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 calendar 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 calendar 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 calendar 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 calendar 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 calendar 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 B, 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 calendar 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 UMCM Chapter 5..

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 calendar 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 calendar 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 UMCM, Chapter 6.1.

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 calendar 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 calendar 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 calendar 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 22.3.20** 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 calendar days after the Contract's Effective Date. **Section 2.3.2.3.31.1** 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. 2.3.30**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 calendar 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 11of 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 22.2.4**, 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 calendar 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 calendar 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 UMCM Chapter 5.

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 B, HHSC DENTAL CONTRACT TERMS AND CONDITIONS** and the **UMCM.** The Respondent is responsible for all requirements set forth in **ATTACHMENT B, 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 calendar 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 0** 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 B, 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 B, 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

calendar 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 B, 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 calendar 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 calendar days.
4. Preventive dental must be provided within 14 calendar 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 calendar 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 UMCM Chapter 5.28.1, Access to Network Providers Performance Standards and Specifications.

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 UMCM Chapter 5.28.1 Access to Network Providers Performance Standards and Specifications. 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, prosthodontist, 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 the UMCM, Chapter 5, "Access to Network Providers Performance Standards and Specifications." 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 UMCM Chapter 5.

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 UMCM Chapter 5.

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 calendar days of enrollment with the Dental Contractor. If the Member has not selected a Main Dentist within 30 calendar 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 calendar 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. 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.

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 calendar 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 calendar days of receipt of the written notice, the Dental Contractor must complete the process within 90 calendar days from receipt of the original application. If the provider responds with the missing information after more than 10 calendar days of receipt of the written notice, the Dental Contractor has 90 calendar 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 calendar 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 calendar 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 calendar 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 calendar 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 the **UMCM Chapter 2**;
    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.

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 **UMCM Chapter 5**. 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 calendar 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 calendar days prior to the planned effective date of the reduction. If HHSC does not issue a written statement of disapproval within 45 calendar 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 calendar 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 calendar days after the Medicaid fee schedule change, and any retroactive claim adjustments must be completed within 60 calendar 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 calendar 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 calendar 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 calendar 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 calendar 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 calendar 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 calendar 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 B, 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 calendar 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 calendar 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 calendar 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 the Medically Necessary Covered Dental Services change within the same timeframe.

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 UMCM Chapter 3 (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 the UMCM Chapter 4.

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 UMCM Chapter 3. 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 **UMCM Chapter 5**. 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 calendar 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.

UMCM Chapter 16

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 calendar 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 calendar 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.

2.3.21 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.

As part of the QAPI process, the Dental Contractor must inform HHSC whether it has been accredited by a private independent accrediting entity and authorize the private independent accrediting entity to provide HHSC or its External Quality Review Organization (EQRO) a copy of its most recent accreditation review in accordance with 42 C.F.R. § 438.332.

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 quality-based alternative payment models, increasing year-over-year percentages of provider payments linked, to measures of quality or efficiency. Dental Contractor alternative payment models (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 incentivize Providers.

The Dental Contractor must:

1. Achieve a minimum Overall APM Ratio and a Risk-Based APM Ratio as defined in **Chapter 8of the UMCM**, in year one and reach target ratios within four years. The ratios are expressions of APM-based provider payments relative to total provider payments. The calculations and minimum yearly values for the APM Ratios, as well as exceptions to the APM Ratios, are delineated under the methodology tab of **Chapter 8.10 of the UMCM**.
2. Submit to HHSC its inventories of APMs with Providers by July 1st of each year, using the data collection tool in **Chapter 8.10 of the UMCM**. The data collection tool will capture APM activity for the previous year and will be used to calculate the APM ratios. 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).
3. To the extent feasible, collaborate with other Dental Contractors on common APM/VBP models for targeted clinical interventions. Common APM/ VBP may be identified by HHSC.
4. To the extent feasible, utilize performance measures recommended by HHSC.
5. Implement processes to share data and performance reports with Providers on a regular basis. Dental Contractor must dedicate sufficient resources for Provider outreach and negotiation, assistance with data or report interpretation, and other activities to support Provider's improvement. HHSC may request evidence of these reports and processes from the Dental Contractor. To the extent possible Dental

Contractors should collaborate on development of standardized formats for the Provider performance reports and data requested from Providers.

6. Dedicate resources to evaluate the impact of APMs on utilization, quality and cost, as well as return on investment.

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 calendar 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 calendar days before initiating any such arrangement. The Dental Contractor must ensure notices comply with UMCM Chapter 4.

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 UMCM Chapter 3.

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 calendar 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.

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. Medicaid and CHIP is the payer of last resort for Covered Services, unless an exception applies under federal law or HHSC policy. If a 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 2.5.5** 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 report requests.

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.

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 calendar 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 calendar days, the Dental Contractor is to provide the deliverable by the 15th day of the second month following the end of the reporting period.

The Dental Contractor's chief executive and chief financial officers, or persons in equivalent positions, must certify that the financial data, Encounter Data, and other measurement data 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 7of 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 in 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 B, 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 calendar 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 B, 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 6of 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 B, 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 B, 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 calendar 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 calendar 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 calendar 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 calendar 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 calendar 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 calendar 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 calendar 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 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 calendar 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 calendar 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 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 B, 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 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 UMCM Chapter 18.
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. 5 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 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: Litigation Division**, 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.

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 calendar 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 calendar 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 calendar 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 calendar 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 calendar days prior to the proposed effective date of the policy change.

The Dental Contractor must notify their Dental Members of any policy change 30 calendar 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 B, 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 calendar 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.

2.4 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 B, 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 B, 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 B, 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 UMCM Chapter 12.

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 calendar 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 3of 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 calendar 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 calendar 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 calendar days allowed as stated in **Chapter 3of 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 3of 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 calendar 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 B, 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 calendar 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 calendar 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 calendar days after receipt of the initial written or oral request for Appeal. The timeframe for an Internal Appeal may be extended up to 14 calendar 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 calendar 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 calendar 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 calendar 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 calendar 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 calendar 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.

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 calendar 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 calendar 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 calendar 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 UMCM Chapter 3.21.

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 calendar 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 calendar 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 calendar day of each month, a report indicating the claims where the Dental Contractor has billed or made a recovery up to the 120th calendar 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-TRP) email address at: TPL_ManagedCare@hhsc.state.tx.us 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 Contractors is expected to recover may be factored into the rate setting process.

HHSC will provide the Dental Contractor, by plan code, a weekly member file, also known as a third-party resources client file, which is an extract of those 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 Members, organized by name and 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 Members with HHSC that differs or is not included on the TPR client file, in accordance with UMCM, Chapter 5, per the current process of submitting the TPR Dental Contractor Referral Form found in the UMCM, Chapter 5.

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 UMCM, Chapter 5.

After 120 calendar 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 calendar days from the claim adjudication date. Any collections by the Dental Contractor billed after 120 calendar days from claim adjudication date must be sent to OIG-TPR in the format prescribed in UMCM Chapter 5, "TPR Managed Care Recovery Payment Submission Requirements." 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 UMCM Chapter 5, "TPR Managed Care Recovery Payment Submission Requirements."

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 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 Services provided to Dental Contractor 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 UMCM Chapter 5. 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 calendar 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 calendar 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 calendar 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 calendar 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 last payer 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 TPL Contractor Action Plan, 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 must be in accordance with state and federal laws and regulations, including Section 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 Member in which state child support enforcement action is being carried out.. The Dental Contractors must submit the TPL Dental Contractor Action Plan to the Office of Inspector General, Third Party Recoveries email address at: TPL_ManagedCare@hhsc.state.tx.us no later than September 1 of each year for the upcoming state fiscal year for review and approval. Dental Contractor 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 UMCM Chapter 5.

The Dental Contractor has 120 calendar 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 calendar day of each month, a report indicating the claims where the Dental Contractor has billed and made a recovery up to the 120th calendar day from adjudication of a claim that is subject to TPR. After 120 calendar 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 calendar days from claim adjudication date. Any collections by the Dental Contractor billed after 120 calendar days from the claim adjudication date must be sent to OIG-TPR in the format prescribed in UMCM Chapter 5. The Dental Contractors are to continue to cost avoid and cost recover where applicable.

After 365 calendar 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 calendar 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 UMCM Chapter 5.

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 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 Services provided to MCO 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 UMCM Chapter 5. 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 B, 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 calendar 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 calendar 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 and Human Services

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 A, §2.2.3 Transition Phase Schedule and Tasks Contract Attachment A, §2.2.4 Transition Phase Planning Contract Attachment A, §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 A.	Operational Start Date	Each calendar day of noncompliance, Per program.	HHSC may assess up to $10,000 per calendar day of noncompliance, per program for each calendar day beyond the Operational Start Date that the Dental Contractor is not operational until the calendar 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 calendar 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 calendar 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 A, §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 calendar 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 calendar day of noncompliance, per report, per Program.	HHSC may assess up to $1,000 per calendar day of noncompliance and per report, per Program for each calendar day a Deliverable is not submitted or is late, inaccurate, or incomplete.
OR-3	Contract Attachment A, §2.2.6.4 Operations Readiness	Final versions of the Provider directory must be submitted to the HHSC Enrollment Broker no later than 95 calendar days prior to the Operational Start Date.	Transition Phase	Each calendar day of noncompliance, per directory, per Program.	HHSC may assess up to $1,000 per calendar day of noncompliance and per directory, per Program for each calendar day the directory is not submitted or is late, inaccurate, or incomplete.
DSOR-1	Contract Attachment A, §2.2 Transition Phase Scope Contract Attachment A, §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 calendar days prior to the Operational Start Date.	Transition Phase	Each calendar day of noncompliance.	HHSC may assess up to $25,000 per each calendar day of noncompliance for each calendar day beyond the 90 calendar 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 A, §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 A.	Transition Phase and Operations Phase	Per calendar day, per each incident of noncompliance, per Dental Contractor.	HHSC may assess up to $1,000 per calendar 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 B, "Dental Contract Terms and Conditions" Contract Attachment A, §§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 calendar day, per each incident of noncompliance, per Program.	HHSC may assess up to $5,000 per calendar 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 B, "Dental Contract Terms and Conditions" Contract Attachment A, §§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 calendar day of noncompliance, per each inident of noncompliance.	HHSC may assess up to $7,500 per calendar day of noncompliance and per each incident of noncompliance.
GA-3	Contract Attachment A, §§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 A 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 calendar day of noncompliance per Program.	Unless other liquidated damages apply to specific reports and Deliverables herein, HHSC may assess up to $250 per calendar 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 A, §§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 Attachment A 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 B, "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 B, "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 B, "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 B, "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 calendar 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 calendar 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 B, "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 calendar day of noncompliance, per Program.	HHSC may assess up to $5,000 per calendar day of noncompliance, per Program.
MS-2	Contract Attachment B, "Dental Contract Terms and Conditions," §4.08 Subcontractors and Agreements with Third Parties	The Dental Contractor must notify HHSC in writing 180 calendar days prior to the termination date of a Material Subcontract for MIS systems operation or reporting.	Transition Phase and quarterly during Operations Phase	Each calendar day of noncompliance, per Program.	HHSC may assess up to $5,000 per calendar day of noncompliance, per Program.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
MS-3	Contract Attachment B, "Dental Contract Terms and Conditions," §4.08 Subcontractors and Agreements with Third Parties	The Dental Contractor must notify HHSC in writing 90 calendar 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 calendar day of noncompliance, per Program.	HHSC may assess up to $5,000 per calendar day of noncompliance, per Program.
MS-4	Contract Attachment B, "Dental Contract Terms and Conditions," §4.08 Subcontractors and Agreements with Third Parties	The Dental Contractor must notify HHSC in writing 30 calendar days prior to the termination date of any other Material Subcontract.	Transition Phase and quarterly during Operations Phase	Each calendar day of noncompliance, per Program.	HHSC may assess up to $5,000 per calendar day of noncompliance, per Program.
Claims (CL)					
CL-1	Contract Attachment A, §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 calendar day of each month following the reporting period.	Operations Phase	Per calendar day of noncompliance, per Program..	HHSC may assess up to $1,000 per calendar 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 A, §2.5.2.2 Provider Appeal of Dental Contractor Claim Determinations Contract Attachment A, §2.7.3 Appeal of Provider Claims	The Dental Contractor must resolve at least 98% of appealed claims within 30 calendar 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 A, §2.3.29.5 Claims Project UMCM Chapters 2 and 5	The Dental Contractor must complete all claims projects within 60 calendar 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 calendar 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 calendar days of the claims project's start date.
CL-4	Contract Attachment A, §2.3.29.4 Claims Processing Requirements UMCM Chapter 2	For a Clean Claim not adjudicated within 30 calendar 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 calendar 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 A, §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 Aand in UMCM Chapter 2. The Dental Contractor must pay or deny 98% of dental Clean Claims within 30 calendar 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 A, §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 Aand in UMCM Chapter 2. The Dental Contractor must pay or deny 99% of dental Clean Claims within 90 calendar 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 A, §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 calendar day, per incident of noncompliance, per Program.	For the initial quarter: HHSC may assess up to $500 per calendar 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 calendar 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 A, § 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 A, § 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 A, §2.3.14 Provider Hotline Contract Attachment A, §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 A, §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 A,§2.3.14 Provider Hotline Contract Attachment A, §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 A,§2.3.14 Provider Hotline Contract Attachment A, §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 A, §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 calendar 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 A, §2.5.2.1 Provider Complaints Contract Attachment A, §2.7.1 CHIP Provider Complaint and Internal Dental Contractor Appeals	The Dental Contractor must resolve at least 98% of Provider Complaints within 30 calendar 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 A, §2.5.4.3 Medicaid Dental Contractor's Internal Appeals Process Contract Attachment A, §2.5.4.4 Expedited Medicaid Dental Contractor's Internal Appeals Process Contract Attachment A, §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 A, §2.5.2.1 Provider Complaints Contract Attachment A, §2.5.4 Member Complaints and Internal Appeals System Contract Attachment A, §2.7.2 Complaints from Providers Contract Attachment A, §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 calendar day, per each incident of noncompliance, per Program.	HHSC may assess up to $250 per calendar day and per each incident of noncompliance, per Program for each calendar day beyond the due date specified within the Dental Contractor notification correspondence.
DSCA-1	Contract Attachment A, §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 A, §2.5.2.1 Provider Complaints Contract Attachment A, §2.5.4 Member Complaints and Internal Appeals System Contract Attachment A, §2.7.2 Complaints from Providers Contract Attachment A, §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 A, §2.3.8 Access to Care Contract Attachment A, §2.3.8.3 Dentist Access Contract Attachment A, §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.
PN-2	Contract Attachment A, §2.3.23.5 Dental Contractor Alternative Payment Models with Providers UMCM Chapter 8	The Dental Contractor must meet minimum APM ratios as follows: 1. CY2018 or Year 1: o Overall APM Ratio: >=25% o Risk Based APM Ratio: >=2% 2. CY2019 or Year 2: 125% of CY2018 Minimum Target APM Ratios 3. CY2020 or Year 3: 125% of CY2019 Minimum Target APM Ratios 4. CY2021 or Year 4: 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 A, §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 A, §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 A, §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 A, §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 A, §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 calendar day of noncompliance, per Program.	HHSC may assess up to $5,000 per calendar day of noncompliance, per Program.
MI-2	Contract Attachment A, §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 A.	Quarterly during the Operations Phase	Per calendar day of noncompliance, per Program.	HHSC may assess up to $5,000 per calendar 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 A, §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 calendar days after the conclusion of each state fiscal quarter. The first annual report is due no later than 120 calendar days after the end of each Contract year, and the second annual report is due no later than 365 calendar 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 calendar day of noncompliance, per Program.	HHSC may assess up to $1,000 per calendar 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 A §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 calendar day of the month following the reporting period.	Operations Phase and Turnover Phase	Per calendar day of noncompliance, per Program.	HHSC may assess up to $1,000 per calendar day of noncompliance, per Program for each report that is not submitted or is late, inaccurate, or incomplete.
FR-3	Contract Attachment A §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 calendar days of the event triggering the change.	Transition Phase and Operations Phase	Per calendar day of noncompliance.	HHSC may assess up to $1,000 per calendar 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 A §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 calendar day of noncompliance.	HHSC may assess up to $1,000 per calendar day of noncompliance for each report that is either not submitted or is late, inaccurate, incomplete, or has material omissions.
FR-5	Contract Attachment A §2.3.28.2.2 Financial Reporting Requirements UMCM Chapter 5	*Third Party Liability and Recovery (TPl/TPR) Reports:* The Dental Contractor must submit reports quarterly by Program as described in UMCM Chapter 5.3.4 Third Party Liability and Recoveries (TPL/TPR)	Operations Phase	Per calendar day of noncompliance, per TPL/TPR report.	HHSC may assess up to $500 per calendar day of noncompliance per TPL/TPR report that is not submitted or is late, inaccurate, or incomplete.
FR-6	Contract Attachment A §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 calendar days after the change.	Transition Phase, Operations Phase, and Turnover Phase	Per calendar day of noncompliance.	HHSC may assess up to $1,000 per calendar 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 A §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 calendar 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 calendar day of noncompliance.	HHSC may assess up to $1,000 per calendar day of noncompliance for each report that is not submitted or is late, inaccurate, or incomplete.
FR-8	Contract Attachment A §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 calendar days after the Dental Contractor's submission to TDI.	Transition Phase and Operations Phase	Per calendar day of noncompliance.	HHSC may assess up to $500 per calendar day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-9	Contract Attachment A §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 calendar days after such report is filed or otherwise initially distributed.	Transition Phase and Operations Phase	Per calendar day of noncompliance.	HHSC may assess up to $500 per calendar 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 A §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 calendar day of noncompliance.	HHSC may assess up to $500 per calendar day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-11	Contract Attachment A §2.3.28.2.2 Financial Reporting Requirements	Employee Bonus and/or Incentive Payment Plan must be submitted no later than 30 calendar days after the Effective Date of the Contract.	Operations Phase	Per calendar day of noncompliance.	HHSC may assess up to $500 per calendar day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-12	Contract Attachment A §2.3.28.2.2 Financial Reporting Requirements	Registration Statement (aka "Form B") must be submitted by ten calendar days after the Dental Contractor's submission of the item to TDI.	Operations Phase	Per calendar day of noncompliance.	HHSC may assess up to $500 per calendar 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 A, § 2.3.31.1 Fraud, Waste, and Abuse Compliance Plan Contract Attachment A, § 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 calendar day, per Program, per each incident of noncompliance.	HHSC may assess up to $1,000 per calendar day, per Program for each incident of noncompliance.
IG-2	Contract Attachment A, §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 calendar day, per Program, per each incident of noncompliance.	HHSC may assess up to $1,000 per calendar 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 A, §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 calendar day of noncompliance, per Program.	HHSC may assess up to $1,000 per each calendar 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 calendar day of noncompliance, per Program for the fourth and each subsequent occurrence within a 12-month period.
IG-4	Contract Attachment A, §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 calendar day of noncompliance, per Program.	HHSC may assess up to $1,000 per each calendar 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 each calendar day of noncompliance, per Program for the fourth and each subsequent occurrence within a 12-month period.
IG-5	Contract Attachment A, §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 calendar day of noncompliance, per Program.	HHSC may assess up to $1,000 per each calendar 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 calendar day, per Program of noncompliance 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 A, §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 A, §2.3.31.3 General requests for and access to data, records, and other information Contract Attachment A, §2.3.31.4 Claims Data Submission Requirements	The Dental Contractor fails to submit claims data as prescribed by HHSC OIG.	Transition Phase, Operations Phase, and Turnover Phase	Per calendar day, per each incident of noncompliance, per Program.	HHSC may assess up to $1,000 per calendar 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 calendar 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 A, §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 A, §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 calendar day of noncompliance, per Dental Contractor.	HHSC may assess up to $1,000 per calendar 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 A, §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 calendar day of noncompliance, per Program.	HHSC may assess up to $1,000 per calendar day of noncompliance the reports are not submitted or are late, inaccurate, or incomplete, per Program.
Turnover (TO)					
TO-1	Contract Attachment A, §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 calendar days after the turnover of operations.	Measured 30 calendar days after turnover	Per each calendar day of noncompliance, per Program.	HHSC may assess up to $250 per each calendar day of noncompliance the report is not submitted or is late, inaccurate, or incomplete, per Program.
TO-2	Contract Attachment A, §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 calendar day of noncompliance, per Program.	HHSC may assess up to $1,000 per calendar day of noncompliance the Turnover Plan is not submitted or is late, inaccurate, or incomplete, per Program.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
TO-3	Contract Attachment A, §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 calendar 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 calendar 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.