIBILITY

The Dental Contractor must, if possible, provide eligibility renewal assistance as allowed by federal law and CMS policy guidance for Members whose eligibility is about to expire.

2.3.21 DENTAL CONTRACTOR WEBSITE

The Dental Contractor must develop and maintain, consistent with HHSC standards, Tex. Ins. Code § 843.2015, and all other applicable state laws, a website to provide general information about:

1. The Dental Contractor's Dental Program;
2. The Dental Contractor's Network, including an online Provider directory as outlined in **Chapter 3 of the UMCM**;
3. The Dental Contractor's Member and Provider services hotline numbers; and
4. The Dental Contractor's Complaints and Appeals process.

The Dental Contractor's website must meet the requirements of **Chapter 3 of the UMCM** and comply with state and federal accessibility standards, guidelines, policies, and procedures for all work products, including, but not limited to, 29 U.S.C. § 794; 1 Tex. Admin. Code. Chapter 206, Subchapter B; 1 Tex. Admin. Code. Chapter 213, Subchapter B; and Texas Health and Human Services Electronic and Information Resources Accessibility Standards.

The website must contain a link to financial literacy information on the Office of Consumer Credit Commissioner's webpage. The Dental Contractor must also maintain a mobile optimized site for mobile device use. The Dental Contractor may develop a page within its existing website to meet the requirements of this section.

The Dental Contractor must minimize download and wait time and not use tools or techniques that require significant memory, disk resources, or special user interventions. HHSC may require discontinuation, revision, or correction of any Member Materials posted on the Dental Contractor's website, including those previously approved by HHSC.

2.3.21.3 MEMBER PORTAL

The Dental Contractor must provide a Dental Member portal ("DM portal") that supports functionality to provide administrative functions and available health information to Dental Members. For the purposes of the Contract, a DM portal must bring information, which a Dental Member is entitled to access, together from diverse sources in a uniform way. The Dental Contractor may require Dental Members to affirmatively opt-in to participate in its DM portal. The Dental Contractor must provide Dental Members who opt-in with unique log-in credentials. The Dental Contractor must ensure that its DM portal is mobile compatible and has download and printing capabilities. The DM portal's functionality must include the following requirements:

1. **Administrative Functions -** Dental Members must be able to:
    a. Verify eligibility;
    b. View Dental Member demographic information;
    c. Change his or her Main Dentist; and
    d. Request and print Dental Member ID cards.
2. **Health Information -** Dental Members must be able to view:
    a. His or her history and assessment;
    b. Referral history;
    c. PA requests, approvals, and denials
    d. Copies of any Notices of Action sent to the Dental Member in the last 12 months; and
    e. A dental health summary including dentist visits.

In addition, the Dental Contractor must provide HHSC secure access rights as an authorized or guest user to all Dental Member access points, including but not limited to, its DM portal and call monitoring system, for remote monitoring capability.

2.3.21.4 PROVIDER PORTAL

The Dental Contractor must provide a Provider portal that supports functionality to reduce administrative burden on Providers at no cost to the Providers as described in **Chapter 3 of the UMCM**.

The Provider portal should support both online and Batch Processing as applicable to the information being exchanged. To facilitate the exchange of clinical data and other relevant documentation, the Provider portal must provide a secure exchange of information between the Provider and Dental Contractor, including, as applicable, a Subcontractor of the Dental Contractor.

2.3.22 MARKETING AND PROHIBITED PRACTICES

The Dental Contractor and its Subcontractors must comply with all applicable federal and state laws and regulations regarding marketing, gifts, and other inducements. The Dental Contractor and its Subcontractors must adhere to the Marketing policies and procedures as set forth in the Contract, including **Chapter 4 of the UMCM**. HHSC must approve all Marketing Materials before use or distribution. All Marketing Materials must comply with all state and federal marketing requirements, including State insurance laws and TDI regulations regarding marketing.

2.3.23 QUALITY IMPROVEMENT AND PERFORMANCE EVALUATION

The Dental Contractor must provide for the delivery of quality care with the primary goal of improving the dental health status of Dental Members. The Dental Contractor must work in collaboration with Providers to actively improve the quality of care provided to Dental Members, consistent with the Quality Improvement goals, and all other requirements of

the Contract. The Dental Contractor must provide mechanisms for Dental Members and Providers to offer input into the Dental Contractor's Quality Improvement activities.

2.3.23.1 PERFORMANCE MEASURES

The Dental Contractor must provide to HHSC all information necessary to analyze the Dental Contractor's provision of quality care to Dental Members using measures to be determined by HHSC.

2.3.23.2 QUALITY ASSURANCE AND PERFORMANCE MANAGEMENT

This section provides quality assurance and performance requirements of the Dental Contractor.

2.3.23.2.1 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM OVERVIEW

The Dental Contractor must develop, maintain, and operate a quality assurance and performance improvement (QAPI) program consistent with the Contract and TDI requirements, including 28 Tex. Admin. Code §§ 11.1901 and 11.1902. The Dental Contractor must also meet the requirements of 42 C.F.R. § 438.330.

The Dental Contractor must have on file with HHSC an approved plan describing its QAPI program, including how the Dental Contractor will accomplish the activities required by this section. The Dental Contractor must annually submit a QAPI program Annual Summary in a format and timeframe specified by HHSC. The Dental Contractor must keep participating Providers and other providers informed about the QAPI program and related activities. The Dental Contractor must include a requirement securing cooperation with the QAPI in its Provider Contracts.

The Dental Contractor must be accredited by URAC, as required by Tex. Gov't Code § 533.0031. The Dental Contractor must provide HHSC and its EQRO a copy of its most recent accreditation review in accordance with 42 C.F.R. § 438.332. HHSC may use information from an accreditation organization in its oversight processes.

The Dental Contractor must approach all clinical and non-clinical aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement /Total Quality Management and must:

1. Evaluate Provider's performance using objective quality indicators;
2. Foster data-driven decision-making;
3. Solicit Dental Member and Provider input on performance and QAPI activities;
4. Support continuous ongoing measurement of clinical and non-clinical effectiveness and Dental Member satisfaction;
5. Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and

6. Support re-measurement of effectiveness and Dental Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

2.3.23.2.2 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM STRUCTURE

The Dental Contractor must maintain a well-defined QAPI structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. The Dental Contractor must designate a senior executive responsible for the QAPI program, and the Dental Director must have substantial involvement in QAPI program activities. The Dental Contractor must ensure that the QAPI program structure:

1. Is organization-wide, with clear lines of accountability within the organization;
2. Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including dentists, other clinicians, and non-clinicians;
3. Includes annual objectives or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and
4. Evaluates the effectiveness of clinical and non-clinical initiatives.

2.3.23.2.3 CLINICAL INDICATORS

The Dental Contractor must collect clinical indicator data. The Dental Contractor must use such clinical indicator data in the development, assessment, and modification of its QAPI program.

2.3.23.2.4 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM SUBCONTRACTING

If the Dental Contractor subcontracts any of the essential functions or reporting requirements contained within the QAPI program to another entity, the Dental Contractor must maintain detailed files documenting the work of the Subcontractors. The file must be available for review by HHSC upon request.

2.3.23.2.5 PROVIDER CREDENTIALING AND PROFILING

In accordance with **Section 2.3.12**, the Dental Contractor must review and approve the credentials of all participating licensed Providers in the Dental Contractor's Network. Through the QAPI process, the Dental Contractor must report annually to HHSC the results of any credentialing activities conducted during the reporting year. The Dental Contractor must use the QAPI form found in **Chapter 5 of the UMCM**.

The Dental Contractor must conduct Provider profiling activities at least annually. As part of its QAPI program, the Dental Contractor must describe the methodology it uses to

identify which and how many Providers to profile and to identify measures to use for profiling such Providers. Provider profiling activities must include, but not be limited to:

1. Developing Provider-specific reports that include a multi-dimensional assessment of a Provider's performance using clinical, administrative, and Dental Member satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population;
2. Establishing Provider, group, statewide, or regional Benchmarks for areas profiled, where applicable; and
3. Providing feedback to individual Providers regarding the results of his or her performance and the overall performance of the Network.

If the Dental Contractor wishes to move to a preferred Provider arrangement, the Dental Contractor must profile all Providers of the service for a period of no less than 12 months. The results of the Provider profiles must be used to determine the Provider or Providers selected for a preferred Provider arrangement. If the Dental Contractor enters into a preferred Provider arrangement for a service or supply, the Dental Contractor must notify Dental Members using that service or supply of the arrangement in writing and offer Dental Members the opportunity to opt out of using the preferred Provider and use another Provider. The Dental Contractor must provide clear written instructions on how a Dental Member may opt out of using the preferred Provider. The Dental Contractor's Preferred provider arrangements must be in accordance with requirements in the **UMCM**.

2.3.23.3 NETWORK MANAGEMENT

The Dental Contractor must:

1. Use the results of its Provider profiling activities to identify areas of improvement for individual Providers, or groups of Providers;
2. Establish Provider-specific quality improvement goals for priority areas in which a Provider or Providers do not meet established Dental Contractor standards or improvement goals;
3. Develop and implement incentives, which may include financial and non-financial incentives, to motivate Providers to improve performance on profiled measures; and
4. At least annually, measure and report to HHSC on the Network and individual Providers' progress, or lack of progress, towards such improvement goals.

2.3.23.4 PROVIDER INCENTIVE PLANS

If the Dental Contractor implements a Provider incentive plan under 42 C.F.R. § 438.6(h), the plan must comply with all applicable law, including 42 C.F.R. §§ 422.208 and 422.210. The Dental Contractor must not make payments under a Provider incentive plan if the payments are designed to induce Providers to reduce or limit Medically Necessary Covered Dental Services to Dental Members.

If the Provider incentive plan places a Provider or Provider group at a substantial financial risk for services not provided by the Provider or Provider group, the Dental Contractor must ensure adequate stop-loss protection and conduct and submit annual Dental Member surveys no later than five Business Days after the Dental Contractor finalizes the survey results. Refer to 42 C.F.R. § 422.208 for information concerning "substantial financial risk" and "stop-loss protection".

The Dental Contractor must make information regarding Provider incentive plans available to Dental Members upon request, in accordance with **UMCM** requirements. The Dental Contractor must provide the following information to the requesting Dental Member:

1. Whether the Dental Member's Provider or other Providers are participating in the Dental Contractor's Provider incentive plan;
2. Whether the Dental Contractor uses a Provider incentive plan that affects the use of referral services;
3. The type of incentive arrangement; and
4. Whether stop-loss protection is provided.

No later than five Business Days prior to implementing or modifying a Provider incentive plan, the Dental Contractor must provide the following information to HHSC:

1. Whether the Provider incentive plan covers services that are not furnished by a Provider or Provider group.

The Dental Contractor is only required to report on items 2-4 below if the Provider incentive plan covers services that are not furnished by a Provider or Provider group;

2. The type of incentive arrangement (e.g., withhold, bonus, capitation);
3. The percent of withhold or bonus, if applicable;
4. The panel size, and if Dental Members are pooled, the HHSC approved method used; and
5. If the Provider or Provider group is at substantial financial risk, the Dental Contractor must report proof that the Provider or group has adequate stop-loss protection, including the amount and type of stop-loss protection.

2.3.23.5 DENTAL CONTRACTOR ALTERNATIVE PAYMENT MODELS WITH PROVIDERS

HHSC requires the Dental Contractor to transition Provider payment methodologies from volume-based payment (VBP) approaches, i.e. Fee-for-Service, to value-based alternative payment models (APM), increasing year-over-year percentages of provider payments linked, to measures of quality or efficiency, or maintaining every year the percentage achieved the year before. The APMs should be designed to improve oral health outcomes for Dental Members, empower Dental Members and improve experience of care, lower healthcare cost trends and reward high-performing Providers.

The Dental Contractor must demonstrate satisfactory progress towards advancing APM initiatives within an APM performance framework. Dental Contractors will earn credit by meeting or making minimum progress on benchmarks in the APM performance framework

components listed below. Specifications and benchmarks of the APM performance framework are detailed in **Chapter 8 of the UMCM**.

APM Performance Framework Components:

1. **Achieve a minimum Overall APM Ratio and a Risk-Based APM Ratio**. The ratios are expressions of APM-based provider payments relative to total provider payments. The calculations and yearly benchmarks for the APM targets ratios, are delineated **Chapter 8 of the UMCM**.

2. Implement APMs that promote improvements in priority areas and quality measures specified by HHSC in Chapter 8 of the UMCM. Examples of HHSC priority areas include prevention and follow-up from emergency dental care treatment.

3. Implement processes to support and incentivize Providers. The Dental Contractor must engage and support Providers' efforts to implement value-based care models and reward high-performing Providers, as defined by the Dental Contractor. The Dental Contractor must:

a. Share data and performance reports with Providers on a regular basis and provide or make available the data Providers need to coordinate care in an APM. Dental Contractors must provide evidence of these reports and processes upon request by HHSC.

b. Dedicate enough resources for Provider outreach and negotiation, assistance with data or report interpretation, and other activities to support Provider's improvement.

c. To the extent possible Dental Contractors should collaborate on development of standardized formats for the Provider performance reports and data exchanged with Providers and align quality measures. Dental Contractors are encouraged to sponsor or support collaborative learning opportunities for Providers in a Service Area.

HHSC may request evidence of these reports and processes from the Dental Contractors

4. Submit to HHSC its inventories of APMs with Providers by August 1st of each year. The report will be completed using the data collection tool in **Chapter 8 of the UMCM**, Alternative Payment Models Data Collection Tool (DCT). The DCT will capture APM activity for the previous year and will be used to calculate the APM ratios and determine whether the Dental Contractor has achieved minimum progress on the components of the APM performance framework. Some requirements in the DCT will vary by program. Provider types include, but are not limited to, dentists and specialty dentists. Upon request by HHSC, the Dental Contractor must submit to HHSC underlying data for the information reported on the data collection tool (e.g., names of providers, NPIs, TPIs). HHSC will post on its website basic information from reported APMs.

5. Evaluate the impact of APMs on utilization, quality and cost, as well as return on investment (ROI).

a. The Dental Contractor must evaluate the impact of their APMs. Upon request, the Dental Contractor must report on methodologies used for APM evaluations along with results and findings related to the APM's impact on utilization, quality, costs, provider satisfaction, or ROI.

b. The Dental Contractors will report to HHSC, annually, the net financial impact to Providers of APMs, including the sum of incentive payments, shared savings, and payment reductions. The financial impact to Providers must be reported in the DCT for each APM and Medicaid program.

c. The Dental Contractor is encouraged to develop and continually update a strategic plan for advancing value-based care and APMs to advance quality and efficiency.

If the Dental Contractor DCT does not adhere to HHSC requirements or is not submitted by the required deadline, or if the Dental Contractor does not demonstrate minimum required progress within the APM performance framework, the Dental Contractor shall be required to submit a corrective action plan and may be subject to additional contractual remedies, including liquidated damages.

2.3.23.6 COLLABORATION WITH THE EXTERNAL QUALITY REVIEW ORGANIZATION

The Dental Contractor must collaborate with HHSC's External Quality Review Organization (EQRO) to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. The Dental Contractor must supply claims data to the EQRO, or another vendor identified by HHSC, in a format identified by HHSC in consultation with Dental Contractor. The Dental Contractor must supply the EQRO, or another vendor identified by HHSC, dental records for focused clinical reviews conducted by the EQRO, or another contractor. The Dental Contractor must work collaboratively with HHSC and the EQRO, or another vendor identified by HHSC to annually measure HHSC-selected Healthcare Effectiveness Data and Information Set (HEDIS) measures that require chart reviews. Dental Contractor must conduct chart reviews for HEDIS hybrid measures and submit results to the EQRO in a format and timeline specified by HHSC. Dental Contractor is responsible for all costs associated with these reviews.

The Dental Contractor must comply with any requests for data from the EQRO, including but not limited to, data required for these activities:

1. Performing dental record review;
2. Performing encounter data validation for data certification purposes; and
3. Calculating measure results using encounter and enrollment data.

2.3.23.7 PERFORMANCE IMPROVEMENT PROJECTS

Performance Improvement Projects (PIPs) must be designed, conducted, and reported in a methodologically sound manner in accordance with **Chapter 10 of the UMCM**. The Dental Contractor must complete the PIP templates in accordance with **Chapter 10 of the UMCM**. Each Dental Contractor must also complete progress reports as outlined in the **Chapter 10 of the UMCM**.

2.3.23.8 DENTAL CONTRACTOR QUALITY RATING SYSTEM

42 C.F.R. §§ 438.334 and 457.1240 and Tex. Gov't Code § 536.051 require HHSC to adopt an annual quality rating system for Dental Contractors. HHSC may prominently display the results on HHSC's website or a website maintained by HHSC's contractor. Additionally, HHSC may provide the results to Dental Members through other methods at HHSC's election.

If the Dental Contractor requests the recalculation or any other modifications to the quality measure data or member-level results, HHSC may charge the Dental Contractor any costs related to preparing this data for the Dental Contractor.

2.3.23.9 NON-PHARMACY PREFERRED PROVIDER ARRANGEMENT

A preferred provider arrangement is a contracted agreement between the Dental Contractor and one or more Providers. After the effective date of the agreement, services specified in the agreement will be delivered to Members by the Provider(s) in the preferred provider arrangement.

If a Dental Contractor enters into a preferred provider arrangement, the Dental Contractors must notify Members of the arrangement in writing at least 60 Days in advance of effective date of the arrangement. The Dental Contractor must also develop and implement a process whereby Members have the choice to opt out of using the preferred provider arrangement and use another Network Provider. The Dental Contractor must provide clear written instructions on how a Member may opt out of using the preferred provider arrangement. The Dental Contractor must manage its opt out process, including the receipt and review of all Member requests and may not delegate any process steps to its Providers. For preferred provider arrangements in effect prior to September 1, 2021. Dental Contractors must provide notification to impacted Members that gives clear written instructions on how the Member may opt out of using the preferred provider arrangement. Furthermore, the Dental Contractor may not change a Member's Provider without notifying the member of the change and giving clear written instructions on how the Member may opt out of using the Provider.

When implementing a preferred provider arrangement, the Dental Contractor must notify the Providers through its internet website, at minimum every time such an arrangement is implemented. The Dental Contractor must coordinate with other Network Providers of the Covered Service during the transition to ensure Continuity of Care.

The Dental Contractors must provide to HHSC health plan manager all the Member and provider notices pertaining to the new preferred provider arrangement at least 90 Days before initiating any such arrangement. The Dental Contractor must ensure notices comply with **Chapter 4 of the UMCM**.

To be counted as an APM, per Section 2.3.23.5, a preferred provider arrangement must be based on a provider's performance on metrics of quality or value and meet the requirements set forth in 2.3.23.5.

2.3.24 UTILIZATION MANAGEMENT

The Dental Contractor's Utilization Management (UM) program must be consistent with the Texas Dental Practice Act's requirements, Texas State Board of Dental Examiners rules, and national guidelines from the American Dental Association (ADA) and the AAPD.

The Dental Contractor must have a written UM program description, which includes:

1. Procedures to evaluate the need for Medically Necessary Covered Dental Services;
2. For CHIP members who have exhausted their annual benefit limits, a procedure to evaluate PA requests for additional services necessary to return the member to normal, pain and infection-free oral functioning (see **ATTACHMENT G, CHIP MEDICALLY NECESSARY COVERED DENTAL SERVICES**);
3. The clinical review criteria used, the information sources, and the process used to review and approve the provision of Medically Necessary Covered Dental Services;
4. The method for periodically reviewing and amending the UM clinical review criteria;
5. The staff position functionally responsible for the day-to-day management of the UM function; and
6. Evidence-based policies and procedures.

The Dental Contractor must make best efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating dentist as appropriate in making UM determinations.

The Dental Contractor must issue coverage determinations, including Adverse Determinations, within three Business Days after receipt of a request for authorization of services. For prior authorization requests received with insufficient or inadequate documentation, Dental Contractors must follow timeframes established by HHSC as set forth in **Chapter 3 of the UMCM**.

The Dental Contractor must have a process in place that allows a Provider to submit a prior authorization or service authorization request for services at least 60 Days prior to the expiration of the current authorization period. If practicable, the Dental Contractor must review the request and issue a determination prior to the expiration of the existing authorization. The Dental Contractor's process must consider if the request contains sufficient clinical information to justify reauthorization of services.

The Dental Contractor's UM program must include written policies and procedures to ensure each of the following:

1. Compliance with Tex. Ins. Code § 4201.456;
2. Consistent application of review criteria that are compatible with Dental Members' needs and situations;
3. Determinations to deny or limit services are made by Texas-licensed dentist under the direction of the Dental Director. Peer-to-peer consultation regarding UM determinations with a dentist of the same specialty must be available upon Provider's request;
4. Appropriate personnel are available to respond to UM inquiries 8:00 a.m. to 5:00 p.m., Monday through Friday, with a telephone system capable of accepting UM inquiries during non-business hours. The Dental Contractor must respond to calls within one Business Day;
5. Confidentiality of clinical information; and
6. Compensation to individuals or entities conducting UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Dental Services as required by 42 C.F.R. § 438.210(e), and quality of services provided is not adversely impacted by financial and reimbursement-related processes and decisions

For preauthorization or concurrent review programs, the Dental Contractor must ensure that a qualified Texas-licensed dentist supervise the preauthorization and concurrent review decisions.

The Dental Contractor UM program must include policies and procedures to:

1. Routinely assess the effectiveness and the efficiency of the UM program;
2. Target areas of suspected inappropriate service utilization;
3. Detect over- or under- utilization, including procedures to address underutilization of essential services such as dental checkups, First Dental Home visits, and sealants;
4. Routinely generate Provider profiles regarding utilization patterns and compliance with UM criteria and policies;
5. Compare Dental Member and Provider utilization with norms for comparable individuals; and
6. Refer suspected cases of Provider or Dental Member FWA to the OIG as required by **Section 2.3.31**.

2.3.25 COMPLIANCE WITH STATE AND FEDERAL PRIOR AUTHORIZATION REQUIREMENTS

The Dental Contractor must adopt PA requirements that comply with state and federal laws governing authorization of dental services. In addition, the Dental Contractor must comply with Tex. Ins. Code § 1217.004. The Dental Contractor must ensure that the provider requesting prior authorization for a service is also the provider who performs the service, with the exception of services provided in a dental school or teaching facility.

2.3.26 SUBMISSION OF SERVICE AUTHORIZATIONS

The Dental Contractor must provide access to a toll-free fax line and Provider portal where Providers may send requests for authorization of services and any supplemental information related to service authorization. The fax line and Provider portal must be available 24 hours per day, seven days a week.

2.3.27 FINANCIAL REQUIREMENTS FOR MEDICALLY NECESSARY COVERED DENTAL SERVICES

The Dental Contractor must pay for or reimburse Providers for all Medically Necessary Covered Dental Services provided to a Dental Member, up to the Dental Member's applicable benefit limits. The Dental Contractor is not liable for costs incurred in connection with dental care rendered prior to the date of the Dental Member's Effective Date of Coverage with that Dental Contractor. When Medicaid provider rates are increased as a result of a legislative appropriation, MCOs must increase provider rates as required by HHSC to the extent allowed by federal laws and regulations. Medicaid and CHIP are the payers of last resort for Covered Services, unless an exception applies under federal law or HHSC policy. If a Dental Member is entitled to coverage for specific services payable under another insurance plan and the Dental Contractor paid for such Medically Necessary Covered Dental Services, the Dental Contractor must obtain reimbursement from the responsible insurance entity, not to exceed 100 percent of the value of any Medically Necessary Covered Dental Services paid by the Dental Contractor. See **Sections 2.5.5** and **2.7.5** for more information.

2.3.28 REPORTING REQUIREMENTS

The following sections provide reporting requirements required of the Dental Contractor.

2.3.28.1 GENERAL REPORTING REQUIREMENTS

The Dental Contractor must provide and must require its Material Subcontractors to provide, at no cost to HHSC, the following:

1. All information required under this Contract, including but not limited to, the reporting requirements or other information related to the performance of its responsibilities hereunder as reasonably requested by the HHSC;
2. Any information in its possession sufficient to permit HHSC to comply with the Federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats, and instructions as specified by HHSC. Where practicable, HHSC may consult with Dental Contractor to establish time frames and formats reasonably acceptable to both parties; and
3. Ad hoc reports as requested by HHSC.

All information must be provided in accordance with the timelines, definitions, formats, and instructions as specified by HHSC. Where practicable, HHSC may consult with the Dental Contractor to establish timeline and formats reasonably acceptable to both Parties.

Any Deliverable or report not listed in **Chapter 5 of the UMCM**, but referenced in this Contract without a specified due date, is due quarterly on the last day of the month following the end of the reporting period. Where the due date states 30 Days, the Dental Contractor is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 Days, the Dental Contractor is to provide the deliverable by the 15th Day of the second month following the end of the reporting period. See **Chapter 5 of the UMCM**.

The Dental Contractor must provide the reports specified in **Chapter 5 of the UMCM**. This chapter includes a list of required reports, and a description of the format, content, file layout, and submission deadlines for each report

Pursuant to CFR §438.606 and UMCM Chapter 5, Data Certification Instructions, the Dental Contractor's chief executive (CEO); and chief financial officers (CFO); or an individual who reports directly to those positions with delegated authority to sign for them so that the CEO or CFO is ultimately responsible for the certification, , must certify that the financial data, Encounter Data, and other data, as specified by CFR §438.604, has been reviewed, and is true and accurate to the best of the certifying person's knowledge. Such certification may not be delegated.

HHSC is constructing a portal for delivery and receipt of Dental Contractor deliverables. The Dental Contractor will be required to participate in the online portal.

2.3.28.1.1 Dental Contractor Deliverables Related to Management Information System Requirements

The Dental Contractor must comply with all applicable Joint Interface Plans (JIPs), as modified or amended, and all required file submissions for EB, EQRO, and HHSC's Medicaid Claims Administrator. The JIP must include the Dental Contractor's interfaces required to conduct business under the Contract. The JIP must address the coordination with each of the Dental Contractor's interface partners to ensure the development and maintenance of the interface; and the timely transfer of required data elements between contractors and partners. The JIPs are posted in TXMedCentral under the MCOLAYUT folder. See **Chapter 7 of the UMCM**.

The Dental Contractor must submit plans and checklists related to MIS to HHSC according to the format and schedule identified in **Chapter 5 of the UMCM**. Additionally, if a systems readiness review is triggered by one of the events described in **Section 2.3.29**, the Dental Contractor must submit all of the plans identified in this section in accordance with an HHSC approved timeline.

2.3.28.2 ACCOUNTING AND REPORTING REQUIREMENTS

The Dental Contractor's accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with Federal Acquisition Regulations (FAR), Generally Accepted Accounting Principles (GAAP), and the cost principles contained in the HHSC Cost Principles document in **Chapter 6 of the UMCM**. HHSC will not recognize costs that are unallowable, or that cannot be properly substantiated by the Dental Contractor and verified by HHSC. The Dental Contractor must:

1. Maintain accounting records for the Dental Program and the resulting contract separate and apart from other corporate accounting records;
2. Maintain records for all claims payments, refunds, and adjustment payments to Providers, capitation payments, interest income, and payments for administrative services or functions, and must maintain separate records for dental and administrative fees, charges, and payments;
3. Ensure and provide access to HHSC or its auditors to the detailed records and supporting documentation for all costs incurred by the Dental Contractor. The Dental Contractor must ensure access to its Affiliates' records for any costs billed to or passed to the Dental Contractor with respect to the Dental Program; and
4. Maintain an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts.

The Dental Contractor must reimburse HHSC, if reimbursement is sought from the Dental Contractor, for reasonable costs incurred by HHSC to perform examinations, investigations, audits, or other types of attestations that HHSC determines are necessary to ensure Dental Contractor's compliance with the Contract. The use and selection of any external parties to conduct examinations, investigations, audits, or other types of attestations are at HHSC's sole discretion.

2.3.28.2.1 GENERAL ACCESS TO ACCOUNTING RECORDS

The Dental Contractor, and any Affiliate Subcontractor, must provide authorized representatives of the State and federal governments full access to all financial and accounting records related to the performance of the Contract. See **ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS** for additional requirements.

The Dental Contractor and any subcontracted Affiliates must:

1. Cooperate with the state and federal governments in their evaluation, inspection, audit, or review of accounting records and any necessary supporting information;
2. Permit authorized representatives of the State and federal governments full access, during normal business hours, to the accounting records that the State and federal governments determine are relevant to the Contract. Such access is guaranteed at all times during the performance and retention period of the Contract, and may include both announced and unannounced inspections, on-site audits, and the review, analysis, and reproduction of reports produced by the Dental Contractor;

3. Make copies, at no cost to HHSC, of any accounting records or supporting documentation relevant to the Contract, including Provider Contracts, available to the State and federal governments within seven Business Days, or as otherwise specified, of receiving a written request for the specified records or information. If such documentation is not made available as requested, the Dental Contractor agrees to reimburse the requesting party for all costs, including, but not limited to, transportation, lodging, and subsistence for all state and federal representatives, or their designees, to carry out the inspection, audit, review, analysis, and reproduction functions at the location(s) of such accounting records; and
4. Pay all additional costs incurred by the State and federal governments that are the result of the Dental Contractor's failure to provide the requested accounting records or financial information within ten Business Days of receiving a written request from the State or federal government. Failure to provide such required documentation and information in a timely manner may be deemed to be a material breach of the Contract's terms.

2.3.28.2.2 FINANCIAL REPORTING REQUIREMENTS

HHSC will require the Dental Contractor to provide separate financial reports for Medicaid and CHIP to support the Contract monitoring as well as state and federal reporting requirements. All financial information and reports submitted by the Dental Contractor become property of HHSC. HHSC may, at its discretion, release such information and reports to the public at any time and without notice to the Dental Contractor. In accordance with state and federal laws regarding Dental Member confidentiality, HHSC will not release any Dental Member-identifying information contained in such reports.

Any data submitted with respect to the required financial reports or filings that is in portable document format (PDF), or similar file format, must be generated in a text-searchable format. Copies of required filings or reports may not be submitted in non-text-searchable formats, such as JPG or GIF. In certain exceptions, where expressly permitted by HHSC, signature pages may be submitted in a non-text-searchable format.

The Dental Contractor must submit all required financial reports as detailed in **Chapter 5 of the UMCM** and the Contract using the templates in **Chapter 5 of the UMCM**.

Note to Dental Contractors. Not all the above referenced financial reports have been incorporated into the UMCM at the time this Contract was awarded. The development of the report templates is part of the current HHSC UMCM change process, and Dental Contractors will be notified when the templates are published and made part of the Contract.

2.3.29 MANAGEMENT INFORMATION SYSTEM REQUIREMENTS

The Dental Contractor must maintain a Management Information System (MIS) that supports all functions of the Dental Contractor's processes and procedures for the flow and use of Dental Program data. If the Dental Contractor subcontracts an MIS function, the Subcontractor's MIS must comply with the requirements of this section. The Dental

Contractor must have hardware, software, and a network and communications system with the capability and capacity to handle and operate all MIS subsystems, with limited manual intervention for routine processing, for the following operational and administrative areas:

1. Enrollment/eligibility subsystem;
2. Provider subsystem;
3. Encounter/claims processing subsystem;
4. Benefit tracking/limitations subsystem;
5. Financial subsystem;
6. Utilization/Quality Improvement subsystem;
7. Reporting subsystem;
8. Interface subsystem; and
9. Third Party Recovery subsystem.

The MIS must enable the Dental Contractor to meet this Contract's requirements, including all applicable state and federal laws, rules, and regulations. The MIS must have the capacity and capability to capture and utilize various data elements required for Dental Contractor administration.

The Dental Contractor must have a system that can be adapted to changes in business practices or policies within the timeframes negotiated by the Parties. The Dental Contractor is expected to cover the cost of such systems modifications through the Term of the Contract.

The Dental Contractor is required to participate in work groups and regular calls related to MIS convened by HHSC.

The Dental Contractor must provide HHSC prior written notice of a Major Systems Change and implementation no later than 180 Days prior to the planned change or implementation, including any changes relating to Material Subcontractors, in accordance with the requirements of the Contract and **ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**. HHSC may modify or waive the notification requirement contingent upon the nature of the request from the Dental Contractor.

The Dental Contractor must notify HHSC of a Major Systems Change in writing, as well as by email, to HHSC's Managed Care Compliance & Operations division's staff. The notification must detail the following:

1. The aspects of the system that will be changed and date of implementation;
2. How these changes will affect the Provider and Dental Member community, if applicable;
3. The communication channels that will be used to notify these communities, if applicable;
4. A detailed implementation plan and schedule of proposed changes; and
5. A contingency plan in the event of downtime of system(s) or substantial non-performance of the system(s).

Major Systems Change is subject to HHSC desk review and onsite review of the Dental Contractor's facilities as necessary to test readiness and functionality prior to implementation. See **Section 2.3.2.**

2.3.29.1 ENCOUNTER DATA

The Dental Contractor must provide complete and accurate Encounter Data that reflects information received on claims for all Medically Necessary Covered Dental Services, including VAS. Encounter Data must follow the format and data elements as described in the most current version of Health Insurance Portability and Accountability Act (HIPAA)-compliant 837D Companion Guides, and Encounters Submission Guidelines. The Dental Contractor will adhere to the method of transmission, the submission schedule, and any other requirements specified in the **UMCM.** HHSC will use Encounter data to set rates, monitor utilization, conduct system reporting, quality monitoring, FWA activities, and for other programmatic purposes.

Encounter Data quality validation must incorporate assessment standards developed jointly by the Dental Contractor and HHSC. The Dental Contractor must ensure that HHSC receives complete and accurate Encounter Data not later than the 30th day after the last day of the month in which the claim was adjudicated. The Dental Contractor must make original records and data available for inspection by HHSC for validation purposes upon HHSC request. Encounter Data that do not meet quality standards must be corrected and resubmitted within a time period specified by HHSC.

In addition to providing Encounter Data in the format described above, HHSC may request that the Dental Contractor submit an Encounter Data file to HHSC's EQRO, in the format provided in the **UMCM**.

For reporting Encounters to HHSC, the Dental Contractor must use the procedure codes, diagnosis codes, and other codes as directed by HHSC. Any exceptions will be considered on a code-by-code basis after HHSC receives written notice from the Dental Contractor requesting an exception. The Dental Contractor must also use the Provider numbers as directed by HHSC, in the format provided in the **UMCM** for Encounter submissions.

2.3.29.2 SYSTEM-WIDE FUNCTIONS

The Dental Contractor's MIS system must include key business processing functions or features, which must apply across all subsystems as follows:

1. Process electronic data transmission or media to add, delete, or modify membership records with accurate begin and end dates;
2. Track Medically Necessary Covered Dental Services received by Dental Members through the system, and accurately and fully maintain those Medically Necessary Covered Dental Services as HIPAA compliant Encounter transactions;
3. Transmit or transfer Encounter Data transactions on electronic media in the HIPAA format to the contractor designated by HHSC to receive the Encounter Data;

4. Maintain a history of changes and adjustments and audit trails for current and retroactive data;
5. Maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure;
6. Employ industry standard dental billing taxonomies (procedure codes, diagnosis codes) to describe services delivered and Encounter transactions produced;
7. Accommodate the coordination of benefits;
8. For CHIP members, produce standard explanation of benefits (EOBs);
9. Pay financial transactions to Providers in compliance with federal and state laws, rules, and regulations;
10. Ensure that all financial transactions are auditable according to GAAP guidelines;
11. Ensure that FSRs conform to the FAR and **Chapter 6 of the UMCM**, with respect to segregating costs that are allowable for inclusion in HHSC-designed financial reports;
12. Relate and extract data elements to produce report formats in the **UMCM** or otherwise as required by HHSC;
13. Ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS;
14. Maintain and cross-reference all Dental Member-related information with the most current Main Dentist number;
15. Maintain and cross-reference all Dental Member-related information with current and historical Medicaid or CHIP Provider numbers;
16. Track utilization of benefits within the Program's benefit limit(s); and
17. Report benefit utilization information to other Dental Contractor and HHSC.

2.3.29.3 ELECTRONIC DATA INTERCHANGE AND HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT COMPLIANCE

In addition to other requirements in this Contract, the Dental Contractor must comply with HIPAA Electronic Data Interchange (EDI) requirements including the HIPAA-compliant format version. The Dental Contractor must be able to receive, load, and read eligibility files received from HHSC in the 834 HIPAA-compliant format. Eligibility inquiries must be in the 270/271 HIPAA-compliant format. Claim transactions must be in the 837D/835 HIPAA-compliant format.

The Dental Contractor must develop a privacy notice, commonly referred to as Notice of Privacy Practice (NOPP), as required by HIPAA, including 45 C.F.R. § 164.520. The Dental Contractor must provide HHSC with a copy of its NOPP prior to distribution and after any changes are made to the NOPP prior to distribution. The Dental Contractor must provide its new Dental Members with a NOPP, and to all existing Dental Members after making revisions to the NOPP.

The Dental Contractor must offer its Providers and Subcontractors the option of submitting and receiving claims information through an EDI that allows for automated processing and adjudication of claims. EDI processing must be offered as an alternative to the filing of paper claims. The Dental Contractor must use HIPAA-compliant electronic formats.

HHSC may require the Dental Contractor to receive initial electronic claims through an HHSC-contracted vendor. The Dental Contractor must allow Providers to send claims to one location, which will then identify where the claim should be submitted. The Dental Contractor's interface must allow receipt of these electronic submissions. The Dental Contractor must maintain a mechanism to receive claims from an HHSC-contracted vendor in addition to the HHSC claims portal. The Dental Contractor must allow Providers to send claims directly to the Dental Contractor or its Subcontractor.

The Dental Contractor must make an electronic funds transfer payment process for direct deposit available to Providers when processing claims for Medically Necessary Covered Dental Services.

The Dental Contractor may deny a claim submitted by a Provider for failure to file in a timely manner as provided for in **Chapter 2 of the UMCM**.

2.3.29.4 CLAIMS PROCESSING REQUIREMENTS

The Dental Contractor must administer an effective, accurate, and efficient claims payment process in compliance with federal and state laws, rules, and regulations including **Chapter 2 of the UMCM**. The Dental Contractor must process and adjudicate all claims for Medically Necessary Covered Dental Services that are filed within the timeframes specified in **Chapter 2 of the UMCM**. The Dental Contractor and its Subcontractor cannot directly or indirectly charge or hold a Dental Member or Provider responsible for claims adjudication or transaction fees.

The Dental Contractor should employ a fully automated claims processing system to the extent practicable. If not practicable to be fully automated, the Dental Contractor must maintain an automated claims processing system that requires minimal and limited manual intervention for routine claims processing and that registers the date a claim is received by the Dental Contractor, the detail of each claim transaction or action, including date of service, at the time the transaction occurs, and has the capability to report each claim transaction by date and type to include interest payments. The claims system must maintain information at the claim and line detail level. The claims system must maintain adequate audit trails and report accurate claims performance measures to HHSC.

The Dental Contractor's claims system must maintain online and archived files. The Dental Contractor must keep online automated claims payment history for the most current 18 months. The Dental Contractor must retain other financial information and records, including all original claims forms, for the time period established in **Section 9.01 of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**. All claims data must be easily sorted and produced in formats as requested by HHSC.

The Dental Contractor must withhold all or part of payment for any claim submitted by a Provider:

1. Who has been excluded or suspended from the Medicare, Medicaid, or CHIP programs based on a determination of FWA;
2. For whom his or her license has been terminated or suspended;

3. Who is on payment hold under the authority of HHSC;
4. With debts, settlements, or pending payments due to HHSC, the State or federal government;

With the following exceptions, the Dental Contractor must complete all audits of a provider claim no later than 18 months after receipt of a Clean Claim, regardless of whether the provider participates in the Dental Contractor's Network. This limitation does not apply in cases of provider FWA that the Dental Contractor did not discover within the two-year period following receipt of a claim. In addition, the two-year limitation does not apply when the officials or entities identified in **Section 9.02(c) of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**, conclude an examination, audit, or inspection of a provider more than two years after the Dental Contractor received the claim, or when HHSC has recovered a capitation from the Dental Contractor based on a Dental Member's ineligibility. If an exception to the two-year limitation applies, then the Dental Contractor may recoup related payments from providers, only if approved by HHSC.

A Clean Claim must meet all requirements for accurate and complete data as defined in the appropriate 837 encounter guides as follows:

(1) 837 Dental Implementation Guide; and

(2) 837 Dental Companion Guide;

The Dental Contractor may not require a dentist or dental provider to submit documentation that conflicts with the requirements of 28 Tex. Admin. Code Chapter 21, Subchapters C and T.

If an additional payment is due to a provider as a result of an audit, the Dental Contractor must make the payment no later than 30 Days after it completes the audit. If the audit indicates that the Dental Contractor is due a refund from the provider, the Dental Contractor must send the provider written notice of the basis and specific reasons for the recovery no later than 30 Days after it completes the audit. If the provider disagrees with the Dental Contractor's request, the Dental Contractor must give the provider an opportunity to appeal and may not attempt to recover the payment until the provider has exhausted all appeal rights. If the Dental Contractor recouped and did not allow provider time to appeal, Dental Contractor must repay the provider for funds recouped.

The Dental Contractor must obtain recovery of payment from a liable third party and not from the provider unless the provider received payment from both the Dental Contractor and the liable third party. The Dental Contractor must notify HHSC of a claims processing Major Systems Change in writing no later than 180 Days prior to implementation. The Dental Contractor must provide an implementation plan and schedule of proposed changes. HHSC may require a desk or on-site readiness review of the changes.

The Dental Contractor must inform all Providers about the information required to submit a claim at least 30 Days prior to the Operational Start Date and as a provision within its Provider Contract. The Dental Contractor must make any policies affecting claims adjudication and claims coding and processing guidelines available to Providers for the

applicable Provider type. Providers must receive 90 Days written notice prior to the Dental Contractor's implementation of changes to these claims policies and guidelines.

The Provider Contract must specify that program violations arising out of performance of the Provider Contract are subject to administrative enforcement by the HHSC OIG as specified in 1 Tex. Admin. Code Chapter 371, Subchapter G.

2.3.29.5 CLAIMS PROJECT

For purposes of this section, claims project means a project initiated by a Dental Contractor, outside of the Provider Appeal process, after payment or denial of claim(s) for the purpose of conducting any necessary research on the claim(s) or to adjust the claim(s), if appropriate.

Dental Contractor may initiate a claims project at its own initiative. All claims included in a particular claims project must be finalized within 60 Days of the claims project being opened or within an agreed upon timeframe between the Provider and the Dental Contractor. The Dental Contractor must enter a written agreement with the Provider before the expiration of the initial 60 day period to establish the claims project's agreed upon timeframe. Dental Contractor must maintain the agreement for 18 months from the conclusion of the claims project and make the agreement available to HHSC upon request. Dental Contractor will report monthly to HHSC the start and end date for all claims projects using HHSC's report template.

Claims projects must be included in the quarterly claims report including interest paid. All claims projects must be reported to the HHSC MCCO team on the required standardized report. Any claims project that exceeds 60 Days must receive prior approval for an extension from MCCO.

2.3.29.6 NATIONAL CORRECT CODING INITIATIVE

For all claims filed, the Dental Contractor must comply with the requirements of 42 U.S.C. § 1396b(r)(1)(B)(iv), regarding the National Correct Coding Initiative, including all applicable rules, regulations, and methodologies implemented as a result of this initiative.

2.3.30 ELECTRONIC FUND TRANSFER

Dental Contractor must offer Providers electronic fund transfers (EFT) for claims payment, or other direct deposit operations such as paycheck deposits, as a safe alternative to paper checks for payment of claims. Dental Contractor must make EFT available to Providers whether claims are filed electronically or in hardcopy. Dental Contractor must utilize a financial subsystem that provides the technological capability to process EFT using HIPAA national standards for electronic payment and remittance advice. Dental Contractor must ensure that no less than 85 percent of the dollars processed as claims payments are issued via EFT.

The Dental Contractor not meeting the stated EFT processing standard must develop a plan and corresponding timeline for HHSC approval that improves the payment processing system to a level of maturity to support and achieve the stated performance standard.

2.3.31 FRAUD, WASTE, AND ABUSE

The Dental Contractor is subject to all state and federal laws and regulations relating to Fraud, Waste, and Abuse (FWA) in the Dental Program including Gov't. Code §§ 531.102, 531.113, 531.1131, and 533.012; 1 Tex. Admin. Code §§ 353.501-353.505; 1 Tex. Admin. Code §§ 370.501-370.505; and 1 Tex. Admin. Code Chapter 371 Subchapter G.

The Dental Contractor must cooperate and assist the HHSC Office of Inspector General (OIG) and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected FWA.

The Dental Contractor must submit a written Fraud, Waste, and Abuse compliance plan to HHSC OIG for approval each year per 1 Texas Admin. Code 353.502. The plan must be submitted 90 Days prior to the start of the State Fiscal Year. See Section 7, "Transition Phase Requirements" for requirements regarding timeframes for submitting the original plan.

The Dental Contractor must require all employees who process Medicaid and CHIP claims, including Subcontractors, to attend annual training as provided by HHSC per Tex. Gov't Code § 531.105.

The Dental Contractor must perform pre-payment review for identified providers as directed by OIG. When requested by the HHSC OIG, the Dental Contractor will be required to provide employees to participate in administrative proceedings pursued by the HHSC OIG. Such employees must be knowledgeable about the subject matter on which they are called to testify and must be available for preparatory activities and for formal testimony. The Dental Contractor must provide the employees at no cost to HHSC.

Failure to comply with any requirement of Sections 2.3.31 may subject the Dental Contractor to liquidated damages, as specified in Attachment F, or administrative enforcement pursuant to 1 Tex. Admin. Code Chapter 371 Subchapter G, in addition to any other legal remedy.

2.3.31.1 FRAUD, WASTE, AND ABUSE COMPLIANCE PLAN

The Dental Contractor must submit a written FWA compliance plan to HHSC OIG for approval each year. The plan must be submitted 90 Days prior to the start of the SFY. The compliance plan must address how the Dental Contractor will meet each of the requirements outlined in 42 C.F.R. § 438.608 (a) and 1 Tex. Admin. Code § 353.502.

As part of the FWA compliance plan, the Dental Contractor must:

a. Designate executive and essential personnel to attend mandatory HHSC conducted training in FWA detection, prevention, and reporting. Executive and essential FWA

personnel means Dental Contractor staff persons who supervise staff in the following areas:

i Data collection;
ii Provider credentialing and Network oversight;
iii Encounter Data;
iv Claims processing;
v Utilization Management;
vi Complaint or Appeal;
vii Quality assurance and marketing;
viii Special investigation unit; and
ix Those who are directly involved in the decision making and administration of the FWA detection program within the Dental Contractor's organization.

Training will be conducted free of charge by the HHSC Office of Inspector General (OIG). The Dental Contractor must schedule, and all designated executive and essential personnel must complete training no later than 90 Days after the Effective Date;

b. Designate an officer or director, who must have additional resources in addition to him or herself, within the Dental Contractor's organization, responsible for carrying out the provisions of the FWA compliance plan;

If a Dental Contractor has not made any changes to its plan from the previous year, it may submit a notice to HHSC OIG in lieu of the compliance plan that:

1. No changes have been made to the previously approved plan and;
2. The plan will remain in place for the upcoming SFY.

HHSC OIG may request an updated plan, regardless of such notice. In addition to the compliance plan, the Dental Contractor must submit supplemental documentation describing how it has met the requirement of the compliance plan for the previous year. The notification must be signed and certified by an officer or director of the Dental Contractor that is responsible for carrying out the FWA compliance plan.

2.3.31.2 SPECIAL INVESTIGATIVE UNITS

In order to facilitate cooperation with OIG, the Dental Contractor must establish and maintain a special investigative unit (SIU), either-in house or by contract with another entity, to investigate possible acts of FWA for all services provided under the Contract, including those that the Dental Contractor subcontracts to outside entities.

The Dental Contractor's SIU does not have to be physically located in Texas but must be adequately staffed and with resources apportioned at the levels and experience sufficient to effectively work Dental Program cases based on objective criteria considering, but not necessarily limited to, the Dental Contractor's total Dental Member population, claims processes, risk exposure, current caseload, and other duties as described in 1 Tex. Admin. Code §§ 353.501-353.505, and 1 Tex. Admin. Code §§ 370.501-370.505..

The Dental Contractor must maintain a full-time SIU manager dedicated solely to the Texas Medicaid and CHIP programs to direct oversight of the SIU and Fraud, Waste, and Abuse activities.

The Dental Contractor SIU must employ or subcontract, at minimum, one full-time investigator, in addition to the SIU manager, who is dedicated solely to the services provided under the Texas Medicaid and CHIP contracts. The investigator must hold credentials such as a certification from the Association of Certified Fraud Examiners, an accreditation from the National Health Care Anti-Fraud Association, or have a minimum of three (3) years Medicaid or CHIP Fraud, Waste, and Abuse investigatory experience.

2.3.31.3 General Requests for and Access to Data, Records, and Other Information

The Dental Contractor and its Subcontractors must allow access to all premises and provide complete, unredacted and accurate originals or copies of all records and information requested free of charge to HHSC OIG, HHSC, CMS, the U.S. Department of Health and Human Services (DHHS), the Federal Bureau of Investigation (FBI), the Office of the Attorney General (OAG), TDI, or other units of the State that have requested the information. The Dental Contractor must provide all copies of records free of charge. See **Attachment A, HHSC Dental Contract Terms and Conditions**, for additional requirements. The Dental Contractor must:

1. Designate one primary and one secondary contact person for all records requests. Each Dental Contractor must also identify a central group email inbox that will receive all HHSC OIG records requests. HHSC OIG records requests will be sent to the designated Dental Contractor contact person(s) in writing by email, fax, mail, or established file exchange process and will provide the specifics of the information being requested;
2. Respond to the appropriate requestor within the timeframe designated in the request. If the Dental Contractor is unable to provide all of the requested information within the designated timeframe to HHSC OIG, the Dental Contractor may request an extension in writing to the requestor no less than two Business Days prior to the due date; and
3. The Dental Contractor's response must include complete, unredacted and accurate data for all data fields, as available. The data must be provided in the order and format requested. If any data field is left blank, an explanation must accompany the response. The Dental Contractor must not add or delete any additional data fields in its response. All requested information must be accompanied by a notarized business records affidavit unless indicated otherwise in the record request
4. The Dental Contractor must retain records in accordance with **Chapter 18 of the UMCM**.
5. The Dental Contractor must respond to requests for interpretations or clarifications of the Dental Contractor's policy and procedures within five Business Days.
6. The Dental Contractor must provide the basis for providing case-by-cases, value-added services, and Comprehensive Care Program (CCP) services provided through Texas Health Steps on an as needed basis.

The most common requests include but are not limited to:

a. 3 Business Days - 1099 and other financial information; urgent claims data requests;
b. 10 Business Days - Claims data
c. 10 Business Days - provider education information
d. 15 Business Days - files associated with an investigation conducted by a Dental Contractor
e. The OIG may request other information as needed, these requests must be submitted within the timeframes specified by the OIG.
f. Requests submitted to the Dental Contractor for interpretations or clarifications of the Dental Contractor policy and procedure- five Business Days Other time-sensitive requests – as needed.

2.3.31.4 CLAIMS DATA SUBMISSION REQUIREMENTS

The Dental Contractor and its Subcontractors must submit Adjudicated claims data per the frequency and scope prescribed by HHSC OIG. This data must include submission of complete, unredacted and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of all paid and denied claims. In the event that the Dental Contractor or its Subcontractors denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the Dental Contractor and its Subcontractors are required to submit all available claims data for such denied claims to HHSC OIG without alteration or omission.

The Dental Contractor and its Subcontractors must submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by HHSC OIG, in order to support comprehensive financial reporting, utilization analysis, and investigative efforts.

The Dental Contractor and its Subcontractors must supply EFT account numbers in the frequency and scope required by HHSC OIG for all Medicaid or CHIP providers who have elected to receive payments via EFT.

2.3.31.5 PAYMENT HOLDS AND SETTLEMENTS

42 C.F.R. § 455.23 and 1 Tex. Admin. Code § 371.1709, require the HHSC OIG to suspend all Medicaid payments to a provider in certain circumstances after HHSC OIG determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program. HHSC OIG may include the Dental Contractor's capitation payments in a suspension when an individual Provider is under investigation based upon credible allegations of fraud.

The Dental Contractor must cooperate with HHSC OIG timely and efficiently when HHSC OIG imposes payment suspensions or lifts a payment hold. When HHSC OIG sends notice to the Dental Contractor that payments to a provider have been suspended or the suspension lifted by HHSC OIG, the Dental Contractor must also suspend or lift suspension of payments to the provider within one Business Day of receiving the notice and notify HHSC OIG within three Business Days of the action taken. If the Dental Contractor fails to

implement the payment hold or improperly releases funds, HHSC may assess actual damages in the amount not held or released improperly.

The Dental Contractor must report information on payment holds initiated by HHSC OIG or the Dental Contractor, as specified in **Chapter 5 of the UMCM**. The Dental Contractor must respond to the HHSC OIG request for payment hold amounts accurately and, in the manner, and format requested. HHSC may assess actual damages for the difference between the accurate adjudicated amount required to be reported by the Dental Contractor under **Chapter 5 of the UMCM** and the amount received by HHSC OIG. The Dental Contractor must follow the requirements set forth in a settlement agreement involving a Dental Contractor's Provider and HHSC OIG. The Dental Contractor must withhold the designated percentage of funds to be paid toward an identified overpayment. Upon HHSC OIG request, the Dental Contractor must forward the held funds to **HHSC OIG, Attn: Senior Case Analyst**, along with an itemized spreadsheet detailing the Provider's claims paid.

Dental Contractor must maintain all documents and claim data on Providers who are under HHSC OIG investigation or any internal investigations that are referred to HHSC OIG for recoupment. The Dental Contractor's failure to comply with this section and all state and federal laws and regulations relating to FWA are subject to administrative enforcement by HHSC OIG.

The Dental Contractor will have no claim to any funds that are recovered by the State of Texas or the United States Government from a Provider through an action under the Federal False Claims Act, Texas Medicaid Fraud Prevention Act, or similar laws. The recovery of an overpayment by a Dental Contractor from a Provider does not preclude the prosecution of, nor recovery from a Provider under the Federal False Claims Act, Texas Medicaid Fraud Prevention Act, or similar laws.

The Dental Contractor must apply payment holds to providers participating in cost reporting with HHSC, at the request of HHSC.

2.3.31.6 Treatment of Recoveries by the Dental Contractor for Fraud Waste and Abuse

Pursuant to 42 C.F.R. § 438.608(d)(1)(i), the Dental Contractor must comply with all state and federal laws pertaining to Provider recoveries including Texas Government Code § 531.1131 and § 353.1454.

The Dental Contractor must have internal policies and procedures for the documentation, retention, and recovery of all overpayments, specifically for the recovery of overpayments due to Fraud, Waste, and Abuse.

In cases identified by the HHSC OIG, the HHSC OIG has the right to recover any identified overpayment directly from the Provider or to require the Dental Contractor to recover the identified overpayment and distribute funds to the State:

1. The Dental Contractor will have no claim to any funds that are recovered by the State of Texas or the United States Government from a Provider through an action under the Federal False Claims Act, Texas Medicaid Fraud Prevention Act, or similar laws. The recovery of an overpayment by a Dental Contractor from a Provider does not preclude the prosecution of nor recovery from a Provider under the Federal False Claims Act, Texas Medicaid Fraud Prevention Act, or similar laws.
2. Upon discovery of Fraud, Waste, or Abuse the Dental Contractor shall:
    - i Submit a referral using the fraud referral form through the Waste, Abuse, and Fraud Electronic Reporting System (WAFERS);
    - ii Proceed with recovery efforts related to waste; and
    - iii Proceed with recovery efforts per 1 Tex. Admin. Code § 353.505.
3. The Dental Contractor may retain recovery amounts pursuant to Texas Government Code § 531.1131(c) and (c-1).
4. Pursuant to Government Code § 531.1131(c-3), the Dental Contractor is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a Provider when the issues, services, or claims upon which the recoupment or withhold are based meet one or more of the following criteria:
    a. Upon written notice from HHSC OIG that it has begun recovery efforts, the Dental Contractor is prohibited from taking any actions to recoup or withhold improperly paid funds.
        i. The prohibition described in this subsection shall be limited to a specific provider(s), for specific dates, and for specific issues, services, or claims. The Dental Contractor must not engage in any reprocessing, recoupments, and other payment recovery efforts or claims adjustments of any kind based on the parameters set by HHSC OIG.
        ii. The prohibition does not impact any current Dental Contractor contractual obligations as well as any reprocessing, recoupment, other payment recovery efforts, or claims adjustments for claims that fall outside those identified in the written notice from HHSC OIG.
    b. The improperly paid funds have already been recovered by HHSC OIG.
5. The Dental Contractor must report at least annually, or at the request of the HHSC OIG, to the status of their recoveries of overpayments in the manner specified by the HHSC OIG.

2.3.31.7 False Claims Act and Whistleblowing

In accordance with Section 1902(a)(68) of the Social Security Act (False Claims Act), Dental Contractor and its Subcontractors that receive or make annual Medicaid payments of at least $5 million must:

1. Establish written policies for all employees, managers, officers, contractors, Subcontractors, and agents of the Dental Contractor or Subcontractor, that provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A) of the Social Security Act;
2. Include detailed provisions regarding the Dental Contractor's or Subcontractor's policies and procedures must include for detecting and preventing FWA; and
3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A) of the Social Security Act, the rights of employees to be protected as whistleblowers, and the Dental Contractor's or Subcontractor's policies and procedures for detecting and preventing FWA.

2.3.32 CONTINUITY OF CARE AND OUT-OF-NETWORK PROVIDERS

The Dental Contractor must ensure that the care of newly enrolled Dental Members is not disrupted or interrupted.

Upon notification from a Dental Member or Provider of the existence of a PA, the new Dental Contractor must ensure Dental Members receiving services through a PA from either another Dental Contractor or Fee-for-Service (FFS) receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following:

1. 90 Days after the transition to a new Dental Contractor;
2. Until the end of the current authorization period; or
3. Until the Dental Contractor has evaluated and assessed the Dental Member and issued or denied a new authorization. For instances in which a newly enrolled Dental Member transitioning from FFS to managed care was receiving a service that did not require a PA in FFS, but does require one by the new Dental Contractor, the Dental Contractor must ensure Dental Members receive services for the same amount, duration, and scope for the shortest period of one of the following:
   a. 90 Days; or
   b. Until the Dental Contractor has evaluated and assessed the Dental Member and issued or denied a new authorization.

Additionally, if a Dental Member is new to a Dental Contractor, and is completing one or more dental procedures initiated prior to joining, the Dental Contractor is only responsible for payment for the continued course of treatment, if such treatment is a Medically Necessary Covered Dental Service and has not already been paid in full by the Dental Member's previous Dental Contractor.

The Dental Contractor must pay a Dental Member's existing Out-of-Network (OON) providers for Medically Necessary Covered Dental Services until the Dental Member's records, clinical information, and care can be transferred to a Network Provider, or until such time as the Member is no longer enrolled with that Dental Contractor, whichever is

shorter. The Dental Contractor must comply with OON rules as described in 1 Tex. Admin. Code § 353.4.

The Dental Contractor must provide Dental Members with timely and adequate access to OON services for as long as those services are necessary and covered benefits are not available within the Network, in accordance with 42 C.F.R. § 438.206(b)(4). The Dental Contractor will not be obligated to provide a Dental Member with access to OON services if such services become available from a Network Provider.

The Dental Contractor must ensure that each Dental Member has access to a second opinion regarding any Medically Necessary Covered Dental Service. A Dental Member must be allowed access to a second opinion from a Network Provider or OON provider if a Network Provider is not available, at no cost to the Dental Member, in accordance with 42 C.F.R. § 438.206(b)(3). The requirements in this section regarding access to and payment of OON providers apply only to OON providers who are enrolled Texas Medicaid providers.

If a Medicaid Dental Member enrolled with a Dental Contractor for at least one month is receiving orthodontic treatment and either ages out of the Dental Program or loses eligibility, the Dental Contractor is responsible for completion of the course of treatment. The only exception is if the Medicaid Dental Member is disenrolled with cause but is still Medicaid eligible. For example, if a Medicaid Dental Member goes into a state supported living center, the Dental Contractor will no longer be responsible for services rendered.

2.3.33 PAYMENTS TO FEDERALLY QUALIFIED HEALTH CENTERS, RURAL HEALTH CLINICS, AND CERTAIN PHYSICIANS

The Dental Contractor must pay full encounter rates to Rural Health Clinics (RHCs) for Medically Necessary Covered Dental Services using the prospective payment methodology described in Social Security Act §§ 1902(bb) and 2107(e)(1). Because the Dental Contractor is responsible for the full payment amount in effect on the date of service for RHCs, HHSC cost settlements, or "wrap payments", will not apply.

When the Dental Contractor negotiates payment amounts with Federally Qualified Health Clinics (FQHCs), the amounts must be greater than or equal to the average of the Dental Contractor's payment terms for other Providers providing the same or similar services. Because the Dental Contractor may negotiate payment amounts with FQHCs, wrap payments apply. Dental Contractor may elect to pay the FQHC wrap payment at the time of claim adjudication but no later than the 15th Day of the following month for claims paid in the prior month. After the Dental Contractor pays a wrap payment, HHSC will make a supplemental payment to the Dental Contractor in the amount of the wrap payment.

If a Dental Member visits an FQHC, RHC, or a Municipal Health Department's public clinic for Health Care Services (public clinic) at a time that is outside of normal business hours, as defined by HHSC in rules, including weekend days or holidays, the Dental Contractor must reimburse the FQHC, RHC, or public clinic for Medically Necessary Covered Dental Services. The Dental Contractor must do so at a rate that is equal to the allowable rate for those services as determined under Tex. Hum. Res. Code § 32.028. The

Member does not need a referral from his or her Main Dentist. If a Member visits an Out-of-Network (OON) FQHC, the Dental Contractor is obligated to reimburse the FQHC a full encounter rate for Medically Necessary Covered Dental Services provided as if the OON FQHC were a Network Provider. This encounter rate is paid entirely as a wrap payment no later than the 15th Day of the following month for services provided in the prior month. After the Dental Contractor pays a wrap payment, HHSC will make a supplemental payment to the Dental Contractor in the amount of the wrap payment by the last day of the following month. An FQHC's OON claim is subject to the same claim standards requirements as the Dental Contractor's in-network providers. This section applies to services provided to Medicaid and CHIP Dental Members.

If a Dental Member who is an Indian enrollee visits an OON Indian Health Care Provider (IHCP) for Covered Services, the Dental Contractor is obligated to timely reimburse the IHCP in compliance with 42 C.F.R. § 438.14 or as follows:

1. At a rate negotiated between the Dental Contractor and the IHCP, or
2. If the Dental Contractor and IHCP have not negotiated a rate, at a rate not less than the level and amount the Dental Contractor would pay a participating provider that is not an IHCP for the services.

An IHCP's OON claim is subject to the same claims standards requirements as the Dental Contractor's Providers.

2.3.34 OBJECTION TO PROVIDE CERTAIN SERVICES

In accordance with 42 C.F.R. § 438.102, the Dental Contractor may file an objection to providing, reimbursing for, or providing coverage of, a counseling or referral service for a Covered Dental Service based on moral or religious grounds. The Dental Contractor must work with HHSC to develop a work plan to complete the necessary tasks and determine an appropriate date for implementation of the requested changes to the requirements related to Medically Necessary Covered Dental Services. The work plan will include timeframes for completing the necessary Contract and waiver amendments, adjustments to Capitation Rates, identification of the Dental Contractor and enrollment materials needing revision, and notifications to Dental Members.

In order to meet the requirements of this section, the Dental Contractor must notify HHSC of grounds for and provide detail concerning its moral or religious objections and the specific services covered under the objection, no less than 120 Days prior to the proposed effective date of the policy change.

The Dental Contractor must notify their Dental Members of any policy change 30 Days before the policy effective date and must inform Dental Members when these services are not covered and how to obtain information on receiving these services from HHSC.

2.3.35 PAYMENT BY ELIGIBLE MEDICAID MEMBERS

Except as provided in **Section 2.3.35.1**, Dental Contractor, Network Providers, and OON providers are prohibited from billing or collecting any amount from a Dental Member, their

authorized representatives, LAR, or guardian, for Medically Necessary Covered Dental Services. See 1 Tex. Admin. Code § 354.1005.

As provided in **Section 10.10 of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**, the Dental Contractor must inform Dental Members of their responsibility to pay the costs for non-covered services, and must require its Providers to:

1. Inform Dental Members of costs for non-covered services prior to rendering such services; and
2. Obtain a signed private pay form from such Dental Members.

2.3.35.1 CHIP DENTAL CONTRACTOR

CHIP Network Providers and OON Providers may collect copayments from CHIP Dental Members as authorized in the CHIP State Plan. For purposes of this section, CHIP Dental Members will be referred to as member(s).

The EB will notify the Dental Contractor when a member's family's cost share limit has been reached. Upon such notification, the Dental Contractor must generate and mail to the member a new Dental Member ID card within five Days, showing that the member's cost-sharing obligation for that term of coverage has been met. No cost-sharing may be collected from these members for the balance of their term of coverage.

The Dental Contractor must ensure that Providers do not collect copayments at any income level for Medically Necessary Covered Dental Services that qualify as routine preventive and diagnostic dental services, as defined by Section 2103(e)(2) of the Social Security Act and 42 C.F.R. § 457.520.

Except for costs associated with unauthorized non-emergency services provided to a member by OON providers and for non-covered dental services, the copayments outlined in the CHIP Cost Sharing Table in **Chapter 6 of the UMCM** are the only amounts that a provider may collect from a CHIP-eligible family. Although the Emergency Dental Services described in **Section 2.3.7** are Non-capitated Services, the Dental Contractor must educate members and Providers that cost sharing for such Emergency Dental Services is limited to the copayment amounts set forth in **Chapter 6 of the UMCM**. If the cost of a Covered Dental Service is less than the member's copayment for that Covered Dental Service, the copayment amount the member pays will be capped at the cost of the Covered Dental Service.

The Dental Contractor's Provider Contracts must limit the amount CHIP Providers may charge members for services in excess of the member's benefit limits. The Dental Contractor must ensure that a Provider agrees to limit charges to the Providers' contracted rates for services that would have been Covered Dental Services, if the services were within the benefit limit.

Federal law prohibits charging premiums, deductibles, coinsurance, copayments, or any other cost-sharing to members that are Native Americans or Alaskan Natives. The HHSC Administrative Dental Services Contractor will notify the Dental Contractor of members

who are not subject to cost-sharing requirements. The Dental Contractor must train Providers regarding the cost-sharing waiver for this population.

The Dental Contractor's monthly Premium Payment will not be adjusted for a member's family's failure to make its CHIP premium payment. There is no relationship between the Premium Payment owed to the Dental Contractor for coverage provided during a month, and the family's payment of its CHIP premium obligations for that month.

2.3.36 COORDINATION WITH OTHER STATE HEALTH AND HUMAN SERVICES PROGRAMS

The Dental Contractor must coordinate with other state Health and Human Services Programs regarding the provision of essential public health care services. The Dental Contractor must meet the following requirements:

1. Cooperate and coordinate with managed care organizations or the Fee-for-Service Medical Transportation Program, as appropriate, to ensure Dental Members have access to NEMT Services.
2. Cooperate and coordinate with the THSteps outreach unit to ensure prompt delivery of services to Dental Members who miss dental checkups.
3. Cooperate and coordinate with HHSC, outreach programs, and THSteps regional program staff and agents to ensure prompt delivery of services to Farmworker Child(ren) and other migrant populations who may transition into and out of the Dental Contractor's Program more rapidly or unpredictably than the general population.
4. Coordinate care protocols for working with Dental Contractors, as well as protocols for reciprocal referral and communication of data and clinical information regarding the Member's Medically Necessary Covered Dental Services.

2.3.37 ATTORNEY GENERAL COOPERATION

To the extent HHSC, the State of Texas, or any other State agency is named in any lawsuit, the defense must be coordinated by Dental Contractor with the Office of the Attorney General, and Dental Contractor may not agree to any settlement without first obtaining the concurrence from the Office of The Attorney General.

2.3.38 CMS INTEROPERABILITY AND PATIENT ACCESS

Effective January 1, 2021, Dental Contractors and CHIP Dental Contractors are required by federal law to implement and maintain a Patient Access Application Programming Interface (API) and a Provider Directory API using the required Health Level 7 Fast Healthcare Interoperability Resources-based standards.

The Dental Contractor must comply with the Patient Access API requirements in 42 C.F.R. § 438.242(b)(5) and the Provider Directory API requirements in 42 C.F.R. § 438.242(b)(6), including the provider directory information specified in 42 C.F.R. § 438.10(h)(1) and (2). The CHIP Dental Contractor must comply with the Patient Access API requirements in 42

C.F.R. § 457.1233(d) and the Provider Directory API requirements in 42 C.F.R. § 457.1233, including the provider directory information specified in 42 C.F.R. § 438.10(h)(1) and (2). More detailed information regarding the federal compliance requirements can be found in the CMS Interoperability and Patient Access Final Rule in the May 1, 2020 issue of the Federal Register (85 FR 25510-01). Additional guidance can also be found in the 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program in the May 1, 2020 issue of the Federal Register.

2.3.38.1 PAYER-TO-PAYER DATA EXCHANGE

Effective January 1, 2022, the Dental Contractor must comply with an individual's request to have the individual's health data transferred from payer to payer.

The rule finalizes the requirements in 42 C.F.R. § 438.62(b)(1)(vi) and (vii) for the creation of a process for the electronic exchange of, at a minimum, the data classes and elements included in the United States Core Data for Interoperability (USCDI) content standard adopted at 45 C.F.R. § 170.213.

2.3.39 MATERIAL SUBCONTRACTORS

The Dental Contractor or its designee will conduct routine monitoring of each Material Subcontractor that is also a delegated entity or a third-party administrator, in accordance with its assessed risk process, to ensure compliance with the performance of all delegated functions. The Dental Contractor must maintain a monitoring plan for each Material Subcontractor that is also a delegated entity or a third-party administrator.

The Dental Contractor must maintain documentation as to the compliance of the Material Subcontractor with all requirements defined in the monitoring plan. This documentation must contain evidence that all appropriate and necessary actions were taken to correct any noncompliance.

The Dental Contractor must allow HHSC to attend meetings between the Dental Contractor and its Material Subcontractors and/or to receive the minutes from these meetings upon request. Upon request, the Dental Contractor must provide a final report of the routine monitoring results

2.4 PERFORMANCE INCENTIVES AND DISINCENTIVES

This section documents performance incentives and disincentives related to HHSC's value-based purchasing approach. For further information, refer to **ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS.**

The Dental Contractor must provide the Services and Deliverables, including Medically Necessary Covered Dental Services to enrolled Dental Members, in order for monthly Capitation Payments to be paid by HHSC.

Refer to **Article 9 of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS** for information concerning Capitation Rate development and for information and requirements on the:

1. Time and manner of payment (**Section 9.02**),
2. Adjustments to capitation payments (**Section 9.07**), and
3. Experience Rebate (**Section 9.08**).

Incentives and disincentives are subject to change by HHSC over the course of the Contract. The methodologies required to implement these strategies will be refined by HHSC after collaboration with contracting Dental Contractor. The Dental Contractor is prohibited from passing down financial disincentives or sanctions imposed on the Dental Contractor to Dental Providers, except on an individual basis and related to the individual Provider's inadequate performance.

2.4.1 NON-FINANCIAL INCENTIVES AND DISINCENTIVES

HHSC will distribute information on key performance indicators to Dental Contractor on a regular basis, identifying a Dental Contractor's performance, and comparing that performance to other Dental Contractors, and HHSC standards or external Benchmarks. HHSC may recognize the Dental Contractor that attains superior performance or improvement. HHSC may post its final determination regarding poor or exceptional Dental Contractor peer group performance comparisons on its website.

2.4.1.1 PERFORMANCE INDICATOR DASHBOARD FOR QUALITY MEASURES

HHSC will track key indicators of Dental Contractor performance through the use of a performance indicator dashboard for quality measures, described in **Chapter 10 of the UMCM**. HHSC will compile the performance indicator dashboard based on Dental Contractor submissions, data from the EQRO, and other data available to HHSC. The performance indicator dashboard is not an all-inclusive set of performance measures; HHSC will measure other aspects of the Dental Contractor's performance as well. The performance indicator dashboard assembles performance indicators that assess many of the most important dimensions of the Dental Contractor's performance, and includes measures that when publicly shared, will also serve to incentivize excellence.

2.4.1.2 AUTO-ASSIGNMENT METHODOLOGY FOR MEDICAID DENTAL CONTRACTOR

HHSC may revise its auto-assignment methodology for enrollees who do not select a Dental Contractor based on Dental Contractor performance.

2.4.2 FINANCIAL INCENTIVES AND DISINCENTIVES

Financial Incentives and Disincentives of the Contract are set forth below.

2.4.2.1 DENTAL PAY-FOR-QUALITY

Under the dental pay-for-quality (P4Q) program, HHSC will place each Dental Contractor at risk for a percentage of the capitation payment(s) for performance in a calendar year. HHSC may modify the percentage of the capitation payment placed at risk.

HHSC will pay the Dental Contractor the full monthly capitation payments as described in **Article 9 of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**. At the end of the dental P4Q data collection period, HHSC will evaluate the Dental Contractor's performance and assign points and dollar amounts using the measures and methodology set out in **Chapter 6 of the UMCM**.

Failure to timely provide HHSC with necessary data related to the calculation of the dental P4Q performance indicators will result in HHSC's assignment of a zero percent performance rate for each related performance indicator.

Dental Contractor must report actual capitation payments received on the FSRs during the FSR Reporting Periods that are at risk (i.e., the Dental Contractor will not report Revenues at a level equivalent to, for example, 96% of the payments received, leaving some percentage as contingent). Any subsequent loss of the at-risk amount that may be realized will be reported below the income line as an informational item, and not as an offset to Revenues or as an allowable cost as described in the **Chapter 5 of the UMCM**.

HHSC may modify the methodology and measures of the dental P4Q program as it deems necessary and appropriate, in order to motivate, recognize, and reward Dental Contractor for superior performance.

2.4.3 REMEDIES AND LIQUIDATED DAMAGES

All areas of responsibility and all requirements in the Dental Contract will be subject to performance evaluation by HHSC. HHSC may impose remedies for violations of any and all responsibilities or requirements that the Dental Contractor has not fulfilled. Refer to the Attachment A, "HHSC Dental Contract Terms and Conditions," and Attachment F, "Deliverables/Liquidated Damages Matrix", for performance standards that carry liquidated damage values

2.4.4 FREW INCENTIVES AND DISINCENTIVES

As required by the *Frew v. Smith* "Corrective Action Order: Managed Care," this Contract includes a system of incentives and disincentives associated with Children of Migrant Farm Workers Reports. These incentives and disincentives apply only to Medicaid.

The incentives and disincentives and corresponding methodology are set forth in **Chapter 12 of the UMCM**.

2.4.5 ADDITIONAL INCENTIVES AND DISINCENTIVES

HHSC will evaluate all performance-based incentive and disincentive methodologies annually and in consultation with the Dental Contractor. HHSC may modify the methodologies as needed, or develop additional methodologies, as funds become available, or as mandated by court decree, statute, or rule in order to promote and recognize Dental Contractor's' performance under the Contract. The Dental Contractor must participate in any incentive or disincentive programs or methodologies as determined by HHSC.

2.5 ADDITIONAL CHILDREN'S MEDICAID DENTAL SERVICES SCOPE OF WORK

The following provisions apply only to the Children's Medicaid Dental Members. The Children's Medicaid Dental Members will be referred to as "members" throughout **Section 2.5**.

2.5.1 PROVISIONS RELATED TO MEDICALLY NECESSARY COVERED DENTAL SERVICES FOR CHILDREN'S MEDICAID DENTAL MEMBERS

2.5.1.1 TEXAS HEALTH STEPS (EPSDT) DENTAL CHECKUPS

The Dental Contractor must develop effective methods to ensure that children birth through age 20 receive Texas Health Steps (THSteps) dental services and must arrange for these services for all eligible members, except when a member knowingly and voluntarily declines or refuses services after receiving sufficient information to make an informed decision.

The Dental Contractor must provide dental checkups to its members every 6 months, starting at 6 months of age. Children from 6 through 35 months of age who are participating in the First Dental Home services may be eligible for visits every 3 months, if determined Medically Necessary. Newly enrolled members must receive a dental checkup no later than 90 Days after enrollment. The Dental Contractor must ensure dental checkups are provided in a timely manner to its members.

The Dental Contractor must cooperate and coordinate with the THSteps outreach unit and THSteps regional program staff and agents to ensure prompt delivery of services to all members, but particularly for Farmworker Child(ren) who may transition into and out of the Dental Contractor's Dental Program more rapidly or unpredictably than the general population.

2.5.1.2 TEXAS HEALTH STEPS EDUCATION/OUTREACH

The Dental Contractor must ensure that Members are provided information and educational materials about the dental services available through the THSteps Program, and how and when Members may obtain the services. The information must inform the Members how they can obtain dental benefits, NEMT Services through their managed care organizations

or the Fee-for-Service Medical Transportation Program, and advocacy and assistance from the Dental Contractor. The Dental Contractor must use the standard language describing THSteps services as provided in **Chapter 3 of the UMCM**. Any additions to or deviations from the standard language must be reviewed and approved by HHSC prior to publication and distribution to Members.

Each month, the Dental Contractor must retrieve from the HHSC EB bulletin board system a list of Members who are due for THSteps dental checkups. Using these lists and its own internally generated list, the Dental Contractor must contact such Members to encourage scheduling the service as soon as possible.

The Dental Contractor must cooperate and coordinate with the Texas Health Steps Outreach and Informing Unit to ensure prompt delivery of services to Members who miss dental checkups.

The Dental Contractor must coordinate and cooperate with existing community and school-based health and education programs that offer services to school-aged children in a location that is convenient to the Members. Upon request from a Head Start program, the Dental Contractor must coordinate with the Head Start program to assist Members with scheduling THSteps dental checkups. This coordination should include informing Head Start programs how to request scheduling assistance from the Dental Contractor when a member needs a THSteps dental checkup.

2.5.1.3 TEXAS HEALTH STEPS DATA VALIDATION

The Dental Contractor must require all Providers delivering THSteps services to submit claims for services paid, either on a capitated or fee-for service basis, on the ADA claim form, and use the HIPAA compliant code set required by HHSC.

2.5.1.4 FARMWORKER CHILD(REN)

The Dental Contractor must identify community and statewide groups that work with Farmworker Child(ren) (FWC) in Texas. The Dental Contractor must cooperate and coordinate with as many of these groups as possible and encourage the groups to assist with identification of FWC.

The Dental Contractor must make efforts to reach identified FWC to provide timely THSteps dental checkups and needed follow-up care. Checkups and follow-up care must be in accordance with the timeframes in the Contract for appointment availability.

For purposes of this section, "Accelerated Services" are services that are needed by FWC prior to leaving their home area for work in other states. Accelerated Services include the provision of preventive services that will be due during the time the FWC is out of Texas, as well as treatment services that should not be delayed until after the return to Texas. When necessary, the Dental Contractor must provide Accelerated Services to FWC members. The need for Accelerated Services must be determined on a case-by-case basis and according to the needs of the FWC.

The Dental Contractor must maintain accurate lists of all identified FWC. Additionally, the Dental Contractor must maintain confidentiality of information about the identity of the FWC.

In accordance with **Chapter 12 of the UMCM**, the Dental Contractor must submit an annual report that describes:

1. Methods used to identify FWC enrolled with the Dental Contractor and encourage timely checkups;
2. Efforts to coordinate with community and statewide groups working with FWC;
3. Methods used to assess FWC oral health needs and provide Accelerated Services when necessary;
4. How the Dental Contractor maintains accurate lists of FWC enrolled in the Dental Program; and
5. How the Dental Contractor maintains confidentiality about the identify of FWC.

2.5.1.5 MEDICAID NON-CAPITATED SERVICES

The following Texas Medicaid programs, services, or benefits have been excluded from Medically Necessary Covered Dental Services. Members are eligible to receive these Non-capitated Services on another basis, such as a Fee-for-Service basis, or through a Medical Dental Contractor for most medical services. Dental Contractor should refer to relevant chapters in **ATTACHMENT H, TEXAS MEDICAID PROVIDER PROCEDURES MANUAL** for more information:

1. THSteps environmental lead investigation;
2. Early Childhood Intervention case management/service coordination;
3. Case Management for Children and Pregnant Women;
4. Texas School Health and Related Services;
5. HHSC's Fee-for-Service Medical Transportation Program and NEMT Services; and
6. Emergency Dental Services as described in **Section 2.3.7**.

Members are eligible to receive these Non-capitated Services on a Fee-for-Service basis. Dental Contractor should refer to relevant chapters in the Texas Medicaid Provider Procedures Manual for more information.

2.5.1.6 REFERRALS FOR NON-CAPITATED SERVICES

The Dental Contractor must educate members regarding the availability of Non-capitated Services and provide appropriate referrals for members to obtain or access these services. The Dental Contractor is responsible for informing Providers that bills for Non-capitated Services must be submitted to HHSC's Claims Administrator or Dental Contractor for reimbursement. The Dental Contractor is not responsible for paying for or reimbursing for these services described in 1 Tex. Admin. Code §§ 380.101, *et seq.*, and 25 Tex. Admin. Code §§ 27.1 *et seq.*

2.5.2 PROVIDER COMPLAINTS AND INTERNAL DENTAL CONTRACTOR APPEALS

The following sections outline minimum requirements for the Dental Contractor's Provider Complaints and Internal Appeals process.

2.5.2.1 PROVIDER COMPLAINTS

The Dental Contractor must develop, implement, and maintain a system for tracking and resolving all Provider Complaints. The Dental Contractor must resolve Provider Complaints within 30 Days from the date the Complaint is received by the Dental Contractor. The Dental Contractor's tracking system must include the status and final disposition of each Provider complaint. Dental Contractor must also resolve Provider Complaints received by HHSC in accordance with **Chapter 3 of the UMCM**. The Dental Contractor must provide information specified in 42 C.F.R. § 438.10(g)(2)(xi) about the Complaints and internal Dental Contractor Appeals system to all Providers and Subcontractors at the time they enter into a contract.

2.5.2.2 PROVIDER APPEAL OF DENTAL CONTRACTOR CLAIMS DETERMINATIONS

The Dental Contractor must develop, implement, and maintain a system for tracking and resolving all Provider Internal Appeals related to claims payment, as required by Tex. Gov't Code § 533.005(a)(15). Within this process, the Dental Contractor must respond fully and completely to each Provider's claims payment appeal and establish a tracking mechanism to document the status and final disposition of each Provider's claims payment appeal. In addition, the Dental Contractor's process must comply with the requirements of Tex. Gov't Code § 533.005(a)(19).

The Dental Contractor must contract with dentists who are OON providers to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a Provider appeal. The dentist resolving the dispute must not be an employee of the Dental Contractor's Medicaid or CHIP business but may be an employee in the Dental Contractor's commercial lines of business. The determination of the dentist resolving the dispute must be binding on the Dental Contractor and the Provider. The dentists resolving the dispute must be licensed in the State of Texas and hold the same specialty or a related specialty as the appealing Provider. HHSC may amend this process to include an independent review process established by HHSC for final determination on these disputes.

2.5.3 MEMBER RIGHTS AND RESPONSIBILITIES

In accordance with 42 C.F.R. § 438.100, all Dental Contractor must maintain written policies and procedures for informing members of their rights and responsibilities and must notify their members of their right to request a copy of these rights and responsibilities.

The Member Handbook must include notification of member rights and responsibilities, as set forth in **the UMCM**.

2.5.4 MEMBER COMPLAINTS AND INTERNAL APPEALS SYSTEM

The Dental Contractor must develop, implement, and maintain a Member Complaints and Internal Appeals system for tracking, resolving, and reporting member's Complaints regarding its services, processes, procedures, and staff and for tracking, resolving, and reporting Member Internal Appeals regarding the denial or limited authorization of a requested service, including the type or level of service and the denial, in whole or in part, of payment for service that complies with the requirements in applicable federal and state laws and regulations, including 42 C.F.R. § 431.200, 42 C.F.R. Part 438, Subpart F and the provisions of 1 Tex. Admin. Code Chapter 357 relating to Medicaid managed care organizations. The Dental Contractor must not identify a member Complaint as any form of inquiry or request. The Dental Contractor must acknowledge the Member's Complaint, in writing, within five Business Days after the Dental Contractor receives the Complaint unless the complaint is an Initial Contact Complaint. As the Texas Department of Insurance does not require the reporting of those issues to TDI (see 28 Tex. Admin. Code §3.9202(2)), the Dental Contractor must report this subcategory of Complaints to HHSC as "Initial Contact Complaint."

The Dental Contractor must ensure that member Complaints are resolved within 30 Days after receipt. The State will refer member Complaints that it receives regarding the Dental Contractor to the Dental Contractor for resolution.

Dental Contractor also must resolve Member Complaints received by HHSC no later than the due date indicated on HHSC's notification form. HHSC will provide Dental Contractor up to ten Business Days to resolve such Complaints, depending on the severity or urgency of the Complaint and no more than the maximum Days allowed as stated in **Chapter 3 of the UMCM** unless an extension has been granted. Dental Contractor must provide a valid reason for the extension request prior to the due date and the request must include requirements in **Chapter 3 of the UMCM**. HHSC may, in its discretion, grant a written extension if the Dental Contractor demonstrates good cause.

The Complaints and Appeals system must include a Complaints process, an Appeals process, and access to HHSC's State Fair Hearing System. The procedures must be the same for all members and must be reviewed and approved in writing by HHSC. Modifications and amendments to the Member Complaint and Internal Dental Contractor Appeal system must be submitted for HHSC's approval at least 30 Days prior to their implementation.

The Dental Contractor must ensure that standard and expedited Member Internal Appeals are resolved within the specified timeframes, unless the Dental Contractor can document that the member requested an extension, or the Dental Contractor shows there is a need for additional information and the delay is in the member's interest. The Dental Contractor must respond fully and completely to each Internal Appeal and establish a tracking mechanism to document the status and final disposition of each Internal Appeal.

2.5.4.1 MEMBER ADVOCATES

The Dental Contractor must provide Member Advocates to assist members. Member Advocates must be physically located within the state unless an exception is approved by HHSC. Member Advocates must inform members of the following:

1. Their rights and responsibilities;
2. The Complaints process;
3. The Appeals process;
4. Available Medically Necessary Covered Dental Services, including preventive services; and
5. Available Non-capitated Services.

Member Advocates must assist members in writing Complaints and are responsible for monitoring the Complaint through the Dental Contractor's Complaints process.

Member Advocates are responsible for making recommendations to the Dental Contractor's management on any changes needed to improve either the dental services provided, or the way dental services are delivered. Member Advocates are also responsible for helping or referring members to community resources available to meet member needs that are not available from the Dental Contractor as Medically Necessary Covered Dental Services.

2.5.4.2 DENTAL CONTRACTOR MEMBER COMPLAINTS PROCESS

For purposes of this section, an "authorized representative" is any person or entity acting on behalf of the member and with the member's written consent. A Provider may be an authorized representative.

The member or member's authorized representative may file a Complaint either orally or in writing. The Dental Contractor must also inform members how to file a Complaint directly with HHSC, once the member has exhausted the Dental Contractor's Complaints process.

The Dental Contractor must designate an officer of the Dental Contractor who has primary responsibility for ensuring that Complaints are resolved in compliance with written policy and within the required timeframe. For purposes of this section, an "officer" of the Dental Contractor means a president, vice president, secretary, treasurer, or chairperson of the board for a corporation, the sole proprietor, the managing general partner of a partnership, or a person having similar executive authority in the organization.

The Dental Contractor must have a routine process to detect patterns of Complaints. Dental Contractor's management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Complaints.

The Dental Contractor's Complaints process must be provided to members in writing and through oral interpretive services. A written description of the Dental Contractor's Complaints process must be available in Prevalent Languages identified by HHSC, at no

more than a 6th grade reading level. The Dental Contractor must provide such oral interpretive service to callers free of charge.

The Dental Contractor must include a written description of the Complaints process in the Member Handbook. The Dental Contractor must maintain and publish in the Member Handbook, at least one toll-free telephone number with Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capabilities for making Complaints.

The Dental Contractor's process must require that every Complaint received in person, by telephone, or in writing must be acknowledged and recorded in a written record and logged with the following details:

1. A description of the reason for the member's Complaint;
2. The date received;
3. The date of each review or, if applicable, review meeting;
4. Resolution at each level of the member's Complaint if applicable;
5. Date of resolution at each level, if applicable; and
6. Name of the member for whom the Complaint was filed.

The records must be accurately maintained in a manner accessible to HHSC and available upon request to CMS.

For Complaints that are received in person or by telephone, the Dental Contractor must provide members or their representatives with written notice of resolution, if the Complaint cannot be resolved within one working day of receipt.

The Dental Contractor is prohibited from discriminating or taking punitive action against a member or his or her representative for making a Complaint.

If a member makes a request for disenrollment from a Dental Contractor and wants to select a different Dental Contractor, or if a member is voluntarily enrolled in the Dental Program and would like to disenroll, the Dental Contractor must give the member information on the disenrollment process and direct the member to the EB. If the member is enrolled in the Dental Program on a mandatory basis and requests disenrollment, the Dental Contractor must direct the member to the HHSC Ombudsman. If the request for disenrollment includes a Complaint by the member, the Complaint will be processed separately from the disenrollment request, through the Complaint process.

The Dental Contractor will cooperate with HHSC to resolve all member Complaints. Such cooperation may include, but is not limited to, providing information or assistance to HHSC.

The Dental Contractor must provide designated Member Advocates, as described in **Section 2.5.4.1**, to assist members in understanding and using the Dental Contractor's Complaints process. The Dental Contractor's Member Advocates must assist members in writing or filing a Complaint and monitoring the Complaint through the Dental Contractor's Complaints process until the issue is resolved.

2.5.4.3 MEDICAID DENTAL CONTRACTOR'S INTERNAL APPEALS PROCESS

The Dental Contractor must develop, implement, and maintain an Internal Appeals process that complies with state and federal laws and regulations, including 42 C.F.R. § 431.200 and 42 C.F.R. Part 438, Subpart F. An Appeal is a disagreement with a Dental Contractor Adverse Benefit Determination as further defined in **ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS**. The Internal Appeals process must be the same for all members. When a member or his or her authorized representative, LAR, or guardian expresses orally or in writing any dissatisfaction or disagreement with an Adverse Benefit Determination, the Dental Contractor must regard the expression of dissatisfaction as a request to Appeal an Action.

Texas Medicaid is using the External Medical Review process provided in 42 C.F.R. 438.408(f)(1)(ii). Medicaid Dental Contracts are still expected to comply with the other applicable requirements of the Texas Insurance Code, including Chapter 4201.

The Dental Contractor must have policies and procedures in place outlining the Dental Director's role in an Appeal of an Action. The Dental Director must have a significant role in monitoring, investigating, and hearing Appeals. In accordance with 42 C.F.R. § 438.406, the Dental Contractor's policies and procedures must require that individuals who make decisions on Appeals are not involved in any previous level of review or decision-making, and are dental care professionals who have the appropriate dental expertise in treating the member's dental condition or disease.

The Dental Contractor must provide designated Member Advocates, as described in **Section 2.5.4.1**, to assist members in understanding and using the Internal Appeals process. The Dental Contractor's Member Advocates must assist members in writing or filing an Appeal and monitoring the Appeal through the process until the issue is resolved.

The Dental Contractor must have a routine process to detect patterns of Internal Appeals. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Internal Appeals.

The Dental Contractor's Internal Appeals process must be provided to members in writing and through oral interpretive services. A written description of the Internal Appeals process must be available in Prevalent Languages identified by HHSC, at no more than a 6th grade reading level. The Dental Contractor must include a written description of the Appeals process in the Member Handbook. The Dental Contractor must maintain and publish in the Member Handbook at least one toll-free telephone number with TTY/TDD and interpreter capabilities for requesting an Internal Appeal. The Dental Contractor must provide such oral interpretive service to callers free of charge.

The Dental Contractor's process must treat every oral request for a Dental Contractor Internal Appeal in the same manner as a written request. The date of the oral request should be treated as the filing date of the request. All Dental Contractor's Internal Appeals must be recorded in a written record and logged with the following details:

1. A general description of the reason for the member's Internal Appeal.
2. The date received.

3. The date of each review or, if applicable, review meeting.
4. Resolution at each level of the member's Internal appeal, if applicable.
5. Date of resolution at each level, if applicable.
6. Name of the covered person from whom the Internal Appeal was filed.

The record must be accurately maintained in a manner accessible to the HHSC and available upon request to CMS.

A member must file a request for a Dental Contractor Internal Appeal within 60 Days from receipt of the notice of the Adverse Benefit Determination. To ensure continuation of currently authorized services, the member must file the Internal Appeal on or before the later of:

1. Ten Days following the Dental Contractor's sending of the notice of the Adverse Benefit Determination, or
2. The intended effective date of the proposed Adverse Benefit Determination.

The Dental Contractor must send a letter to the member within five Business Days acknowledging receipt of the Internal Appeal request. Except for the resolution of an Expedited Dental Contractor Internal Appeal as provided in **Section 2.5.4.4**, the Dental Contractor must complete the entire Internal Appeal process within 30 Days after receipt of the initial written or oral request for Appeal. The timeframe for an Internal Appeal may be extended up to 14 Days if the member or his or her representative requests an extension; or the Dental Contractor shows that there is a need for additional information and how the delay is in the member's interest. If the timeframe is extended, the Dental Contractor must give the member written notice of the reason for delay, if the member had not requested the delay. The Dental Contractor must designate an officer who has primary responsibility for ensuring that Internal Appeals are resolved within these timeframes and in accordance with the Dental Contractor's written policies.

During the Internal Appeals process, the Dental Contractor must provide the member a reasonable opportunity to present evidence and any allegations of fact or law, in person, as well as, in writing. The Dental Contractor must inform the member of the time available for providing this information and in the case of an expedited resolution, that a limited time will be available.

The Dental Contractor must provide the member and his or her representative opportunity, before and during the Internal Appeals process, to examine the member's case file, including dental records and any other documents considered during the Appeal process. The Dental Contractor must include, as parties to the Appeal, the member and his or her representative or the legal representative of a deceased member's estate.

In accordance with 42 C.F.R. § 438.420, the Medicaid Dental Contractor must continue the benefits currently being received by the member, including the benefit that is the subject of the Appeal, if all of the following criteria are met:

1. The member or his or her representative files the Appeal timely as defined in the Contract;

2. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
3. The services were ordered by an authorized Provider;
4. The original period covered by the original authorization has not expired; and
5. The member requests an extension of the benefits.

If, at the member's request, the Medicaid Dental Contractor continues or reinstates the member's benefits while the Appeal is pending, the benefits must be continued until one of the following occurs:

1. The member withdraws the Appeal or request for a State Fair Hearing;
2. Ten Days pass after the Dental Contractor mails the notice resolving the Appeal against the member, unless the member, within the ten-day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision can be reached; or
3. A State Fair Hearing officer issues a hearing decision adverse to the member, or the time period or service limits of a previously authorized service have been met.

In accordance with state and federal regulations, if the final resolution of the Internal Appeal is adverse to the member and upholds the Dental Contractor's Action, then, to the extent that the services were furnished to comply with the Contract, the Dental Contractor must not recover such costs from the member without written permission from HHSC.

If the Dental Contractor, Independent Review Organization (IRO), or State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the Internal Appeal was pending, the Dental Contractor must authorize or provide the disputed services as expeditiously as the member's health condition requires; but no later than 72 hours from the date it receives notice reversing the determination.

If the Dental Contractor, IRO, or State Fair Hearing Officer reverses a decision to deny authorization of services and the member received the disputed services while the Internal Appeal was pending, the Dental Contractor is responsible for the payment of services.

The Dental Contractor is prohibited from discriminating or taking punitive action against a member or his or her representative for making an Internal Appeal and is subject to corrective action or remedies for any action against a member or their LAR, guardian, or authorized representative for making an Internal Appeal.

2.5.4.4 EXPEDITED MEDICAID DENTAL CONTRACTOR'S INTERNAL APPEALS PROCESS

In accordance with 42 C.F.R. § 438.410, the Dental Contractor must establish and maintain an expedited review process for Internal Appeals, when the Dental Contractor determines (for a request from a member) or the Provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain or regain maximum function. The Dental Contractor must follow

all Internal Appeals requirements as set forth in **Section 2.5.4.3**, except where differences are specifically noted in this section.

The Dental Contractor must accept oral or written requests for Expedited Internal Appeals. A Dental Contractor must provide access to the member's case file free of charge and sufficiently in advance of the timeframe for the Expedited Internal Appeal.

Members must exhaust the Expedited Internal Appeal process before making a request for an expedited State Fair Hearing/EMR. After the Dental Contractor receives the request for an Expedited Internal Appeal, it must hear an approved request for a member to have such an appeal and notify the member of the outcome within 72 hours.

The timeframe for notifying the member of the outcome may be extended up to 14 Days, if the member requests an extension or the Dental Contractor shows, to the satisfaction of HHSC, upon HHSC's request, that there is a need for additional information and how the delay is in the member's interest. If the timeframe is extended, the Dental Contractor must give the member written notice of the reason for delay, if the member had not requested the delay.

If the decision is adverse to the member, the Dental Contractor must follow the procedures relating to the notice in **Section 2.5.4.5.1**. The Dental Contractor is responsible for notifying the member of his or her right to access an EMR and/or an expedited State Fair Hearing from HHSC. The Dental Contractor will be responsible for providing documentation to HHSC and the member, indicating how the decision was made, prior to HHSC's expedited State Fair Hearing.

The Dental Contractor is prohibited from discriminating or taking punitive action against a member or his or her representative for requesting an Expedited Internal Appeal. The Dental Contractor must ensure that punitive action is not taken against a Provider who requests an Expedited Internal Appeal or supports a member's request. The Dental Contractor is subject to corrective action or remedies for any action against a member, their authorized representative, LAR, guardian or a Provider for making an Expedited Internal Appeal.

If the Dental Contractor denies a request for expedited resolution of an Appeal, it must:

1. Transfer the Appeal to the timeframe for standard resolution, and
2. Make a reasonable effort to give the member prompt oral notice of the denial and follow up within two Days with a written notice.

2.5.4.5 Access to State Fair Hearing and External Medical Review for Medicaid Members

The Dental Contractor must inform members that they have the right to access the State Fair Hearing process, with or without an External Medical Review (EMR), only after exhausting its Internal Appeal process. The Member may request an EMR and/or State Fair Hearing if the Dental Contractor fails to respond to the Member's Appeal within the timeframe in 42 C.F.R. § 438.408. The Dental Contractor must notify Members that they may be represented by an authorized representative in the State Fair Hearing process. The

Dental Contractor must notify members that they may be represented by an authorized representative, LAR, or guardian in the State Fair Hearing process.

The EMR is an optional, extra step a Member may request to further review the Dental Contractor's Adverse Benefit Determination. The EMR will not consider new evidence. The Dental Contractor must provide the IRO the same set of records the Dental Contractor reviewed to determine service denial. EMRs will be conducted by Independent Review Organizations (IROs) contracted by HHSC. The role of the IRO is to act as an objective arbiter and decide whether the Dental Contractor's original Adverse Benefit Determination must be reversed or affirmed. The EMR will take place between the Dental Contractor Internal Appeal and the State Fair Hearing. The Dental Contractor is responsible for implementing the IRO EMR decisions of "overturned" or "partially overturned" within 72 hours of receiving the EMR decision from the IRO.

If a member requests a State Fair Hearing, the Dental Contractor will complete and submit the request via facsimile to the appropriate State Fair Hearings office, within five Days of the member's request for the hearing. If the Member requests an EMR, the Dental Contractor will enter the request into TIERS, along with MCO Internal Appeal decision supporting documentation, and submit the request via TIERS to the HHSC Intake Team within three Days of the Member's request for EMR.

Within five Days of notification that the State Fair Hearing is set, the Dental Contractor will prepare an evidence packet for submission to the HHSC Fair Hearings staff and send a copy of the packet to the member. The evidence packet must comply with HHSC's State Fair Hearings requirements.

The Dental Contractor must ensure that the appropriate staff members who have firsthand knowledge of the member's Appeal, in order to be able to speak and provide relevant information on the case, attend all scheduled State Fair Hearings.

2.5.4.5.1 INDEPENDENT REVIEW ORGANIZATION (IRO) REIMBURSEMENT FOR EXTERNAL MEDICAL REVIEWS (EMRS)

The Dental Contractor is responsible for all IRO costs for EMRs related to Adverse Benefit Determinations of medical necessity. The Dental Contractor must reimburse HHSC for such costs within the timeframes specified by HHSC. The Dental Contractor must not pass any IRO-related costs on to providers or Members.

The Dental Contractor will reimburse the, HHSC at a rate calculated by HHSC, for an EMR HHSC assigns to the IRO which the Member subsequently withdraws prior to or on the 10-Day due date of the IRO EMR decision.

Dental Contractor will pay the IRO $300.00 if the Member withdraws a non-expedited EMR request within five Calendar Days from the date the IRO receives notice of the EMR request, provided the IRO has not rendered an EMR decision.

2.5.4.6 NOTICES OF ADVERSE BENEFIT DETERMINATION AND DISPOSITION OF INTERNAL DENTAL CONTRACTOR APPEALS FOR MEDICAID MEMBERS

The Dental Contractor must notify the member, in accordance with 1 Tex. Admin. Code Chapter 357, whenever the Dental Contractor takes an Adverse Benefit Determination. The notice must, at a minimum, include:

1. The dates, types, and amount of service requested;
2. The Adverse Benefit Determination the Dental Contractor has taken or intends to take;
3. The reasons for the Adverse Benefit Determination. If the Adverse Benefit Determination taken is based upon a determination that the requested service is not Medically Necessary, the Dental Contractor must provide an explanation of the medical basis for the decision, application of policy or accepted standards of dental practice to the individual's oral health condition, in its notice to the member;
4. The member's right to access the Dental Contractor's Internal Appeal process;
5. The procedures by which the member may Appeal the Dental Contractor's Action;
6. The circumstances under which expedited resolution is available and how to request it;
7. The circumstances under which a member may continue to receive benefits pending resolution of the Internal Appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services;
8. The date the Adverse Benefit Determination will be taken;
9. A reference to the Dental Contractor policies and procedures supporting the Dental Contractor's Action;
10. An address where written requests may be sent and a toll-free number that the member can call to request the assistance of a member representative, file an Internal Appeal, or request a State Fair Hearing;
11. An explanation that members may represent themselves, or be represented by a Provider, a friend, a relative, legal counsel, or another spokesperson;
12. A statement that if the member wants a State Fair Hearing on the Action, the member must make the request for a State Fair Hearing within 120 Days of the date on the notice or the right to request a hearing is waived;
13. A statement explaining that the Dental Contractor must make its decision within 30 Days from the date the Internal Appeal is received by the Dental Contractor, or 72 hours in the case of an Expedited Internal Appeal; and
14. A statement explaining that the hearing officer must make a final decision within 90 Days from the date a State Fair Hearing is requested.

Note to Respondents. The above services may not have been incorporated into the UMCM at the time this Contract was awarded. In the event they have not been, such services will be as part of the current HHSC UMCM change process. The Contract will be amended appropriately at that time.

2.5.4.7 TIMEFRAME FOR NOTICE OF ACTION

In accordance with 42 C.F.R. § 438.404(c), the Dental Contractor must mail a notice of Adverse Benefit Determination within the following timeframes:

1. For termination, suspension, or reduction of previously authorized Medicaid-Covered Dental Services, at least 15 Business Days before the termination, suspension, or reduction of previously authorized services, or within the timeframes specified in 42 C.F.R. §§ 431.211, 431.213, and 431.214;
2. For denial of payment, at the time of Adverse Benefit Determination affecting the claim;
3. For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R. § 438.210(d)(1);
4. If the Dental Contractor extends the timeframe in accordance with 42 C.F.R. § 438.210(d)(1), it must:
    a. Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file an Internal Appeal if he or she disagrees with that decision; and
    b. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires;
5. For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d), which constitutes a denial and is thus an Adverse Benefit Determination, on the date that the timeframes expire; and
6. For expedited service authorization decisions, within the timeframes specified in 42 C.F.R. § 438.210(d): and
7. All timeframes required in **Chapter 3.21 of the UMCM**.

2.5.4.8 NOTICE OF DISPOSITION OF INTERNAL APPEAL

In accordance with 42 C.F.R. § 438.408(e), the Dental Contractor must provide written notice of disposition of all Internal Appeals, including Expedited Internal Appeals. The written resolution notice must be sent to the member and legal representative acting on behalf of the member and must include the results and date of resolution. For decisions not wholly in the member's favor, the notice must contain:

1. The right to request a State Fair Hearing/EMR;
2. How to request a State Fair Hearing/EMR;
3. The circumstances under which the member may continue to receive benefits pending a State Fair Hearing/EMR;
4. How to request the continuation of benefits;
5. If the Dental Contractor's Adverse Benefit Determination is upheld in a State Fair Hearing, the member may be liable for the cost of any services furnished to the member while the Internal Appeal is pending; and

Any other information required by 1 Tex. Admin. Code Chapter 357 that relates to a managed care organization's notice of disposition of an Internal Appeal.

2.5.4.9 Timeframe for Notice of Resolution of Appeals

In accordance with 42 C.F.R. § 438.408, the Dental Contractor must provide written notice of resolution of Appeals, including Expedited Dental Contractor Appeals, as expeditiously as the Member's health condition requires, but the notice must not exceed the timelines provided in this section for Appeals or Expedited Dental Contractor Appeals. For expedited resolution of Appeals, the Dental Contractor must make reasonable efforts to give the Member prompt oral notice of resolution of the Appeal and follow up with a written notice within the timeframes set forth in this section. If the Dental Contractor denies a request for expedited resolution of an Appeal, the Dental Contractor must transfer the Appeal to the timeframe for resolution as provided in this section, and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two Days with a written notice.

2.5.5 THIRD PARTY LIABILITY, RECOVERY, AND COORDINATION OF BENEFITS

Medicaid is the payer of last resort for Covered Dental Services when coordinating benefits with all other insurance coverage, unless an exception applies under federal or state law. Coverage provided under Medicaid will pay benefits for Medically Necessary Covered Dental Services that remain unpaid after all other insurance coverage has been paid. For Network Providers and OON providers with written reimbursement arrangements with the Dental Contractor, the Dental Contractor must pay the unpaid balance for Medically Necessary Covered Dental Services up to the agreed rates. For OON providers with no written reimbursement arrangement, the Dental Contractor must pay the unpaid balance for Medically Necessary Covered Dental Services in accordance with HHSC's administrative rules regarding OON payment. 1 Tex. Admin. Code § 353.4

The Dental Contractor has 120 Days from the date of adjudication of a claim that is subject to TPR to attempt recovery of the costs for services that should have been paid through a third party. The Dental Contractor must obtain recovery of payment from a liable third party and not from the provider, unless the provider received payment from both the Dental Contractor and the liable third party. The Dental Contractor must provide HHSC, on a monthly basis, by the tenth Day of each month, a report indicating the claims where the Dental Contractor has billed or made a recovery up to the 120th Day from adjudication of a claim that is subject to TPR.

The Dental Contractor must establish and document a plan and process, referred to as the Third Party Liability (TPL) Dental Contractor Action Plan, in accordance with UMCM Chapter 5, for avoiding and recovering costs for services that should have been paid through a third party, including health insurers, self-insured plans, group health plans, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1166(1), service benefit plans, managed care organizations, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a dental care item or service.

The TPL Dental Contractor Action Plan and process must be in accordance with state and federal law and regulations, including Sections 1902(a)(25)(E) and (F) of the Social Security Act, which require Dental Contractors to first pay and later seek recovery from liable third parties:

1. For preventive pediatric care, and
2. Services provided to an individual on whose behalf child support enforcement is being carried out by the State agency under Part D of title IV of the Social Security Act.

Each Dental Contractor must submit the TPL Dental Contractor Action Plan to the Office of Inspector General-Third Party Recoveries (OIG-TPR), in accordance with UMCM Chapter 5, no later than September 1 for the upcoming state fiscal year for review and approval. Dental Contractors must submit any change requests to the TPL Dental Contractor Action Plan for review and approval no later than 90 Days prior to the date of the proposed changes. The projected amount of TPR that the Dental Contractors is expected to recover may be factored into the rate setting process.

HHSC will provide the Dental Contractor, by plan code, a daily member file, also known as a TPR Client Insurance File, which is an extract of those Dental Members who are known to have other insurance. The file contains any Third Party Recovery (TPR) data that HHSC's claims administrator has on file for individual Dental Members, organized by name and Dental Member number, and adding additional relevant information where available, such as the insured's name and contact information, type of coverage, the insurance carrier, and the effective dates. The file will be considered the system of record. The Dental Contractor is required to continue to share other insurance information for its enrolled Dental Members with HHSC that differs or is not included on the TPR Client Insurance File, in accordance with **Chapter 5 of the UMCM**, per the current process of submitting the TPR Dental Contractor Referral Form found in the **Chapter 5 of the UMCM**.

The Dental Contractor must provide financial reports to HHSC, as stated in Section 2.3.28.2.2, "Financial Reporting Requirements" in accordance with UMCM Chapter 5.

The Dental Contractor must provide all TPR reports to OIG-TPR at the frequency stated in and in accordance with **Chapter 5 of the UMCM**.

After 120 Days, HHSC will attempt recovery for any claims in which the Dental Contractor did not attempt recovery and will retain, in full, all funds received as a result of the HHSC-initiated TPR. The Dental Contractor is precluded from attempting to bill for any recovery after 120 Days from the claim adjudication date. Any collections by the Dental Contractor billed after 120 Days from claim adjudication date must be sent to OIG-TPR in the format prescribed in **Chapter 5 of the UMCM**. The Dental Contractor is to continue to cost avoid and cost recover where applicable.

After 365 Days from adjudication of a claim, the Dental Contractor loses all rights to pursue or collect any recoveries subject to TPR. HHSC has sole authority for recoveries of any claim subject to TPR after 365 Days from the date of adjudication of a claim. Should the

Dental Contractor receive payment on a HHSC-initiated recovery, the Dental Contractor must send the payment to the OIG-TPR in the format prescribed in **Chapter 5 of the UMCM**.

HHSC retains the responsibility to pursue, collect, and retain recoveries of all resources and insurances other than health insurance wherein payments have been made on behalf of a Dental Member. These resources and other insurances include, but are not limited to: casualty insurance, liability insurance, estates, child support, and personal injury claims. The Dental Contractor must pay valid claims for Covered Dental Services provided to Dental Members who have, or may have, resources and insurances other than health insurance. Since HHSC retains the right of recovery for such resources and insurances other than health insurance, the Dental Contractor is not permitted to cost avoid or seek recovery for such items. Should the Dental Contractor receive payment on a claim in which resources or insurances other than health insurance are utilized, the Dental Contractor must send the payment to OIG-TPR in the format prescribed in **Chapter 5 of the UMCM**. Dental Members with these other resources shall remain enrolled with the Dental Contractor.

2.6 SSI MEMBERS

A Member's SSI status is effective the date the State's eligibility system identifies the Member as Type Program 13 (TP13). HHSC is responsible for updating the State's eligibility system within 45 Days of official notice of the Member's SSI eligibility by the Social Security Administration. For CHIP Dental Program Members identified as TP13, when HHSC has updated the State's eligibility system, following standard eligibility cut-off rules, HHSC will allow the CHIP Member to prospectively move to the Medicaid Dental Program. HHSC will not retroactively disenroll a Dental Member from the CHIP Dental Program.

2.7 ADDITIONAL CHIP SCOPE OF WORK

Dental Contractor must not avoid costs for Covered Services by referring Members to publicly funded health care resources.

The provisions in 2.7 only apply to CHIP.

2.7.1 CHIP PROVIDER COMPLAINT AND INTERNAL DENTAL CONTRACTOR APPEALS

CHIP Provider Complaints and claims payment appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. The Dental Contractor must resolve Provider complaints and claims payment appeals within 30 Days from the date of receipt.

2.7.2 COMPLAINTS FROM PROVIDERS

The Dental Contractor must develop, implement, and maintain a system for tracking and resolving all Provider Complaints. The Dental Contractor must respond fully and completely to each Complaint and establish a tracking mechanism to document the status and final disposition of each Provider Complaint that is received.

Dental Contractor must resolve Provider Complaints received by HHSC by the due date indicated on HHSC's notification form, but no later than ten Business Days from receipt of Complaint from HHSC. If a Dental Contractor cannot resolve a complaint by the due date indicated on the notification form, it must submit a written request to HHSC to extend the deadline. HHSC may grant a written extension if the Dental Contractor demonstrates good cause for an extension in its written request.

2.7.3 APPEAL OF PROVIDER CLAIMS

The Dental Contractor must develop, implement, and maintain a system for tracking and resolving all Appeals from Providers and OON providers related to claims payment. Within this process, the Dental Contractor must respond fully and completely to each provider's claims payment appeal. The Dental Contractor must establish a tracking mechanism to document the status and final disposition of each Provider's claims payment appeal. The Dental Contractor must finalize all claims, including appealed claims, within 24 months of the date of service.

2.7.4 CHIP MEMBER COMPLAINTS AND APPEALS PROCESSES

CHIP Member Complaints and Appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. HHSC will require the Dental Contractor to resolve Complaints and Appeals that are not elevated to TDI within 30 Days from the date the Complaint or Appeal is received unless the Dental Contractor can document that the CHIP Dental Member requested an extension, or the Dental Contractor demonstrates to HHSC there is a need for additional information and the delay is in the CHIP Dental Member's interest. If the Dental Contractor extends the timeframes not at the request of the CHIP Dental Member, it must make reasonable efforts to give the Member prompt oral notice of the delay; within two Days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file an appeal if the Dental Member disagrees with that decision; and resolve the appeal as expeditiously as the Dental Member's health condition requires and no later than the date the extension expires. Any person, including those dissatisfied with a Dental Contractor's resolution of a CHIP Dental Member's Complaint or Appeal, may report an alleged violation to TDI.

2.7.5 THIRD PARTY LIABILITY AND RECOVERY AND COORDINATION OF BENEFITS

CHIP is the payer of last resort for Covered Dental Services when coordinating benefits with all other insurance coverage, unless an exception applies under federal law. Coverage provided under CHIP will pay benefits for Medically Necessary Covered Dental Services that remain unpaid after all other insurance coverage has been paid. For Network Providers and Out-of-Network providers with written reimbursement arrangements with the Dental Contractor, the Dental Contractor must pay the unpaid balance for Covered Dental Services up to the agreed CHIP rates. For Out-of-Network providers with no written reimbursement arrangement, the Dental Contractor must pay the unpaid balance for Covered Dental Services in accordance with 1 Tex. Admin. Code §353.4 regarding Out-of-Network payment.

The Dental Contractor is responsible for establishing and documenting a plan and process, referred to as the Third Party Liability (TPL) Dental Contractor Action Plan, in accordance with **Chapter 5 of the UMCM**, for avoiding and recovering costs for services that should have been paid through a third party in accordance with applicable state and federal laws, rules, and regulations (including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service).

The TPL Dental Contractor Action Plan and process must be in accordance with state and federal laws and regulations, including Sections 1902(a)(25)(E) and (F) of the Social Security Act, which require Dental Contractors to first pay and later seek recovery from liable third parties for (1) preventive pediatric care, and (2) services provided to a Dental Member on whose behalf child support enforcement action is being carried out by the State agency under Part D of title IV of the Social Security Act. Each Dental Contractor must submit the TPL Dental Contractor Action Plan to the Office of Inspector General, Third Party Recoveries (OIG-TPR), in accordance with **Chapter 5 of the UMCM**, no later than September 1 for the upcoming state fiscal year for review and approval. Dental Contractors must submit any change requests to the TPL Dental Contractor Action Plan for review and approval no later than 90 calendar Days prior to the date of the proposed changes.

The projected amount of TPR that the Dental Contractor is expected to recover may be factored into the rate setting process.

The Dental Contractor must provide financial reports that include TPR data to HHSC, as stated in Section 2.3.28.2.2, Financial Reporting Requirements.

The Dental Contractor must provide all TPR reports to Office of Inspector General-Third Party Recoveries (OIG-TPR) at the frequency and in accordance with the **Chapter 5 of the UMCM**.

The Dental Contractor has 120 Days from the date of adjudication of a claim that is subject to TPR to attempt recovery of the costs for services that should have been paid through a third party. The Dental Contractor must obtain recovery of payment from a liable third party and not from the provider, unless the provider received payment from both the Dental Contractor and the liable third party. The Dental Contractor shall provide to HHSC, on a monthly basis by the tenth Day of each month, a report indicating the claims where the Dental Contractor has billed and made a recovery up to the 120th Day from adjudication of a claim that is subject to TPR. After 120 Days, HHSC will attempt recovery for any claims in which the Dental Contractor did not attempt recovery and will retain, in full, all funds received as a result of the any state-initiated TPR. The Dental Contractor is precluded from attempting to bill for any recovery after 120 Days from claim adjudication date. Any collections by the Dental Contractor billed after 120 Days from the claim adjudication date must be sent to OIG-TPR in the format prescribed in **Chapter 5 of the UMCM**. The Dental Contractors are to continue to cost avoid and cost recover where applicable.

After 365 Days from adjudication of a claim, the Dental Contractor loses all rights to pursue or collect any recoveries subject to TPR. HHSC has sole authority for recoveries of any claim subject to TPR after 365 Days from the date of adjudication of a claim. Should the Dental Contractor receive payment on a HHSC-initiated recovery, the Dental Contractor must send the payment to the OIG-TPR in the format prescribed in **Chapter 5 of the UMCM**.

HHSC retains the responsibility to pursue, collect, and retain recoveries of all resources and insurances other than health insurance wherein payments have been made on behalf of a Dental Member. These resources and other insurances include, but are not limited to: casualty insurance, liability insurance, estates, child support, and personal injury claims. The Dental Contractor must pay valid claims for Covered Dental Services provided to Dental Members who have, or may have, resources and insurances other than health insurance. Since HHSC retains the right of recovery for such resources and insurances other than health insurance, the Dental Contractor is not permitted to cost avoid or seek recovery for such items. Should the Dental Contractor receive payment on a claim in which resources or insurances other than health insurance are utilized, the Dental Contractor must send the payment to OIG-TPR in the format prescribed in **Chapter 5 of the UMCM**. Dental Members with these other resources shall remain enrolled with the Dental Contractor.

2.8 TURNOVER REQUIREMENTS

This section presents the Turnover Phase. The Dental Contractor is required to perform all required activities prior to, or upon, and following termination, expiration, merger, or acquisition of the Contract in accordance with the HHSC-approved Turnover Plan.

2.8.1 TURNOVER PLAN

Twelve months after the Effective Date, the Dental Contractor must provide a Turnover Plan covering the turnover of the records, information, and services maintained or performed by the Dental Contractor to either HHSC or a subsequent contractor. The Turnover Plan will be updated annually and submitted to HHSC.

If the Dental Contractor intends to terminate the Contract, or intends to allow the Contract to expire, Dental Contractor shall remain obligated to continue performing under this Contract, subject to the same terms, conditions, and rates, for the period of time necessary to complete Turnover to the satisfaction of HHSC.

The Turnover Plan must detail the proposed schedule, activities, and resource requirements associated with the Turnover.

The Turnover Plan describes the Dental Contractor's policies and procedures that will assure:

1. The least disruption in the delivery of Dental Care Services to Dental Members who are enrolled with the Dental Contractor during the transition to a subsequent vendor;
2. The least disruption in authorization and payment to Providers contracted with the Dental Contractor during transition to a subsequent contractor;
3. Cooperation with HHSC and the subsequent contractor in notifying Dental Members and Providers of the transition, as requested and in the form required or approved by HHSC;
4. Cooperation with HHSC and the subsequent contractor in transferring information to the subsequent contractor, as requested and in the form required or approved by HHSC; and
5. The Turnover Plan must also include information about third-party software used by the Dental Contractor in the performance of duties under this Contract, including the manner in which the software is used and terms of the software license agreement, so that HHSC can determine if this software is needed to transition operations.

The Turnover Plan must be approved by HHSC, and include:

1. The Dental Contractor's approach and schedule for the transfer of data and information, as described above;
2. The quality assurance process that the Dental Contractor must use to monitor Turnover; and
3. The Dental Contractor's approach to training HHSC or a subsequent contractor's staff in the operation of its business processes;

HHSC may require additional information, as needed, from the Dental Contractor or require the modification of the Turnover Plan as necessary.

2.8.2 TRANSFER OF DATA AND INFORMATION

The Dental Contractor must transfer to HHSC or a subsequent contractor all data and information necessary to transition operations, including: data and reference tables; data entry software; license agreements for third-party software and modifications, if required by HHSC; documentation relating to software and interfaces; functional business process flows; and operational information, including correspondence, documentation of ongoing or outstanding issues, operations support documentation, and operational information regarding Subcontractors. For purposes of this section, "documentation" means all operations, technical and user manuals used in conjunction with the software, Medically Necessary Covered Dental Services, Services and Deliverables, in whole or in part, that HHSC determines are necessary to view and extract application data in a proper format. The Dental Contractor must provide the documentation in the formats in which such documentation exists at the expiration or termination of the Contract. See **Article 15 of ATTACHMENT A, HHSC DENTAL CONTRACT TERMS AND CONDITIONS** for additional information concerning intellectual property rights.

In addition, the Dental Contractor must provide to HHSC the following:

1. Data, information and services necessary and sufficient to enable HHSC to map all Dental Contractor program data from the Dental Contractor's system(s) to the replacement system(s) of HHSC or a successor contractor, including a comprehensive data dictionary as defined by HHSC;
2. All necessary data, information and services will be provided in the format defined by HHSC, and must be HIPAA compliant; and
3. All of the data, information and services mentioned in this section must be provided and performed in a manner by the Dental Contractor using its best efforts to ensure the efficient administration of the Contract.

The data and information must be supplied in media and format specified by HHSC and according to the schedule approved by HHSC in the Turnover Plan. The data, information and services provided pursuant to this section must be provided at no additional cost to HHSC.

All relevant data and information must be received and verified by HHSC or the subsequent contractor. If HHSC determines that data or information are not accurate, complete, or HIPAA compliant, HHSC may hire an independent contractor to assist HHSC in obtaining and transferring all the required data and information and to ensure that all the data are HIPAA compliant. The reasonable cost of providing these services will be borne by the Dental Contractor.

2.8.3 TURNOVER SERVICES

Twelve (12) months prior to the end of the Contract Period, including any extensions, the Dental Contractor must update its Turnover Plan and submit it to HHSC. If HHSC terminates the Contract prior to the expiration of the Contract Period, then HHSC may require the Dental Contractor to submit an updated Turnover Plan sooner than twelve (12)

months prior to the termination date. In such cases, HHSC's notice of termination will include the date the Turnover Plan is due.

2.8.4 POST TURNOVER SERVICES

Within 30 Days of the Turnover, the Dental Contractor must provide HHSC with a Turnover results report documenting the completion and results of each step of the Turnover Plan. Turnover will not be considered complete until this report is approved by HHSC.

If the Dental Contractor does not provide the required data or information necessary for HHSC or the subsequent contractor to assume the operational activities successfully, the Dental Contractor must reimburse HHSC for all travel costs incurred by HHSC to carry out inspection, audit, review, analysis, reproduction and transfer functions at the location(s) of such records. Reimbursement by the Dental Contractor will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the Dental Contractor. The Dental Contractor may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

Texas Health & Human Services Commission

Deliverables/Liquidated Damages Matrix

Deliverables/Liquidated Damages Matrix

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
Operations Readiness (OR)					
OR-1	Contract Attachment B, §2.2.3 Transition Phase Schedule and Tasks Contract Attachment B, §2.2.4 Transition Phase Planning Contract Attachment B, §2.3 Operations Phase Scope	The Dental Contractor must be operational no later than the agreed upon Operational Start Date. HHSC will determine when the Dental Contractor is considered to be operational based on the requirements in Sections 2.3 and 2.4 of Attachment B.	Operational Start Date	Each Day of noncompliance, Per program.	HHSC may assess up to $10,000 per Day of noncompliance, per program for each Day beyond the Operational Start Date that the Dental Contractor is not operational until the Day that the Dental Contractor is operational, including all systems.

[1] Derived from the Contract, General Terms & Conditions, or HHSC's Uniform Managed Care Manual.
[2] Standard specified in the Contract. Note: Where the due date states 30 Days, the Dental Contractor is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 Days, the Dental Contractor is to provide the deliverable by the 15th day of the second month following the end of the reporting period.
[3] Period during which HHSC will evaluate service for purposes of tailored remedies.
[4] Measure against which HHSC will apply remedies.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
OR-2	Contract Attachment B §2.2.6.3.2 System Readiness Review	The Dental Contractor must submit to HHSC or to the designated Readiness Review Contractor the following plans for review, no later than 120 Days prior to the Operational Start Date: 1. Joint Interface Plan; 2. Disaster Recovery Plan; 3. Business Continuity Plan; 4. Risk Management Plan; 5. Systems Quality Assurance Plan; and 6. Security Plan.	Transition Phase	Each Day of noncompliance, per report, per Program.	HHSC may assess up to $1,000 per Day of noncompliance and per report, per Program for each Day a Deliverable is not submitted or is late, inaccurate, or incomplete.
OR-3	Contract Attachment B, §2.2.6.4 Operations Readiness	Final versions of the Provider directory must be submitted to the HHSC Enrollment Broker no later than 95 Days prior to the Operational Start Date.	Transition Phase	Each Day of noncompliance, per directory, per Program.	HHSC may assess up to $1,000 per Day of noncompliance and per directory, per Program for each Day the directory is not submitted or is late, inaccurate, or incomplete.
DSOR-1	Contract Attachment B, §2.2 Transition Phase Scope Contract Attachment B, §2.2.2 Transition Phase Readiness Reivew Duration	The Dental Contractor must timely and successfully meet Readiness Review requirements set forth in §2.2 Transition Phase Scope no later than 90 Days prior to the Operational Start Date.	Transition Phase	Each Day of noncompliance.	HHSC may assess up to $25,000 per each Day of noncompliance for each Day beyond the 90 Days prior to the Operational Start Date due date that the Dental Contractor has not met a particular Readiness Review standard, unless a delay is otherwise approved in writing by HHSC.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
DSOR-2	Contract Attachment B, §2.2.6 Organization and Financial Readiness Review	The Dental Contractor must submit updated financial documents and Material Subcontractor information as listed in §§ 7.1.3.3, 7.1.3.4, and 7.1.4 of Attachment E as part of the Financial and Organizational Readiness Review mandated in §2.2.6 of Attachment B.	Transition Phase and Operations Phase	Per Day, per each incident of noncompliance, per Dental Contractor.	HHSC may assess up to $1,000 per Day, per each incident of noncompliance, and per Dental Contractor.
General/ Administrative (GA)					
GA-1	General Requirement: Failure to Perform an Administrative Service Contract Attachment A, "Dental Contract Terms and Conditions" Contract Attachment B, §§2.2, 2.3, 2.4, 2.5, 2.6, 2.7, and 2.8	The Dental Contractor fails to timely, accurately, or completely perform a Dental Administrative Service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, such failure either: 1) results in actual harm to a Dental Member or enrollee or places him/her at risk of imminent harm or 2) materially affects HHSC's ability to administer the Dental Program.	Transition Phase, Operations Phase, and Turnover Phase	Per Day, per each incident of noncompliance, per Program.	HHSC may assess up to $5,000 per Day and per Program for each incident of noncompliance.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
GA-2	General Requirement: Failure to Provide a Covered Service Contract Attachment A, "Dental Contract Terms and Conditions" Contract Attachment B, §§2.2, 2.3, 2.4, 2.5, 2.6, 2.7, and 2.8	The Dental Contractor fails to timely provide a Covered Service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, such failure results in actual harm to a Dental Member or places a Dental Member at risk of imminent harm.	Transition Phase, Operations Phase, and Turnover Phase	Per each Day of noncompliance, per each inident of noncompliance.	HHSC may assess up to $7,500 per Day of noncompliance and per each incident of noncompliance.
GA-3	Contract Attachment B, §§2.2, 2.3, 2.4, 2.5, 2.6, 2.7, and 2.8 UMCM	All reports and Deliverables as specified in §§2.2, 2.3, 2.4, 2.5, 2.6, 2.7, and 2.8 of Attachment B must be submitted timely and be accurate and complete according to the timeframes and requirements stated in the Contract, including all attachments, and the UMCM. (Specific reports or Deliverables listed separately in this matrix are subject to the specified liquidated damages.)	Transition Phase and Operations Phase	Per each Day of noncompliance per Program.	Unless other liquidated damages apply to specific reports and Deliverables herein, HHSC may assess up to $250 per Day of noncompliance, per Program if the monthly, quarterly, or annual report or Deliverable is not submitted or is late, inaccurate, or incomplete.
GA-4	Contract Attachment B, §§2.2, 2.3, 2.4, 2.5, 2.6, 2.7, and 2.8 UMCM	All reports as specified in §§2.2, 2.3, 2.4, 2.5, 2.6, 2.7, and 2.8 of AttachmentB must be submitted according to the format or template requirements stated in the Contract, including all attachments, and the UMCM.	Transition Phase and Operations Phase	Per incident of noncompliance per Program.	Unless other liquidated damages apply to specific reports and Deliverables herein, HHSC may assess up to $1000 per incident of noncompliance, per Program if either the monthly, quarterly, or annual report is not submitted in the format or template required by HHSC.
Privacy/ Security (PS)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PS-1	Contract Attachment A, "Dental Contract Terms and Conditions" §7.07 HIPAA and Article 11 Disclosure & Confidentiality of Information	The Dental Contractor must meet all privacy standards under applicable state or federal law, rule, regulation and HHSC contract requirement.	Transition Phase and quarterly during Operations Phase	Per quarterly reporting period, per violation.	HHSC may assess up to $5,000 per quarterly reporting period for each privacy violation of applicable federal law, state law, or HHSC privacy standards and requirements.
PS-2	Contract Attachment A, "Dental Contract Terms and Conditions" §7.07 HIPAA and Article 11 Disclosure & Confidentiality of Information	The Dental Contractor must meet all security standards under applicable state or federal law, rule, regulation and HHSC contract requirement.	Transition Phase and quarterly during Operations Phase	Per quarterly reporting period, per violation.	HHSC may assess up to $1,000 per quarterly reporting period for each security violation of security requirements under federal law, state law, or HHSC security standards and requirements.
PS-3	Contract Attachment A, "Dental Contract Terms and Conditions" §7.07 HIPAA and Article 11 Disclosure & Confidentiality of Information	The Dental Contractor must meet all confidentiality standards under applicable state or federal law, rule, regulation and HHSC contract requirement.	Transition Phase and quarterly during Operations Phase	Per quarterly reporting period, per privacy/security incident.	HHSC may assess up to $5,000 per quarterly reporting period for each breach by Dental Contractor scenario as required by HHSC.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PS-4	Contract Attachment A, "Dental Contract Terms and Conditions" §7.07 HIPAA and Article 11 Disclosure & Confidentiality of Information	The Dental Contractor must meet the privacy breach notification and/or breach response standard required by applicable federal and state law and HHSC contract requirements.	Transition Phase and quarterly during Operations Phase	Per Day, per violation of breach notification and/or response standards of an actual or suspected privacy breach which may or actually requires notification to HHSC, an individual, the press and/or a federal regulatory body or may require appropriate mitigation and/or remediation activity.	HHSC may assess up to $1,000 per Day for each Dental Contractor violation of breach notice, breach response standard for each violation, and/or for each privacy violation impacting an individual according to applicable federal or state breach notification law or the HHSC breach notification and response requirements.
Material Subcontractors (MS)					
MS-1	Contract Attachment A, "Dental Contract Terms and Conditions," §4.08 Subcontractors and Agreements with Third Parties	The Dental Contractor must notify HHSC in writing three Business Days after receiving notice from a Material Subcontractor of its intent to terminate a Subcontract.	Transition Phase and quarterly during Operations Phase	Each Day of noncompliance.	HHSC may assess up to $5,000 per Day of noncompliance.
MS-2	Contract Attachment A, "Dental Contract Terms and Conditions," §4.08 Subcontractors and Agreements with Third Parties	The Dental Contractor must notify HHSC in writing 180 Days prior to the termination date of a Material Subcontract for MIS systems operation or reporting.	Transition Phase and quarterly during Operations Phase	Each Day of noncompliance.	HHSC may assess up to $5,000 per Day of noncompliance.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
MS-3	Contract Attachment A, "Dental Contract Terms and Conditions," §4.08 Subcontractors and Agreements with Third Parties	The Dental Contractor must notify HHSC in writing 90 Days prior to the termination date of a Material Subcontract for non-MIS Dental Contractor Administrative Services.	Transition Phase and quarterly during Operations Phase	Each Day of noncompliance .	HHSC may assess up to $5,000 per Day of noncompliance .
MS-4	Contract Attachment A, "Dental Contract Terms and Conditions," §4.08 Subcontractors and Agreements with Third Parties	The Dental Contractor must notify HHSC in writing 30 Days prior to the termination date of any other Material Subcontract.	Transition Phase and quarterly during Operations Phase	Each Day of noncompliance .	HHSC may assess up to $5,000 per Day of noncompliance .
Claims (CL)					
CL-1	Contract Attachment B, §2.3.28.1 General Reporting Requirements UMCM Chapter 5	Claims Summary Report (CSR): The Dental Contractor must submit monthly Claims Summary Reports to HHSC by Program by the last Day of each month following the reporting period.	Operations Phase	Per Day of noncompliance, per Program..	HHSC may assess up to $1,000 per Day of noncompliance, and per Program the report is not submitted or is late, inaccurate, or incomplete.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CL-2	Contract Attachment B, §2.5.2.2 Provider Appeal of Dental Contractor Claim Determinations Contract Attachment B §2.7.3 Appeal of Provider Claims	The Dental Contractor must resolve at least 98% of appealed claims within 30 Days from the date the appealed claim is filed with the Dental Contractor.	Operations Phase and Turnover Phase	Per month, per Program.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month and per Program that a Dental Contractor's monthly performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month and per Program that a Dental Contractor's monthly performance percentages fall below the performance standards.
CL-3	Contract Attachment B, §2.3.29.5 Claims Project UMCM Chapters 2 and 5	The Dental Contractor must complete all claims projects within 60 Days of the claims project's start date unless the Dental Contractor enters into a written agreement with the Provider before the initial expiration of the 60 Days to establish the claims project's agreed upon timeframe.	Operations Phase	Per incident of noncompliance.	HHSC may assess up to $5,000 per incident of noncompliance. A claim's project incident of noncompliance is considered any claims project not completed within 60 Days of the claims project's start date.
CL-4	Contract Attachment B, §2.3.29.4 Claims Processing Requirements UMCM Chapter 2	For a Clean Claim not adjudicated within 30 Days of receipt by the Dental Contractor, the Dental Contractor must pay the provider interest at 18% per annum, calculated daily for the full period in which the Clean Claim remains unadjudicated beyond the 30 Day claims processing deadline. Interest owed to the provider must be paid on the same date as the claim.	Operations Phase	Per month, per claim, per Program.	HHSC may assess up to $1,000 per month, per Program, and per claim if the Dental Contractor fails to pay interest timely.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CL-5	Contract Attachment B, §2.3.29.4 Claims Processing Requirements UMCM Chapter 2	The Dental Contractor must comply with the claims processing requirements and standards as described in Section 2.3.29.4 of Attachment Band in UMCM Chapter 2. The Dental Contractor must pay or deny 98% of Clean Claims within 30 Days of the claim being submitted to the Dental Contractor.	Operations Phase	Per month and per Program.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month and per Program that a Dental Contractor's claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month and per Program that the claims performance percentages fall below the performance standards.
CL-6	Contract Attachment B, §2.3.29.4 Claims Processing Requirements UMCM Chapter 2	The Dental Contractor must comply with the claims processing requirements and standards as described in Section 2.3.29.4 of AttachmentBand in UMCM Chapter 2. The Dental Contractor must pay or deny 99% of Clean Claims within 90 Days of the claim being submitted to the Dental Contractor.	Operations Phase	Per month and per Program.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month and per Program that a Dental Contractor's claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month and per Program that the claims performance percentages fall below the performance standards.
Encounter Data (ED)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
ED-1	Contract Attachment B, §2.3.29.1 Encounter Data	The Dental Contractor must submit complete and accurate Encounter Data transmissions in accordance with §2.3.29.1.	Quarterly during Operations Phase	Per Day, per incident of noncompliance, per Program.	For the initial quarter: HHSC may assess up to $500 per Day, per incident of noncompliance, and per Program that the Dental Contractor fails to submit complete and accurate Encounter Data in the quarter. For each subsequent quarter: HHSC may assess up to $1,000 per Day, per incident of noncompliance, and per Program for each quarter the Dental Contractor fails to submit complete and accurate Encounter Data.
ED-2	Contract Attachment B, § 2.3.29.1 Encounter Data	The Dental Contractor will be subject to liquidated damages if the Quarterly Encounter Reconciliation Report, which reconciles the year-to-date paid claims reported in the Financial Statistical Report to the appropriate paid dollars reported in the Vision 21 Data Warehouse, includes more than a 2% variance.	Operations Phase	Per quarter, per incident of noncompliance, per Program.	HHSC may assess up to $2,500 per quarter, per incident of noncompliace, and per Program if the Dental Contractor is not within the 2% variance. HHSC may assess up to $5,000 per quarter, per incident of noncompliance, and per Program for each additional quarter that the Dental Contractor is not within the 2% variance.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
ED-3	Contract Attachment B, § 2.3.29.1 Encounter Data	The Dental Contractor must submit Encounter Data transmissions and include all Encounter Data and Encounter Data adjustments processed by the Dental Contractor on a monthly basis, not later than the 30th calendarday after the last day of the month in which the claim(s) are adjudicated.	Operations Phase	Per month, per incident of noncompliance, per Program	For the initial quarter: HHSC may assess up to $2,500 per month, per incident of noncompliance, per Program if the Dental Contractor fails to submit encounter data in a quarter. For each subsequent quarter: HHSC may assess up to $5,000 per month, per incident of noncompliance, per Program for each month in any subsequent quarter that the Dental Contractor fails to submit Encounter Data.
Hotlines (HL)					
HL-1	Contract Attachment B, §2.3.14 Provider Hotline Contract Attachment B, §2.3.20.5 Member Services Hotline	The Dental Contractor must operate toll-free Member and Provider hotlines from 8 AM to 5 PM, local time, Monday through Friday, excluding State-approved holidays.	Operations Phase and Turnover Phase	Per month, per each incident of noncompliance, per hotline, per Program.	HHSC may assess up to $100 per month, per each incident of noncompliance, per hotline, and per Program for each hour, or portion thereof, that appropriately staffed hotlines are not operational. If the Dental Contractor's failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the Dental Contractor fails to implement its Disaster Recovery Plan.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
HL-2	Contract Attachment B, §2.3.20.5 Member Services Hotline	Call hold rate: At least 80% of calls must be answered by hotline staff within 30 seconds.	Operations Phase and Turnover Phase	Per each percentage point below the standard, per hotline, per Program, per monthly reporting period.	HHSC may assess up to $100 for each percentage point below the standard, per hotline, and per Program that the Dental Contractor fails to meet the requirements for a monthly reporting period for any Dental Contractor's operated hotlines.
HL-3	Contract Attachment B,§2.3.14 Provider Hotline Contract Attachment B, §2.3.20.5 Member Services Hotline	Call abandonment rate: The call abandonment rate must be 7% or less.	Operations Phase and Turnover Phase	Per each percentage point above the standard, per hotline, per Program, per monthly reporting period.	HHSC may assess up to $100 for each percentage point above the standard, per hotline, and per Program that the Dental Contractor fails to meet the requirements for a monthly reporting period for any Dental Contractor's operated hotlines.
HL-5	Contract Attachment B,§2.3.14 Provider Hotline Contract Attachment B, §2.3.20.5 Member Services Hotline	The average hold time must be two minutes or less.	Operations Phase and Turnover Phase	Per month, per hotline, per Program for each 30 second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time	HHSC may assess up to $100 per month, per hotline, and per Program for each 30 second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time.
Complaints/ Appeals (CA)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CA-1	Contract Attachment B, §2.5.4 Member Complaints and Internal Appeals System Contract Attachmetn A, §2.7.4 CHIP Member Complaints and Appeals Processes	The Dental Contractor must resolve at least 98% of Member Complaints within 30 Days from the date the Complaint is received by the Dental Contractor.	Operations Phase	Per monthly reporting period, per Program.	HHSC may assess up to $250 per monthly reporting period and per Program if the Dental Contractor fails to meet the performance standard.
CA-2	Contract Attachment B, §2.5.2.1 Provider Complaints Contract Attachment B, §2.7.1 CHIP Provider Complaint and Internal Dental Contractor Appeals	The Dental Contractor must resolve at least 98% of Provider Complaints within 30 Days from the date the Complaint is received by the Dental Contractor.	Operations Phase	Per monthly reporting period, per Program	HHSC may assess up to $250 per monthly reporting period and per Program if the Dental Contractor fails to meet the performance standard.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CA-3	Contract Attachment B, §2.5.4.3 Medicaid Dental Contractor's Internal Appeals Process Contract Attachment B, §2.5.4.4 Expedited Medicaid Dental Contractor's Internal Appeals Process Contract Attachment B, §2.7.4 CHIP Member Complaints and Appeals Processes	The Dental Contractor must resolve at least 98% of Member appeals within the specified timeframes for standard and expedited appeals.	Operations Phase	Per monthly reporting period, per Program.	HHSC may assess up to $500 per monthly reporting period and per Program if the Dental Contractor fails to meet the performance standard.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CA-4	Contract Attachment B, §2.5.2.1 Provider Complaints Contract Attachment B, §2.5.4 Member Complaints and Internal Appeals System Contract Attachment B, §2.7.2 Complaints from Providers Contract AttachmentB, §2.7.4 CHIP Member Complaints and Appeals Processes UMCM Chapter 3	The Dental Contractor fails to submit a timely response to a Dental Member or Provider Complaint received by HHSC and referred to the Dental Contractor by the specified due date. The Dental Contractor response must be submitted according to the timeframes and requirements stated within the Dental Contractor notification correspondence (letter, email).	Quarterly during Operations Phase	Per Day, per each incident of noncompliance, per Program.	HHSC may assess up to $250 per Day and per each incident of noncompliance, per Program for each Day beyond the due date specified within the Dental Contractor notification correspondence.
DSCA-1	Contract Attachment B, §2.5.4.5 Access to State Fair Hearing and External Medical Review for Medicaid Members	The Dental Contractor must ensure that the appropriate staff members who have firsthand knowledge of the Medicaid Dental member's Appeal in order to be able to speak and provide relevant information on the case attend all State Fair Hearings as scheduled.	Transition Phase and Operations Phase	Per quarter, per incident of noncompliance.	HHSC may assess up to $1000 per quarter and per incident of noncompliance for each State Fair Hearing that the Dental Contractor fails to attend as required by HHSC.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
DSCA-2	Contract Attachment B, §2.5.2.1 Provider Complaints Contract Attachment B, §2.5.4 Member Complaints and Internal Appeals System Contract Attachment B, §2.7.2 Complaints from Providers Contract Attachment B, §2.7.4 CHIP Member Complaints and Appeals Processes	The Dental Contractor must categorize and process Provider and Member Complaints and Dental Contractor Appeals using the same definitions provided in the Dental Contract Terms and Conditions.	Transition Phase and Operations Phase	Per incident	HHSC may assess up to $500 per incident in which a Complaint or Appeal is miscategorized or is not consistent with Complaint or Appeal definitions in the Terms and Conditions.
Provider Networks (PN)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PN-1	Contract Attachment B, §2.3.8 Access to Care Contract Attachment B, §2.3.8.3 Dentist Access Contract Attachment B, §2.3.8.5 Monitoring Access	The Dental Contractor must comply with the Contract's mileage standards and benchmarks for Dental Member access.	Operations Phase	Per quarter, per incident of noncompliance, per plan code, per county, and per Provider type.	HHSC may assess up to $1,000 per quarter, per incident of noncompliance, per plan code, per county, and per Provider type.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PN-2	Contract Attachment B, §2.3.23.5 Dental Contractor Alternative Payment Models with Providers UMCM Chapter 8	The Dental Contractor must meet minimum APM ratios as follows: • Measurement Year 1: o Minimum Overall APM Ratio: >=25% o Minimum Risk Based APM Ratio: >=2% • Measurement Year 2: **o Minimum Overall APM Ratio: Year 1 Overall APM Ratio +25%** o Minimum Risk Based APM Ratio: Year 1 Overall APM Ratio +25% • Measurement Year 3: o Minimum Overall APM Ratio: Year 2 Overall APM Ratio +25% o Minimum Risk Based APM Ratio: Year 2 Overall APM Ratio +25% • Measurement Years 4 and 5 o Overall APM Ratio: >=50% o Risk Based APM Ratio: >=10%	Calendar Year This will be measured on July 1 of each calendar year for the previous calendar period.	Per Member per month for period of measurement.	Failure to meet calendar year target for overall APM, and not eligible for exception, based on HHSC's exception criteria - up to $0.10 per Member per month for period of measurement. Failure to meet target for Risk Based APM, and not eligible for exception - up to $0.10 per Member per month for period of measurement.
PN-3	Contract Attachment B, §2.3.9.3 Provider Network UMCM Chapter 5	No more than 20% of total dollars billed to a Dental Contractor for "other outpatient services" may be billed by Out-of-Network providers.	Quarterly	Per quarter, per Program.	HHSC may assess up to $25,000 per quarter and per Program.
Marketing and Member Materials (MM)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
MM-1	Contract Attachment B, §2.3.22 Marketing and Prohibited Practices UMCM Chapter 4	The Dental Contractor must meet all Marketing and Member Materials policy requirements and may not engage in prohibited marketing practices.	Transition Phase and quarterly during the Operations Phase	Per quarter, per incident of noncompliance.	HHSC may assess up to $1,000 per quarter and per incident of noncompliance.
MM-2	Contract Attachment B, §2.3.22 Marketing and Prohibited Practices UMCM Chapter 4	The Dental Contractor must meet all social media policy requirements and may not engage in any prohibited social media practices.	Transition Phase, Operations Phase, and Turnover Phase	Per Business Day, per incident of noncompliance.	HHSC may assess up to $500 per Business Day for each incident of noncompliance.
MM-3	Contract Attachment B, §2.3.20.1 Member Materials	No later than the fifth Business Day following the receipt of the Enrollment File from the HHSC Enrollment Broker, the Dental Contractor must mail a Member's ID card and Member handbook to the Account Name or Case Head for each new Dental Member. When the Account Name or Case Head is on behalf of two or more new Dental Members, only one Member handbook must be sent.	Transition Phase, Operations Phase, and Turnover Phase	Per each incident that materials are not mailed to the Account Name.	HHSC may assess up to $500 per each incident of the Dental Contractor's failure to mail Member Materials to the Account Name or Case Head for each new Dental Member.
Management Information Systems (MI)					
MI-1	Contract Attachment B, §2.3.29 Management Information System Requirements	The Dental Contractor's MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan.	Quarterly during the Operations Phase	Per Day of noncompliance, per Program.	HHSC may assess up to $5,000 per Day of noncompliance, per Program.
MI-2	Contract Attachment B, §2.3.29.2 System-wide Functions	The Dental Contractor's MIS system must meet all requirements in Section 2.3.29.2 of Attachment B.	Quarterly during the Operations Phase	Per Day of noncompliance, per Program.	HHSC may assess up to $5,000 per Day of noncompliance, per Program.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
Financial Reporting (FR)					
FR-1	Contract Attachment B, §2.3.28.2.2 Financial Reporting Requirements UMCM Chapter 5	Financial Statistical Reports (FSR**)**: The Dental Contractor must file quarterly and annual FSRs. Quarterly reports are due timely, which are accurate, and complete, no later than 30 Days after the conclusion of each state fiscal quarter. The first annual report is due no later than 120 Days after the end of each Contract year, and the second annual report is due no later than 365 Days after the end of each Contract year.	Quarterly and annually during the Operations Phase and continuing during the Turnover Phase. All reports pertaining to periods during which the Contract was operational continue to be due, even if report due dates are after the Turnover Phase.	Per Day of noncompliance, per Program.	HHSC may assess up to $1,000 per Day of noncompliance, per Program for each quarterly or annual FSR report that is either not submitted or is late, inaccurate, or incomplete.
FR-2	Contract Attachment B §2.3.28.2.2 Financial Reporting Requirements UMCM Chapter 5	Claims Lag Reports must be produced timely, and are accurate, and complete on a quarterly basis based on the state fiscal quarter, and must be submitted by the last Day of the month following the reporting period.	Operations Phase and Turnover Phase	Per Day of noncompliance, per Program.	HHSC may assess up to $1,000 per Day of noncompliance, per Program for each report that is not submitted or is late, inaccurate, or incomplete.
FR-3	Contract Attachment B §2.3.28.2.2 Financial Reporting Requirements UMCM Chapter 5	Affiliate Report must be submitted on an as-occurs basis and annually by September 1st of each year in accordance with the UMCM and is submitted timely, and is accurate, and complete. The "as-occurs" update is due within 30 Days of the event triggering the change.	Transition Phase and Operations Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance for each report that is not submitted or is late, inaccurate, or incomplete.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
FR-4	Contract Attachment B §2.3.28.2.2 Financial Reporting Requirements UMCM Chapter 5	*Report of Legal and Other Proceedings, and Related Events:* The Dental Contractor must comply with UMCM requirements regarding the disclosure of certain matters involving the Dental Contractor, its Affiliates, or its Material Subcontractors, as specified. This requirement is both on an as-occurs basis and an annual report due each September 1st.	Transition Phase and Operations Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance for each report that is either not submitted or is late, inaccurate, incomplete, or has material omissions.
FR-5	Contract Attachment B §2.3.28.2.2 Financial Reporting Requirements UMCM Chapter 5	*Third Party Liability and Recovery (TPl/TPR) Reports:* The Dental Contractor must submit TPL/TPR reports quarterly by Dental Contractor Program and plan code, as described in UMCM Chapter 5	Operations Phase	Per Day of noncompliance, per TPL/TPR report.	HHSC may assess up to $500 per Day of noncompliance per TPL/TPR report that is not submitted or is late, inaccurate, or incomplete.
FR-6	Contract Attachment B §2.3.28.2.2 Financial Reporting Requirements UMCM Chapter 5	MCO Disclosure Statement: The Dental Contractor must submit an annual submission no later than September 1st each year and a change notification after a certain specified change, no later than 30 Days after the change.	Transition Phase, Operations Phase, and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance for each report that is not submitted or is late, inaccurate, or incomplete.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
FR-7	Contract Attachment B §2.3.28.2.2 Financial Reporting Requirements	TDI Examination Report: The Dental Contractor must furnish a timely, accurate, and complete report with a full and complete copy of any examination report issued by TDI or another state, by no later than 10 Days after receipt of the final version from TDI. Additionally, by September 1st each year, the Dental Contractor must notify HHSC of the anticipated date of the next issuance of a state department of insurance financial examination report. This annual notification should include a list of any other states in which the Dental Contractor is potentially subject to such examination reports, or a statement that the Dental Contractor is not such a subject in any other state.	Transition Phase, Operations Phase, and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance for each report that is not submitted or is late, inaccurate, or incomplete.
FR-8	Contract Attachment B §2.3.28.2.2 Financial Reporting Requirements	TDI Financial Filings: The Dental Contractor must submit copies to HHSC of reports submitted to TDI no later than ten Days after the Dental Contractor's submission to TDI.	Transition Phase and Operations Phase	Per Day of noncompliance.	HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-9	Contract Attachment B §2.3.28.2.2 Financial Reporting Requirements	Filings with Other Entities and Other Existing Financial Reports: The Dental Contractor must submit an electronic copy of the reports or filings pertaining to the Dental Contractor, or its parent, or its parent's parent no later than 30 Days after such report is filed or otherwise initially distributed.	Transition Phase and Operations Phase	Per Day of noncompliance.	HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
FR-10	Contract Attachment B §2.3.28.2.2 Financial Reporting Requirements	Audit Reports: The Dental Contractor must comply with UMCM requirements regarding notification or submission of audit reports.	Operations Phase	Per Day of noncompliance.	HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-11	Contract Attachment B §2.3.28.2.2 Financial Reporting Requirements	Employee Bonus and/or Incentive Payment Plan must be submitted no later than 30 Days after the Effective Date of the Contract.	Operations Phase	Per Day of noncompliance.	HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-12	Contract Attachment B §2.3.28.2.2 Financial Reporting Requirements	Registration Statement (aka "Form B") must be submitted by ten Days after the Dental Contractor's submission of the item to TDI.	Operations Phase	Per Day of noncompliance.	HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
HHSC Office of the Inspector General (IG)					
IG-1	Contract Attachment B, § 2.3.31.1 Fraud, Waste, and Abuse Compliance Plan Contract Attachment B, § 2.3.31 Fraud, Waste, and Abuse	The Dental Contractor must submit and comply with the requirements of its HHSC-approved Fraud, Waste, and Abuse compliance plan.	Transition Phase, Operations Phase, and Turnover Phase	Per Day, per Program, per each incident of noncompliance.	HHSC may assess up to $1,000 per Day, per Program for each incident of noncompliance.
IG-2	Contract Attachment B, §2.3.31 Fraud, Waste, and Abuse	The Dental Contractor must perform pre-payment review for identified providers as directed by the HHSC OIG within 10 Business Days of receiving the request.	Transition Phase, Operations Phase, and Turnover Phase	Per Day, per Program, per each incident of noncompliance.	HHSC may assess up to $1,000 per Day, per Program, and per each incident of noncompliance.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
IG-3	Contract Attachment B, §2.3.31.3 General requests for and access to data, records, and other information	The Dental Contractor must respond to the HHSC OIG requests for information in the manner and format requested.	Transition Phase, Operations Phase, and Turnover Phase	Per each Day of noncompliance, per Program.	HHSC may assess up to $1,000 per each Day of noncompliance, per Program that the information is not submitted or is late, inaccurate, or incomplete. This amount will increase to $5,000 per Day of noncompliance, per Program for the fourth and each subsequent occurrence within a 12-month period.
IG-4	Contract Attachment B, §2.3.28.1 General Reporting Requirements UMCM Chapter 5	The Dental Contractor must submit timely a Fraudulent Practices Referral that is accurate, and complete to the HHSC OIG within 30 Business Days of receiving a report of possible Fraud, Waste, and Abuse from the Dental Contractor's Special Investigative Unit.	Transition Phase, Operations Phase, and Turnover Phase	Per each Day of noncompliance, per Program.	HHSC may assess up to $1,000 per each Day of noncompliance, per Program, that the referral is not submitted or is late, inaccurate, or incomplete. This amount will increase to $5,000 per each Day of noncompliance, per Program for the fourth and each subsequent occurrence within a 12-month period.
IG-5	Contract Attachment B, §2.3.28.1 General Reporting Requirements UMCM Chapter 5	The Dental Contractor must submit monthly Dental Contractor Open Case List Reports.	Transition Phase, Operations Phase, and Turnover Phase	Per each Day of noncompliance, per Program.	HHSC may assess up to $1,000 per each Day of noncompliance, per Program that the report is not submitted or is late, inaccurate, or incomplete. This amount will increase to $5,000 per Day of noncompliance and per Program for the fourth and each subsequent occurrence within a 12-month period.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
IG-6	Contract Attachment B, §2.3.31.5 Payment Holds and Settlements	The Dental Contractor must respond to HHSC OIG requests for payment hold amounts accurately and in the manner and format requested.	Transition Phase, Operations Phase, and Turnover Phase	Per incident of noncompliance, per Program.	HHSC may assess, per incident of noncompliance, per Program up to the difference between the amount required to be reported by the Dental Contractor under UMCM Chapter 5.5 and the amount received by HHSC OIG.
IG7	Contract Attachment B, §2.3.31.3 General requests for and access to data, records, and other information Contract Attachment B, §2.3.31.4 Claims Data Submission Requirements	The Dental Contractor fails to submit complete, unredacted and accurate claims data as prescribed by HHSC OIG.	Transition Phase, Operations Phase, and Turnover Phase	Per Day, per each incident of noncompliance, per Program.	HHSC may assess up to $1,000 per Day per Program, and per each incident of noncompliance that the report is not submitted or is late, inaccurate, or incomplete. This amount will increase to $5,000 per Day, per Program,and per each incident of noncompliance for the fourth and each subsequent occurrence within a 12-month period.
IG-8	Contract Attachment B, §2.3.31.5 Payment Holds and Settlements	The Dental Contractor must impose payment suspensions or lift payment holds as directed by HHSC OIG.	Transition Phase, Operations Phase, and Turnover Phase	Per incident of noncompliance, per Dental Contractor.	HHSC may assess up to the amount not held or released improperly per incident of noncompliance and per Dental Contractor.
Frew (FW)					
DSFW-1	Contract Attachment B, §2.3.28.1 General Reporting Requirements	*Frew* Quarterly Monitoring Report – Each quarter,the Dental Contractor must submit timely, accurate, and complete responses to questions on this report's template addressing the status of *Frew* Consent Decree paragraphs for Medicaid.	Quarterly during Operations Phase	Per Day of noncompliance, per Dental Contractor.	HHSC may assess up to $1,000 per Day of noncompliance the reports are not submitted or are late, inaccurate, or incomplete, per Dental Contractor.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
DSFW-2	Contract Attachment B, §2.3.28.1 General Reporting Requirements	Farmworker Child Annual Report and Farmworker Child Annual Report Log – The Dental Contractor must submit an annual report and an annual log as described in UMCM Chapter 12.	Annually during Operations Phase	Per Day of noncompliance, per Program.	HHSC may assess up to $1,000 per Day of noncompliance the reports are not submitted or are late, inaccurate, or incomplete, per Program.
Turnover (TO)					
TO-1	Contract Attachment B, §2.8.4 Post Turnover Services	The Dental Contractor must provide a Turnover Results Report timely, and is accurate and complete with the documented completion and results of each step of the Turnover Plan 30 Days after the turnover of operations.	Measured 30 Days after turnover	Per each Day of noncompliance, per Program.	HHSC may assess up to $250 per each Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete, per Program.
TO-2	Contract Attachment B, §2.8.3 Turnover Services	Twelve months prior to the end of the Contract Term, or any extension thereof, the Dental Contractor must propose a Turnover Plan covering the possible turnover of the records and information maintained to either HHSC or a successor Dental Contractor.	Measured at twelve months prior to the end of the Contract Term, or any extension thereof, and ongoing until satisfactorily completed during Operations Phase and Turnover Phase	Per each Day of noncompliance, per Program.	HHSC may assess up to $1,000 per Day of noncompliance the Turnover Plan is not submitted or is late, inaccurate, or incomplete, per Program.
TO-3	Contract Attachment B, §2.8.2 Transfer of Data and Information	The Dental Contractor must transfer all data regarding the provision of Covered Services to Dental Members to HHSC or a new Dental Contractor, at the sole discretion of and as directed by HHSC. All transferred data must comply with this Contract's requirements regarding transfer of data, including HIPAA.	Measured at time of transfer of data and ongoing after the transfer of data until satisfactorily completed during Transition Phase, Operations Phase, and Turnover Phase	Per Day, per incident of noncompliance - failure to provide data or failure to provide data in required format, per Program.	HHSC may assess up to $10,000 per Day and per incident of noncompliance the data is not submitted, is not provided in the required format, or is late, inaccurate, or incomplete, per Program.

DOCUMENT HISTORY LOG

Document Status	Document Revision Number	Effective Date	Description of Revision
Amendment	1	June 5, 2020	**Attachment A Amended and Restated Dental Services Scope of Work and adds the following section:** a. Section 2.2.6.1 Responsibility in the Event of a Federal Emergency Management Agency or Governor-Declared Disaster or other Emergency; b. Section 2.2.6.2 Employee Bonus and/or Incentive Payment Plan; c. Section 2.3.8.5 Monitoring Access; d. Section 2.3.9.2 Indian Health Care Providers; e. Section 2.3.20.4 Provider Directory; f. Section 2.3.31.6 Treatment of Recoveries by the Dental Contractor for Fraud Waste an Abuse; g. Section 2.4.3 Remedies and Liquidated Damages; h. Section 2.4.4 FREW Incentives and Disincentives; i. Section 2.5.4.9 Timeframe for Notice of Resolution of Appeals; and j. Section 2.8.3 Turnover Services. **Attachment A-1 Amended and Restated Dental Services Scope of Work revised to modify the following sections:** a. Global Change to add Acronym UMCM for Uniform Managed Care Manual; b. Section 2.3.5 Value added Services; c. Section 2.3.6 Case-By Case Services; d. Section 2.3.8 Access to Care; e. Section 2.3.8.2 Access to Network Providers; f. Section 2.3.9.2 Provider Network; g. Section 2.3.10 Provider Contract Requirements; h. Section 2.3.17 Out-of-State Providers; i. Section 2.3.20.4.1 Hard Copy of Providers Directory; j. Section 2.3.20.4.2 Online Provider Directory; k. Section 2.3.20.7 Cultural Competency Plan; l. Section 2.3.22 Marketing and Prohibited Practices; m. Section 2.3.31 Fraud, Waste, and Abuse; n. Section 2.3.31.2 Special Investigative Units; o. Section 2.3.31.3 General Requests for and Access to Date, Records, and other Information;

Document Status	Document Revision Number	Effective Date	Description of Revision
			p. Section 2.3.31.6 Treatment of Recoveries by the Dental Contractor for Fraud Waste and Abuse; q. Section 2.5.4 Member Complaints and Internal Appeals system; r. Section 2.5.4.3 Medical Dental Contractor's Internal Appeals Process; s. Section 2.5.4.4 Expedited Medicaid Dental; Contractor's Internal Appeals Process; t. Section 2.5.4.7 Timeframe for Notices of Action; u. Section 2.5.4.8 Notice of Disposition of Internal Appeal; v. Section 2.5.5 Third Party Liability, Recovery, and Coordination of Benefits; w. Section 2.6 SSI Members; x. Section 2.7 Additional CHIP Scope of Work; and y. Section 2.7.5 Third Party Liability and Recovery and Coordination of Benefits. **Attachment B-1 Amended and Restated Dental Services Terms and Conditions Amended revised to modify the following sections:** a. Article 2: Definitions; b. Section 4.02 Dental Contractor's Key Personnel; c. Section 4.08 Subcontractors and Agreements with Third Parties; d. Section 4.12 Employment Verification (E-Verify Program); e. Section 5.04 CHIP Eligibility and Enrollment; f. Section 9.01 Record Retention and Audit; g. Section 10.05 CHIP Premium Rates Structure; h. Section 10.06 Medicaid Premium Rates Structure; i. Section 10.08 Experience Rebate; j. Section 11.08 Dental Contractor's Incident and Breach Notice, Reporting and Mitigation; k. Section 11.08.1 Notification to HHSC; and l. Section 11.09 Information Security and Privacy Requirements. **Attachment B-1 Amended and Restated Dental Services**

Document Status	Document Revision Number	Effective Date	Description of Revision
			Terms and Conditions Amended revised to remove the following sections: a. Section 11.10 Notification to HHSC; b. Section 11.10.2 Dental Contractor's; Investigation, Response, and Mitigation; and c. Section 11.10.3 Breach Notification to Individuals and Reporting to Authorities. **Attachment N – Access Standards Map has been incorporated into the Contract.**
Amendment	2	September 1, 2020	**Attachment A-1 Amended and Restated Dental Services Scope of Work revised to modify the following sections:** a. Global change from MCO to Dental Contractor; b. Section 2.2 Transition Phase Scope; c. Section 2.2.1 Introduction; d. Section 2.2.3 Transition Phase Schedule and Tasks; e. Section 2.2.4 Transition Planning; f. Section 2.2.5 Administration and Key Dental Contractor Personnel; g. Section 2.2.6 Organization and Financial Readiness Review; h. Section 2.2.6.3 System Testing and Transfer Data; i. Section 2.3.2 Operational Readiness Review; j. Section 2.3.6 Case-by-Case Services; k. Section 2.3.8.2 Access to Network Providers; l. Section 2.3.8.3.1 Main Dentists; m. Section 2.3.8.3.2 Specialists; n. Section 2.3.8.4 Exception Process; o. Section 2.3.14 Provider Hotline; p. Section 2.3.20.5 Member Services Hotline; q. Section 2.3.20.7 Cultural Competency Plan; r. Section 2.3.24 Utilization Management; s. Section 2.3.27 Financial Requirements for Medically Necessary Covered Dental Services; t. Section 2.3.29.5 Claims Project; u. Section 2.3.31.2 Special Investitive Unit; v. Section 2.3.31.3 General Requests for and Access to Data, Records, and Other Information;

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			w. Section 2.3.31.4 Claims Data Submission Requirements; x. Section 2.4.3 Remedies and Liquidated Damages. y. Section 2.5.1.2 Texas Health Steps Education/Outreach. z. Section 2.5.4.3 Medicaid Dental Contractor's Internal Appeals Process; aa. Section 2.5.4.5 Access to State Fair Hearing for Medicaid Members; bb. Section 2.5.4.6 Notice of Adverse Benefit Determination and Disposition of Internal Dental Contractor Appeals for Medicaid Members; cc. Section 2.5.4.7 Timeframe for Notice of Action; dd. Section 2.5.4.8 Notice of Disposition of Internal Appeal; ee. Section 2.5.5 Third Party Liability, Recovery, and Coordination of Benefits; ff. Section 2.7.5 Third Party Liability and Recovery and Coordination of Benefits; and gg. Section 2.8 Turnover Requirements. **Attachment B-1 Amended and Restated Dental Services Terms and Conditions Amended revised to modify the following sections:** a. Article 2 Definition; b. Section 1.05 No Implied Authority; c. Section 5.0.1 Eligibility Determination and Disenrollment; d. Section 5.0.5 Disenrollment; e. Section 9.01 Record Retention and Audit; f. Section 10.06 Medicaid Premium Rates Structure; g. Section 12.01 Understanding and Expectations; h. Section 12.02 Tailored Remedies; i. Section 12.03 Termination by HHSC; j. Section 12.04 Termination by Dental Contractor; k. Section 12.05 Termination by Mutual Agreement; l. Section 12.06 Effective Date of Termination; m. Section 12.07 Extension of Termination

Document Status	Document Revision Number	Effective Date	Description of Revision
			Effective Date; n. Section 12.08 Payment and Other Provisions at Contract Termination; o. Section 12.09 Modification of Contract in the Event of Remedies; p. Section 12.10 Turnover Assistance; q. Section 12.13 Dispute Resolution; r. Section 12.14 Liability of Dental Contractor; s. Section 14.04 Insurance Solvency; and t. Section 17.02 Performance Bond. **Attachment B-1 Amended and Restated Dental Services Terms and Conditions Amended revised to remove the following sections:** a. Section 12. 15 Pre-Termination Process. **Attachment C, Capitation Rates Section Added to Contract**
Amendment	3	December 15, 2020	**Attachment B Amended and Restated Dental Contract Terms and Conditions revised to add the following section:** a. Section 1.07 Loss of Program Authority.
Amendment	4	March 1, 2021	**Attachment A Amended and Restated Dental Services Scope of Work revised to add the following sections:** a. 2.3.38 CMS Interoperability and Patient Access; and b. 2.3.38.1 Payer-To-Payer Data Exchange. **Attachment B Amended and Restated Dental Contract Terms and Conditions revised to modify the following section:** a. Section 1.07 Loss of Program Authority; b. Section 4.11 Prohibition Against Performance Outside the United States; and c. Section 11.09 Information Security and Privacy Requirements.

Document Status	Document Revision Number	Effective Date	Description of Revision
Amendment	5	June 1, 2021	**Attachment A, Amended and Restated Dental Services Scope of Work revised to modify the following sections:** a. Section 2.3.13.3 Provider Training; b. Section 2.3.36 Coordination with Other State Health and Human Services Programs; c. Section 2.5.1.2 Texas Health Steps Education/Outreach; and d. 2.5.1.5 Medicaid Non-capitated Services. **Attachment A, Amended and Restated Dental Services Scope of Work revised to add the following sections:** a. Section 2.3.7.1 Nonemergency Medical Transportation Services and Medicaid Dental Services; and b. Section 2.5.4.5.1 Independent Review Organization (IRO) Reimbursement for External Medical Reviews (EMRS). **Attachment B Amended and Restated Dental Services Terms and Conditions Amended revised to modify the following sections:** a. Section Article 2 Definitions.
Amendment	6	September 1, 2021	**Attachment A, Amended and Restated Dental Services Scope of Work revised to modify the following sections:** a. Global Change Remove Subsection of UMCM Chapter References; b. Section 2.2.5 Administration and Key Dental Contractor Personnel; c. Section 2.3.3 HHSC Performance Review and Evaluation; d. Section 2.3.5 Value-Added-Services; e. Section 2.3.8.2 Access to Network Providers; f. Section 2.3.8.3.1 Main Dentists; g. Section 2.3.27, Financial Requirements for Medically Necessary Covered Dental Services; h. Section 2.3.29.4, Claims Processing

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			Requirements; i. Section 2.3.31.6, Treatment of Recoveries by the Dental Contractor for Fraud Waste and Abuse; j. Section 2.5.4.3, Medical Dental Contractor's Internal Appeals Process; k. Section 2.5.4.5, Access to State Fair Hearing and External Medical Review for Medicaid Members; l. Section 2.5.5, Third Party Liability, Recovery, and Coordination of Benefit; and m. Section 2.7.5, Third Party Liability and Recovery and Coordination of Benefits. **Attachment A, Amended and Restated Dental Services Scope of work revised to add the following sections:** a. Section 2.2.8.1, Single Case Agreements; b. Section 2.3.15.1, Provider Preventable Conditions; and c. Section 2.3.23.9, Non-Pharmacy Preferred Provider Arrangement. **Attachment B, Amended and Restated Dental Services Terms and Conditions revised to modify the following sections:** a. Section 5.03(b), Medicaid Member Enrollment and Disenrollment; b. Section 10.08, Experience Rebate; and c. Section 17.02, Performance Bond. **Attachment C, Capitation Rates revised to modify the following sections:** a. State Fiscal Year 2022 Capitation Rates and State Fiscal Year 2021 ACA HIP Fee Rates. **Attachment G, Amended and Restated CHIP Medically Necessary Covered Dental Services revised to modify the following sections:** a. Section Preventive Services; b. Section Endodontic Services; and c. Section Periodontic Services.

Document Status	Document Revision Number	Effective Date	Description of Revision
Amendment	7	March 1, 2022	**Attachment A, Amended and Restated Dental Services Scope of Work revised to modify the following sections:** a. Section 2.2.8 Continuity of Care and Out-Of-Network Providers; and b. Section 2.5.4.5 Access to State Fair Hearing and External Medical Review for Medicaid Members. **Attachment A, Amended and Restated Dental Services Scope of Work revised to modify and withdraw the following section:** a. Section 2.2.81 Single Case Agreements. **Attachment F Amended and Restated Dental Services Deliverables/Liquidated Damages Matrix Amended revised to modify the following sections:** a. Section Hotlines HL-1; and b. Section General Administration GA-3.
Amendment	8	September 1, 2022	**Attachment A, Amended and Restated Dental Services Scope of Work revised to modify the following sections:** a. Section 2.3.8.3.2 Specialists; b. Section 2.3.11 First Dental Home Services for Medicaid Members; c. Section 2.3.13.5 Provider Training; d. Section 2.3.23.2.1 Quality Assessment and Performance Improvement Program Overview; e. Section 2.3.23.5 Dental Contractor Alternative Payment Models with Providers; f. Section 2.3.26 Submission of Service Authorizations; g. Section 2.3.27 Financial Requirements for Medically Necessary Covered Dental Services; h. Section 2.3.31.3 General requests for and access to data, records, and other information; i. Section 2.3.31.5 Payment Holds and Settlements; j. Section 2.3.31.6 Treatment of Recoveries by the MCO for Fraud, Waste and Abuse;

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			k. Section 2.3.39 Material Subcontractors; l. Section 2.5.4.5.1 Independent Review Organization (IRO) Reimbursement for External Medical Reviews (EMRS); m. Section 2.5.5 Third Party Liability, Recovery, and Coordination of Benefits; and n. 2.7.5 Third Party Liability and Recovery and Coordination of Benefits. **Attachment B, Amended and Restated Dental Services Terms and Conditions revised to modify the following sections:** a. Section Article 2: Definitions; b. Section 7.02 Dental Contractor Responsibilities; for Compliance with Laws and Regulations; c. Section 10.08 Experience Rebate Section; and d. Section 17.01 Insurance Coverage. **Attachment F, Amended and Restated Dental Services Deliverables/Liquidated Damages Matrix to modify the following sections:** a. Section FR-5, Financial Reporting (FR); b. Section IG-4 HHSC Office of the Inspector General (IG); c. Section IG-5 HHSC Office of the Inspector General (IG); and d. Section PN-2 Provider Networks (PN).
Amendment	9	March 1, 2023	**Attachment A, Amended and Restated Dental Services Scope of Work revised to modify the following sections:** a. Global Change Attachment B to Attachment A. **Attachment B Amended and Restated Dental Services Terms and Conditions Amended revised to modify the following sections:** a. Global change Exhibit to Attachment; and b. Section 3.01 Contract Elements. **Attachment F, Amended and Restated Dental Services**

Document Status	Document Revision Number	Effective Date	Description of Revision
			Deliverables/Liquidated Damages Matrix to modify the following sections: a. Section MS-1, Material Subcontractors (MS); b. Section MS-2, Material Subcontractors (MS); c. Section MS-3, Material Subcontractors (MS); d. Section MS-4, Material Subcontractors (MS); e. Section CL-5, Claims (CL); and f. Section CL-6, Claims (CL).
Amendment	10	September 1, 2023	**Attachment A, Amended and Restated Dental Services Terms and Conditions Amended revised to modify the following sections:** a. Global Change UMCM Chapter # to Chapter # of the UMCM; b. Section 4.05 Responsibility for Dental Contract Personnel and Subcontractors; c. Section 4.08 Subcontractors and Agreements with Third Parties; d. Section 9.01 Record Retention and Audit; e. Section 9.02 Access to Records, Books, and Documents; f. Section 9.03 Audits of Services, Deliverables and Inspections; g. Section 9.05 Response and Compliance with Audit or Inspection Findings; **Attachment B, Amended and Restated Dental Services Scope of Work amended and modify the following sections:** a. Global Change UMCM Chapter # to Chapter # of the UMCM; b. 2.3.20.5 Member Handbook; c. 2.3.28.1 General Reporting Requirements; d. 2.3.31.3 General Request for and Access to Data, Records, and other information; and e. Section 2.3.31.4 Claims Data Submission Requirements.

Document Status	Document Revision Number	Effective Date	Description of Revision
			Attachment B, Amended and Restated Dental Services Scope of Work amended and adds the following section: a. Section 2.3.20.12 Member Eligibility. **Attachment F, Amended and Restated Dental Services Deliverables/Liquidated Damages Matrix to modify the following section:** a. Section IG-7, HHSC Office of the Inspector General (IG).