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Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

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**Texas Health & Human Services Commission**

**HHSC Dental Contract Terms & Conditions**

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Baseline	n/a	September 1, 2011	Initial version of the Attachment A, "HHSC Medicaid/CHIP Dental Services Contract Terms & Conditions."
Revision	1.1	March 1, 2012	<p>Definition for Rate Period 1 is modified.</p> <p>New Section 4.11 "Prohibition Against Performance Outside of the United States" added.</p> <p>Section 5.02(b) is modified to clarify that Dental Contractors may not sell or transfer their Member base.</p> <p>Section 5.03 is modified to clarify the 12 month lock-in to dental.</p> <p>Section 5.04 is revised to clarify the notification process when Members change plans after their benefit limits are exhausted.</p> <p>Section 7.02 is modified to add a legal reference.</p>
Revision	1.2	September 1, 2012	<p>Definition for Consolidated FSR Report or Consolidated Basis is added.</p> <p>Definition for Emergency Services is added.</p> <p>Definition for Financial Statistical Report is added.</p> <p>Definitions for FSR Reporting Period, FSR Reporting Period 12/13, FSR Reporting Period 14, and FSR Reporting Period 15 are added.</p> <p>Definition for Main Dental Home Provider is modified.</p> <p>Definition for Material Subcontract is modified.</p> <p>Definition for Medically Necessary is revised to ensure consistency with HHSC's administrative rule.</p> <p>Definition for Net Income Before Taxes is modified.</p> <p>Definition for Pre-tax Income is modified.</p> <p>Definition for Program is added.</p> <p>Definition for "Provider Materials" is added.</p> <p>Definitions for Rate Period 1, Rate Period 2, and Rate Period 3 are modified.</p> <p>Section 4.03 is modified to require the Executive Director, or a designee, to attend RAC meetings.</p> <p>Section 4.08 is modified to clarify the applicable federal</p>

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>regulations.</p> <p>Section 4.10 is modified to clarify the applicable federal regulations.</p> <p>Section 5.06 is deleted in its entirety.</p> <p>Section 7.02 is modified to clarify that only applicable provisions of the listed laws apply to the contract.</p> <p>Section 10.08 is modified to consolidate the Experience Rebate across all contracts and all programs.</p>
Revision	1.3	March 1, 2013	<p>All references to the previous Executive Commissioner Suehs are changed to his successor, Executive Commissioner Janek.</p>
Revision	1.4	September 1, 2013	<p>Definition for CAHPS is modified to correct the name to which the acronym refers.</p> <p>Definition for Default Enrollment is modified to add T.A.C. reference.</p> <p>Definition for HEDIS is modified to correct the name to which the acronym refers.</p> <p>Section 7.04 is deleted in its entirety and updated within Section 7.02.</p> <p>Section 9.02 is modified for clarification that records must be provided “at no cost.”</p> <p>Section 9.04 is modified for clarification that records must be provided “at no cost.”</p> <p>Section 13.01 is modified to clarify the required certifications.</p> <p>Section 14.08 is modified to delete outdated language.</p>
Revision	1.5	January 1, 2014	<p>Definition for Expansion Children is removed.</p> <p>Definition for Federal Poverty Level is updated.</p> <p>Section 5.02 is modified to add requirement for default assignment methodologies.</p> <p>Section 5.04 is modified to clarify that HHSC or the ASC will enroll or disenroll Members.</p>

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>Section 11.01(a) is modified to correct an administrative error.</p> <p>Section 12.03 is modified to delete subsection (b)(8) "Termination for Insolvency" and all following subsections are renumbered.</p>
Revision	1.6	February 1, 2014	<p>Definition for Dental Administrative Services is modified to include all required deliverables outside of the Covered Services.</p> <p>Definition for Fee-for-Service (FFS) is clarified that payment is made after the service is provided.</p> <p>Definition for Material Subcontract is modified to clarify excluded subcontractors.</p> <p>Definition for Member(s) with Special Health Care Needs is added.</p> <p>Definition for Population Risk Group or Risk Group is modified to add defined criteria.</p> <p>Definition for Premium Payment is modified to include associated Administrative Services.</p> <p>Definition for Texas Medicaid Bulletin is removed.</p> <p>Definition for Texas Medicaid Provider Procedures Manual is modified to remove the reference to the Texas Medicaid Bulletin.</p> <p>Section 4.08 is renamed "Subcontractors and Agreements with Third Parties" and is modified to include language from Section 4.10 "Agreements with Third Parties."</p> <p>Section 4.10 "Dental Contractor Agreements with Third Parties" is deleted in its entirety.</p> <p>Section 10.01 is modified to clarify the calculation of the monthly Premium Payment.</p> <p>Section 10.02 is modified to include Liquidated Damages due and unpaid including any associated interest.</p> <p>Section 10.07 is modified to clarify the requirements for adjustments.</p> <p>Section 10.08 is modified to include Liquidated Damages assessment.</p> <p>Section 13.02 is modified to include an obligation to</p>

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			comply with 41 U.S.C. § 423.
Revision	1.7	September 1, 2014	<p>Definition for Legally Authorized Representative (LAR) is added.</p> <p>Definition for Major Systems Change is added.</p> <p>Definition for “Medical Assistance Only” is revised.</p> <p>Section 5.03 is revised to clarify the Dental Contractor’s right to request disenrollment.</p> <p>Section 7.07 is modified to clarify the requirement for Dental Contractors to notify HHSC of all breaches or potential breaches of unsecured PHI.</p> <p>Section 7.09 “Compliance with Fraud, Waste, and Abuse requirements” is added.</p>
Revision	1.8	March 1, 2015	<p>In each contract section, after the first appearance of the term, “Uniform Managed Care Manual” is changed to “UMCM.”</p> <p>Definition for Competent Interpreter is added.</p> <p>Section 4.11 is modified to clarify subsections (a)(1)(ii) and (c)(1).</p> <p>Section 5.03 is being modified to add retroactive restoration of enrollment.</p> <p>Section 7.02 is modified to delete the references to OMB and replace it with 2 C.F.R. Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.</p> <p>Section 10.08(c)(2)(iv) is modified to remove the reference to the Quality Challenge Award</p>
Revision	1.9	May 1, 2015	Section 10.15 “Payment/Adjustment to Capitation in Consideration of the ACA Section 9010 Health Insurance Providers Fee” is added.
Revision	1.10	September 1, 2015	<p>Section 1.04 is modified to remove one extraneous word and to replace another.</p> <p>Article 2 is modified to remove an extraneous word.</p> <p>Definition for “Confidential Information” is modified to</p>

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>change “client” to “Member” in part (1).</p> <p>Definition for Consolidated FSR Report or Consolidated Basis is modified to exclude the Dual Demonstration.</p> <p>Definition for Dual Demonstration is added.</p> <p>Definition for First Dental Home is modified to clarify the definition.</p> <p>Section 3.03 is modified to clarify the language.</p> <p>Section 3.07 is modified to require prior approval from HHSC.</p> <p>Section 3.08 is modified to clarify the language.</p> <p>Section 4.03 is modified to clarify the language.</p> <p>Section 4.12 “E-Verify System” is added.</p> <p>Section 7.02 is modified to clarify the language.</p> <p>Section 10.08 is modified to carve-out the Dual Demonstration from the "Consolidated Basis" with respect to the Experience Rebate.</p> <p>Section 11.01 is modified to clarify part (h).</p>
Revision	1.11	March 1, 2016	<p>All references to the previous Executive Commissioner Janek are changed to his successor, Executive Commissioner Traylor.</p> <p>Definition for Texas Medicaid Provider Procedures Manual is modified to remove the publication frequency.</p> <p>Section 4.12 “E-Verify System” is renamed “Employment Verification” and the requirements updated.</p>
Revision	1.12	September 1, 2016	<p>All references to the previous Executive Commissioner Traylor are changed to his successor, Executive Commissioner Smith.</p> <p>Definition for Breach is added.</p> <p>Definition for Discovery/Discovered is added.</p> <p>Definition for Main Dental Home Provider, Main Dentist, or Dental Home is modified to add RHCs.</p> <p>Section 7.02 is modified to add item (a)(17) to require Dental Contractors to report all Member health care information upon HHSC's request and subsequent items</p>

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Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

---

**DOCUMENT HISTORY LOG**

<b>STATUS<sup>1</sup></b>	<b>DOCUMENT REVISION<sup>2</sup></b>	<b>EFFECTIVE DATE</b>	<b>DESCRIPTION<sup>3</sup></b>
			are renumbered. Item (a)(18) is deleted as redundant. Section 9.03 is modified to add item (a)(2) and an explanation of "reasonable notice" Section 11.09 Dental Contractor's Breach Notice, Reporting and Correction Requirements is added.
<p><sup>1</sup> Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.</p> <p><sup>2</sup> Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.</p> <p><sup>3</sup> Brief description of the changes to the document made in the revision.</p>			

**TABLE OF CONTENTS**

**Article 1: Introduction ..... 2**

Section 1.01 Purpose ..... 2

Section 1.02 Risk-based contract..... 2

Section 1.03 Inducements ..... 2

Section 1.04 Construction of the Contract..... 2

Section 1.05 No implied authority..... 3

Section 1.06 Legal Authority..... 3

**Article 2. Definitions ..... 3**

**Article 3. General Contract Terms & Conditions..... 13**

Section 3.01 Contract elements. .... 13

Section 3.02 Term of the Contract..... 13

Section 3.03 Funding..... 13

Section 3.04 Delegation of authority ..... 13

Section 3.05 No waiver of sovereign immunity ..... 13

Section 3.06 Force majeure ..... 13

Section 3.07 Publicity ..... 14

Section 3.08 Assignment..... 14

Section 3.09 Cooperation with other vendors and prospective vendors ..... 14

Section 3.10 Renegotiation and reprourement rights ..... 14

Section 3.11 RFP errors and omissions..... 15

Section 3.12 Attorneys' fees..... 15

Section 3.13 Preferences under service contracts..... 15

Section 3.14 Time of the essence ..... 15

Section 3.15 Notice ..... 15

**Article 4. Contract Administration & Management ..... 15**

Section 4.01 Qualifications, retention and replacement of Dental Contractor employees ..... 15

Section 4.02 Dental Contractor's Key Personnel ..... 15

Section 4.03 Executive Director ..... 16

Section 4.04 Dental Director..... 16

Section 4.05 Responsibility for Dental Contractor personnel and Subcontractors ..... 16

Section 4.06 Cooperation with HHSC and state administrative agencies..... 17

Section 4.07 Conduct of Dental Contractor personnel and Subcontractors. .... 17

Section 4.08 Subcontractors and Agreements with Third Parties..... 18

Section 4.09 HHSC's ability to contract with Subcontractors ..... 19

Section 4.10 This Section Intentionally Left Blank ..... 19

Section 4.11 Prohibition Against Performance Outside the United States. .... 19

Section 4.12 Employment Verification..... 21

**Article 5. Member Eligibility & Enrollment ..... 21**

Section 5.01 Eligibility Determination ..... 21

Section 5.02 General Information Concerning Member Enrollment & Disenrollment ..... 21

Section 5.03 Medicaid Member Enrollment & Disenrollment. .... 21

Section 5.04 CHIP eligibility and enrollment. .... 22

Section 5.05 Default Enrollment. .... 22

Section 5.06 This Section Intentionally Left Blank ..... 23

<b>Article 6. Service Levels &amp; Performance Measurement .....</b>	<b>23</b>
Section 6.01 Performance measurement.....	23
<b>Article 7. Governing Law &amp; Regulations .....</b>	<b>23</b>
Section 7.01 Governing law and venue.....	23
Section 7.02 Dental Contractor responsibility for compliance with laws and regulations .....	23
Section 7.03 TDI licensure and solvency. ....	24
Section 7.04 This Section Intentionally Left Blank .....	25
Section 7.05 Compliance with state and federal anti-discrimination laws.....	25
Section 7.06 Environmental protection laws. ....	25
Section 7.07 HIPAA.....	26
Section 7.08 Historically Underutilized Business Participation Requirements.....	26
Section 7.09 Compliance with Fraud, Waste, and Abuse requirements.....	27
<b>Article 8. Amendments &amp; Modifications.....</b>	<b>27</b>
Section 8.01 Mutual Contract. ....	27
Section 8.02 Changes in law or contract.....	27
Section 8.03 Modifications as a remedy.....	27
Section 8.04 Modification Process .....	27
Section 8.05 Modification of HHSC Uniform Managed Care Manual.....	27
Section 8.06 Required compliance with amendment and modification procedures.....	28
<b>Article 9. Audit &amp; Financial Compliance .....</b>	<b>28</b>
Section 9.01 Record retention and audit.....	28
Section 9.02 Access to records, books, and documents. ....	28
Section 9.03 Audits of Services, Deliverables and inspections.....	28
Section 9.04 SAO Audit.....	29
Section 9.05 Response/compliance with audit or inspection findings.....	29
<b>Article 10. Terms &amp; Conditions of Payment.....</b>	<b>30</b>
Section 10.01 Calculation of monthly Premium Payment .....	30
Section 10.02 Time and Manner of Payment. ....	30
Section 10.03 Certification of Premium Rates.....	30
Section 10.04 Modification of Premium Rates. ....	30
Section 10.05 CHIP Premium Rates Structure. ....	31
Section 10.06 Medicaid Premium Rates Structure.....	31
Section 10.07 Adjustments to Premium Payments .....	32
Section 10.08 Experience Rebate.....	32
Section 10.09 Federal Disallowance .....	35
Section 10.10 Payment by Members. ....	35
Section 10.11 Restriction on assignment of fees .....	35
Section 10.12 Liability for taxes.....	35
Section 10.13 Liability for employment-related charges and benefits.....	35
Section 10.14 No additional consideration .....	35
Section 10.15 Payment/Adjustment to Capitation in Consideration of the ACA Section 9010 Health Insurance Providers Fee .....	35
<b>Article 11. Disclosure &amp; Confidentiality of Information.....</b>	<b>36</b>
Section 11.01 Confidentiality.....	36
Section 11.02 Disclosure of HHSC's Confidential Information.....	37

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

---

Section 11.03 Member Records .....	37
Section 11.04 Requests for public information .....	37
Section 11.05 Privileged Work Product.....	38
Section 11.06 Unauthorized acts.....	38
Section 11.07 Legal action. ....	38
Section 11.08 Information Security.....	38
<b>Article 12. Remedies &amp; Disputes.....</b>	<b>41</b>
Section 12.01 Understanding and expectations.....	41
Section 12.02 Tailored remedies.....	41
Section 12.03 Termination by HHSC. ....	44
Section 12.04 Termination by Dental Contractor. ....	45
Section 12.05 Termination by mutual agreement.....	46
Section 12.06 Effective date of termination.....	46
Section 12.07 Extension of termination effective date .....	46
Section 12.08 Payment and other provisions at Contract termination .....	46
Section 12.09 Modification of Contract in the event of remedies.....	46
Section 12.10 Turnover assistance .....	46
Section 12.11 Rights upon termination or expiration of Contract.....	46
Section 12.12 Dental Contractor responsibility for associated costs .....	46
Section 12.13 Dispute resolution.....	47
Section 12.14 Liability of Dental Contractor. ....	47
Section 12.15 Pre-termination Process.....	48
<b>Article 13. Assurances &amp; Certifications .....</b>	<b>48</b>
Section 13.01 Proposal certifications. ....	48
Section 13.02 Conflicts of interest. ....	48
Section 13.03 Organizational conflicts of interest. ....	48
Section 13.04 HHSC personnel recruitment prohibition.....	49
Section 13.05 Anti-kickback provision .....	49
Section 13.06 Debt or back taxes owed to State of Texas .....	49
Section 13.07 Outstanding debts and judgments.....	49
<b>Article 14. Representations &amp; Warranties .....</b>	<b>49</b>
Section 14.01 Authorization.....	49
Section 14.02 Ability to perform.....	50
Section 14.03 Minimum Net Worth.....	50
Section 14.04 Insurer solvency. ....	50
Section 14.05 Workmanship and performance. ....	50
Section 14.06 Warranty of deliverables.....	50
Section 14.07 Compliance with Contract .....	50
Section 14.08 Technology Access .....	50
Section 14.09 Electronic & Information Resources Accessibility Standards.....	51
<b>Article 15. Intellectual Property.....</b>	<b>52</b>
Section 15.01 Infringement and misappropriation.....	52
Section 15.02 Exceptions. ....	52
Section 15.03 Ownership and Licenses .....	52
<b>Article 16. Liability .....</b>	<b>53</b>

---

Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

---

Section 16.01 Property damage.....	53
Section 16.02 Risk of Loss.....	54
Section 16.03 Limitation of HHSC's Liability .....	54
<b>Article 17. Insurance &amp; Bonding .....</b>	<b>54</b>
Section 17.01 Insurance Coverage .....	54
Section 17.02 Performance Bond.....	55
Section 17.03 TDI Fidelity Bond.....	56

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

**Article 1: Introduction**

**Section 1.01 Purpose**

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

**Section 1.02 Risk-based contract**

This is a risk-based contract.

**Section 1.03 Inducements**

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

- (1) Dental Contractor is an established dental indemnity insurance provider or DMO that arranges for the delivery of Dental Services, that is: (1) currently licensed as such in the State of Texas and is fully authorized to conduct business in the Service Area, or (2) will be fully authorized by TDI to conduct business in the Service Area no later than 120 days after the Contract's Effective Date;
- (2) Dental Contractor and its Material Subcontractors have the skills, qualifications, expertise, financial resources and experience necessary to provide the Services and Deliverables described in this Contract in an efficient, cost-effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities;
- (3) Dental Contractor has thoroughly reviewed, analyzed, and understood the RFP, has timely raised all questions or objections to the RFP, and has had the opportunity to review and fully understand HHSC's current Dental Program and operating environment for the activities that are the subject of the Contract and the needs and requirements of the State during the Contract term;
- (4) Dental Contractor has had the opportunity to review and understand the State's stated objectives in entering into this Contract and, based on such review and understanding, Dental Contractor currently has the capability to perform in accordance with the terms and conditions of this Contract;

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

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

**Section 1.04 Construction of the Contract**

- (a) **Scope of Introductory Article**  
The provisions of any introductory article to the Contract are intended to be a general introduction and are not intended to expand the scope of the Parties' obligations under the Contract or to alter the plain meaning of the terms and conditions of the Contract.
- (b) **References to the "State."**  
References in the Contract to the "State" mean the State of Texas unless otherwise specifically indicated and must be interpreted, as appropriate, to mean or include HHSC and other agencies of the State of Texas that may participate in the administration of the Dental Program, provided, however, that no provision will be interpreted to include any entity other than HHSC as the contracting agency.
- (c) **Severability**  
If any provision of this Contract is construed to be illegal or invalid, such interpretation will not affect the legality or validity of any of its other provisions. The illegal or invalid provision will be deemed stricken and deleted to the same extent and effect as if never incorporated in this Contract, but all other provisions will remain in full force and effect.
- (d) **Survival of terms**  
Termination or expiration of this Contract for any reason will not release either Party from any liabilities or obligations set forth in this Contract that:
  - (1) The Parties have expressly agreed will survive any such termination or expiration; or
  - (2) Arose prior to the effective date of termination and remain to be performed or by their nature would be intended to be applicable following any such termination or expiration.
- (e) **Headings.**  
The article, section and paragraph headings in this Contract are for reference and convenience only and may not be considered in the interpretation of this Contract.
- (f) **Global drafting conventions**
  - (1) The terms "include," "includes," and "including" are terms of inclusion, and where used

Section 1.04  
modified by  
Version 1.10

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

in this Contract, are deemed to be followed by the words “without limitation.”

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

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

### **Section 1.05 No implied authority**

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

- (1) make public policy;
- (2) promulgate amend or disregard administrative regulations or program policy decisions made by State and federal agencies responsible for administration of HHSC Programs; or
- (3) unilaterally communicate or negotiate with any federal or state agency or the Texas Legislature on behalf of HHSC regarding the HHSC Programs.

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

### **Section 1.06 Legal Authority.**

- (a) HHSC is authorized to enter into this Contract under Chapters 531 and 533, Texas Government Code; Section 2155.144, Texas Government Code; and/or Chapter 62, Texas Health & Safety Code. Dental Contractor is authorized to enter into this Contract pursuant to the authorization of its governing board or controlling owner or officer.
- (b) The person or persons signing and executing this Contract on behalf of the Parties, or representing themselves as signing and executing this Contract on behalf of the Parties, warrant and guarantee that he, she, or they have been duly authorized to execute this Contract and to validly and

legally bind the Parties to all of its terms, performances, and provisions.

### **Article 2. Definitions**

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

Article 2  
modified by  
Version 1.10

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

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

**Action** (Medicaid only) means:

- (1) the denial or limited authorization of a requested Medicaid service, including the type or level of service;
- (2) the reduction, suspension, or termination of a previously authorized service;
- (3) the denial in whole or in part of payment for service;
- (4) the failure to provide services in a timely manner; or
- (5) the failure of an Dental Contractor to act within the timeframes set forth in the Contract and 42 C.F.R. §438.408(b)..

An Adverse Determination is a type of Action.

**Adjudicate** means to deny or pay a Clean Claim.

**Administrative Services** see Dental Administrative Services.

**Administrative Services Contractor** see HHSC Administrative Services Contractor.

**Adverse Determination** means a determination by the Dental Contractor or its Utilization Review agent that the dental services furnished, or proposed to be furnished to a patient, are not Medically Necessary or not appropriate.

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

- (1) owns or holds more than a five percent (5%) interest in the Dental Contractor (either directly, or through one or more intermediaries);

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

(2) in which the Dental Contractor owns or holds more than a five percent (5%) interest (either directly, or through one or more intermediaries);

(3) any parent entity or subsidiary entity of the Dental Contractor, regardless of the organizational structure of the entity;

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

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

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

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

**Allowable Expenses** means all expenses related to the Contract between HHSC and the Dental Contractor that are incurred during the Contract Period, are not reimbursable or recovered from another source, and that conform with the HHSC Uniform Managed Care Manual's "Cost Principles for Expenses".

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

**Appeal (Medicaid only)** means the formal process by which a Member or his or her representative request a review of the Dental Contractor's Action, as defined above.

Auxiliary Aids and Services includes:

- (1) qualified interpreters or other effective methods of making aurally delivered materials understood by persons with hearing impairments;
- (2) taped texts, large print, braille, or other effective methods to ensure visually delivered materials are available to individuals with visual impairments; and
- (3) other effective methods to ensure that materials (delivered both aurally and visually) are available to those with

cognitive or other Disabilities affecting communication.

**Batch Processing** is a billing technique that uses a single program loading to process many individual jobs, tasks, or requests for service. In managed care, batch billing is a technique that allows providers to send billing information all at once in a "batch" rather than in separate individual transactions.

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

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

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

**Business Day** means any day other than a Saturday, Sunday, or a state or federal holiday on which HHSC's offices are closed, unless the context clearly indicates otherwise.

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

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

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

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

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

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

- (1) 837 Dental Implementation Guide; and
- (2) 837 Dental Companion Guide;

Definition for Breach added by Version 1.12

Definition for CAHPS modified by Version 1.4

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

The Dental Contractor may not require a dentist or dental provider to submit documentation that conflicts with the requirements of Texas Administrative Code, Title 28, Part 1, Chapter 21, Subchapters C and T.

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

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

**Complainant** means a Member or a treating dental provider or other individual designated to act on behalf of the Member who filed the Complaint.

**Complaint (CHIP Program only)** means any dissatisfaction, expressed by a Complainant, orally or in writing to the Dental Contractor, with any aspect of the Dental Contractor's operation, including, but not limited to, dissatisfaction with plan administration, procedures related to review or appeal of an Adverse Determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G; the denial, reduction, or termination of a service for reasons not related to Medical Necessity; and the way a service is provided. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the CHIP Member.

**Complaint (Medicaid only)** means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the Dental Contractor, about any matter related to the Dental Contractor other than an Action. As provided by 42 C.F.R. §438.400, possible subjects for Complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid Member's rights.

**Comprehensive Care Program** see Texas Health Steps.

**Confidential Information** means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) consisting of:

- (1) Confidential Member information, including Protected Health Information;
- (2) All non-public budget, expense, payment and other financial information;
- (3) All privileged work product;

(4) All information designated by HHSC or any other State agency as confidential, and all information designated as confidential under the Texas Public Information Act, Texas Government Code, Chapter 552; and

(5) Information utilized, developed, received, or maintained by HHSC, the Dental Contractor, or participating State agencies for the purpose of fulfilling a duty or obligation under this Contract and that has not been disclosed publicly.

**Consolidated FSR Report or Consolidated Basis** means FSR reporting results for all Programs and all SDAs operated by the Dental Contractor or its Affiliates, including those under separate contracts between the Dental Contractor or its Affiliates and HHSC, with the exception of the Dual Demonstration. Consolidated FSR Reporting does not include revenues or expenses from any of the Dental Contractor's or its Affiliates' business activities or operations outside of the HHSC Programs.

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

**Contract Period or Contract Term** means the Initial Contract Period plus any and all Contract extensions.

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

**Copayment (CHIP only)** means the amount that a Member is required to pay when utilizing certain CHIP Medically Necessary Covered Dental Services. Once the copayment is made, further payment is not required by the Member.

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

**Covered Services or Covered Dental Services** means dental services the Dental Contractor must arrange to provide to Members, including all services required by the Contract and state and federal law, and all Value-added Services negotiated by the Parties.

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

**Cultural Competency** means the ability of individuals and systems to provide services effectively to people of various cultures, races, ethnic backgrounds, and

Definition for  
Competent  
Interpreter  
Added by  
Version 1.8

Definition for  
Consolidated  
FSR Report  
Added by  
Version 1.2  
and modified  
by Version  
1.10

Definition for  
Confidential  
Information  
modified by  
Version 1.10

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

religions in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves their dignity.

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

**Day** means a calendar day unless specified otherwise.

**Default Enrollment** means the processes established by HHSC per 1 Tex. Admin. Code § 353.403 to assign a potential Program enrollee who has not selected a dental plan to a dental plan.

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

**Dental Administrative Services** means the performance of services or functions other than the direct delivery of Medically Necessary Covered Dental Services necessary for the management of the delivery of and payment for Medically Necessary Covered Dental Services, including Network, quality management, service authorization, claims processing, MIS operation and reporting. This term also includes the infrastructure development for, preparation of, and delivery of, all required Deliverables under the Contract, outside of the Covered Services.

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

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

**Dental Network Provider** or **Provider** means an appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a contract with the Dental Contractor for the delivery of Medically Necessary Covered Dental Services to the Dental Contractor's Members.

**Dental Program** means the State of Texas program in which HHSC contracts with Dental Contractor to provide, arrange for, and coordinate Medically Necessary Covered Dental Services and benefit limitations for enrolled Members.

**Diagnostic** means assessment that may include gathering of information through interview,

observation, examination, and use of specific tests that allows a provider to diagnose existing conditions.

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

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

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

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

**Dual Demonstration** means the Texas Dual Eligibles Integrated Care Demonstration Project, which uses a service delivery model for Dual Eligibles that combines Medicare and Medicaid services under the same health plan.

**EDI** means electronic data interchange.

**Effective Date** means the effective date of this Contract, as specified in the HHSC Dental Program Contract document.

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

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

**Emergency services** mean covered inpatient and outpatient services needed to evaluate or stabilize an emergency medical condition furnished by a provider qualified to furnish these services under this title.

**Encounter** means a Medically Necessary Covered Dental Service or group of Medically Necessary Covered Dental Services delivered by a provider to a Member during a visit between the Member and provider. This also includes Value-added Services.

**Encounter Data** means data elements from claims or capitated services proxy claims that are submitted to HHSC by the Dental Contractor in accordance with HHSC's required format for Dental Contractors.

**Enrollment Report/Enrollment File** means the daily or monthly list of Eligibles that are enrolled with the

Definition for Default Enrollment modified by Version 1.4

Definition for Dental Administrative Services modified by Version 1.6

Definition for Discovery/Discovered added by Version 1.12

Definition for Dual Demonstration added by Version 1.10

Definition for Emergency Services added by Version 1.2

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

Dental Contractor as Members on the day or for the month the report is issued.

**EPSDT** means the federally mandated Early and Periodic Screening, Diagnosis and Treatment program contained at 42 U.S.C. 1396d(r). The name has been changed to Texas Health Steps in the State of Texas.

**Experience Rebate** means the portion of the Dental Contractor's net income before taxes that may be returned to the State in accordance with **Section 10.08** ("Experience Rebate")

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

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

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

**Fair Hearing** means the process adopted and implemented by HHSC in 1 T.A.C. Chapter 357, in compliance with federal regulations and state rules relating to Medicaid Fair Hearings.

**Farmworker Child (FWC)** means a child birth through age 20 of a Migrant Farm Worker.

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

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

**Financial Statistical Report** (see FSR below).

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

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

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

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

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

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

**FSR Reporting Period 12/13** means the 18-month period beginning on March 1, 2012, and ending on August 31, 2013. This is the first FSR Reporting Period under this contract.

**FSR Reporting Period 14** means the 12-month period beginning on September 1, 2013, and ending on August 31, 2014.

**FSR Reporting Period 15** means the 12-month period beginning on September 1, 2014, and ending on August 31, 2015.

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

**HEDIS**, the Healthcare Effectiveness Data and Information Set, is a registered trademark of NCQA.

Definition for Expansion Children deleted by Version 1.5

Definition for Federal Poverty Level (FPL) modified by Version 1.5

Definition for Fee-for-Service (FFS) modified by Version 1.6

Definition for Financial Statistical Report Added by Version 1.2

Definition for First Dental Home modified by Version 1.10

Definition for FSR Reporting Period 12/13 Added by Version 1.2

Definition for FSR Reporting Period 14 Added by Version 1.2

Definition for FSR Reporting Period 15 Added by Version 1.2

Definition for HEDIS modified by Version 1.4

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

HEDIS is a set of standardized performance measures. HEDIS is sponsored, supported and maintained by NCQA.

**HHS Agency** means the Texas health and human service agencies subject to HHSC's oversight under Chapter 531, Texas Government Code, and their successor agencies.

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

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

**Initial Contract Period** means the Effective Date of the Contract through August 31, 2015.

**Joint Interface Plan (JIP)** means a document used to communicate basic system interface information. This information includes: file structure, data elements, frequency, media, type of file, receiver and sender of the file, and file identification. The JIP must include the Dental Contractor's interfaces required to conduct business under this 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.

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

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

**Linguistic Access** means translation and interpreter services, for written and spoken language to ensure effective communication. Linguistic access includes sign language interpretation, and the provision of other auxiliary aids and services to persons with disabilities.

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

are FQHCs, RHCs, and individuals who are general dentists or pediatric dentists.

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

**Major Systems Change** means a new version of an existing software platform often identified by a new software version number or conversion to an entirely new software platform.

**Marketing** means any communication from the Dental Contractor that promotes and informs Dental Program Members about dental coverage and the access and use of those services.

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

- (1) enroll with the Dental Contractor; or
- (2) not enroll in, or to disenroll from, another Dental Contractor.

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

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

- (1) the other entity is an Affiliate of the Dental Contractor;
- (2) the Subcontract is considered by HHSC to be for a key type of service or function, including:
  - (i) Administrative Services (including third party administrator, Network administration, and claims processing);
  - (ii) delegated Networks (including behavioral health, dental, pharmacy, and vision);
  - (iii) management services (including management agreements with parent);
  - (iv) reinsurance; or
  - (v) call lines (including nurse and medical consultation); or
- (3) any other Subcontract that exceeds, or is reasonably expected to exceed, the lesser of a) \$500,000 per year, or b) 1% of the Dental Contractor's annual revenues under this Contract. Any Subcontracts between the Dental Contractor and a single entity that are split into separate agreements by time period, Program, Service

Definition for Major Systems Change is added by Version 1.7

Definition for Material Subcontract Modified by Versions 1.2 and 1.6

Definition for Legally Authorized Representative is added by Version 1.7

Definition for Main Dental Home Provider Modified by Versions 1.2 and 1.12

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

Area, or otherwise, will be consolidated for the purpose of this definition.

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

**Material Subcontractor** or **Major Subcontractor** means any entity with a Material Subcontract with the Dental Contractor. For the purposes of this Agreement, Material Subcontractors do not include providers in the Dental Contractor's Provider Network. Material Subcontractors may include, without limitation, Affiliates, subsidiaries, and affiliated and unaffiliated third parties.

**MCO** means managed care organization.

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

**Medicaid MCOs** means contracted MCOs participating in capitated Medicaid health care service models, including STAR, STAR+PLUS, and/or STAR Health.

**Medical Assistance Only (MAO)** means a person that does not receive SSI benefits but qualifies financially and functionally for Medicaid assistance.

**Medically Necessary** has the meaning defined in 1 T.A.C. §353.2 (Medicaid) and 1 T.A.C. §370.4 (CHIP).

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

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

**Member Materials** means all written materials produced or authorized by the Dental Contractor and distributed to Members or potential members containing information concerning the Dental Program. Member Materials include, but are not limited to, Member ID cards, Member handbooks, Provider directories, and Marketing Materials.

**Member Month** means one (1) Member enrolled with the Dental Contractor during any given month. The total Member Months for each month of a year comprise the annual Member Months.

**Member with Special Health Care Needs (MSHCN)** means a Member, including a child enrolled in the DSHS CSHCN Program as further defined in Tex. Health & Safety Code § 35.0022, who:

- (1) has a serious ongoing illness, a Chronic or Complex Condition, or a Disability that has lasted or is anticipated to last for a significant period of time, and
- (2) requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel.

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

- (1) whose principal employment is in agriculture on a seasonal basis;
- (2) who has been so employed within the last 24 months;
- (3) who performs an activity directly related to the production or processing of crops, dairy products, poultry, or livestock for initial commercial sale or as a principal means of personal subsistence; and
- (4) who establishes for the purposes of such employment a temporary abode.

**MIS** means Management Information System.

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

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

**Non-capitated Services** benefits of the Texas Medicaid or CHIP Program that are excluded from Medically Necessary Covered Dental Services. The Dental Contractor is not responsible for coverage or payment of Non-capitated Services.

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

**Non-Urban County** or **Rural County** means any county with fewer than 50,000 residents as reported

Definition for Member with Special Health Care Needs (MSHCN) added by Version 1.6

Definition for Medically Necessary Modified by Version 1.2 and by 1.7

Definition for Net Income Before Taxes Modified by Version 1.2

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

by the Texas Association of Counties  
at: <http://www.county.org/>.

**Open Panel** means general dentists and pediatric dentists who are accepting new patients for the Dental Program.

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

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

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

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

**Parties** mean HHSC and the Dental Contractor, collectively.

**Party** means either HHSC or the Dental Contractor, individually.

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

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

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

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

**Premium Rate** means a fixed predetermined fee paid by HHSC to the Dental Contractor each month in accordance with the Contract, for each enrolled

Member in a defined Rate Cell, in exchange for the Dental Contractor arranging for or providing a defined set of Medically Necessary Covered Dental Services to such a Member, regardless of the amount of Medically Necessary Covered Dental Services used by the enrolled Member that are within the defined limits as stated in the Medically Necessary Covered Dental Services attachment to the Contract.

**Pre-tax Income** (see Net Income Before Taxes above).

**Preventive** means aspects of oral health concerned with promoting good oral health and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrences of oro-facial injuries.

**Program** means a managed care program operated by HHSC. Depending on the context, the term may include one or more of the following: STAR, STAR+PLUS, STAR Health, CHIP, Children's Medicaid Dental Services, or CHIP Dental Services.

**Proposal** means the proposal submitted by the Dental Contractor in response to the RFP.

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

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

**Provider Network or Network** means all Providers who have entered into a written Network Provider Agreement with the Dental Contractor.

**Provider Agreement or Network Provider**

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

**Proxy Claim Form** means a form submitted by Providers to document services delivered to Members

Definition for  
Pre-Tax  
Income  
Modified by  
Version 1.2

Definition for  
Program  
Added by  
Version 1.2

Definition for  
Provider  
Materials  
Added by  
Version 1.2

Definition for  
Population  
Risk Group  
Modified by  
Version 1.6

Definition for  
Premium  
Payment  
Modified by  
Version 1.6

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

under a capitated arrangement. It is not a claim for payment.

**Public Information** means information that:

- (1) Is collected, assembled, or maintained under a law or ordinance or in connection with the transaction of official business by a governmental body or for a governmental body; and
- (2) The governmental body owns or has a right of access to.

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

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

**Rate Period 1** means the 18-month period beginning on March 1, 2012, and ending on August 31, 2013. For purposes of rate setting only, Rate Period 1 is divided into two sub-periods: March 1, 2012, and ending on August 31, 2012, and September 1, 2012, and ending on August 31, 2013.

**Rate Period 2** means the 12-month period beginning on September 1, 2013, and ending on August 31, 2014.

**Rate Period 3** means the 12-month period beginning on September 1, 2014, and ending on August 31, 2015.

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

**Readiness Review** means the assurances made by a selected Dental Contractor and the examination conducted by HHSC, or its agents, of Dental Contractor's ability, preparedness, and availability to fulfill its obligations under the Contract.

**Request for Proposals** or **RFP** means the procurement solicitation instrument issued by HHSC under which this Contract was awarded and all RFP addenda, corrections or modifications, if any.

**Revenue** means all revenue received by the Dental Contractor pursuant to this Contract during the

Contract Period, including retroactive adjustments made by HHSC. Revenue includes any funds earned on Medicaid or CHIP managed care funds such as investment income and earned interest. Revenue excludes any reinsurance recoveries, which shall be shown as a contra-cost, or reported offset to reinsurance expense. Revenues are reported at gross, and are not netted for any reinsurance premiums paid. See also the Uniform Managed Care Manual's "Cost Principles for Expenses."

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

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

**Rural County** or **Non-Urban County** means any county with fewer than 50,000 residents as reported by the Texas Association of Counties at: <http://www.county.org/>.

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

**SDX** means State Data Exchange.

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

**Service Area** means the geographic area within which Dental Program Medically Necessary Covered Dental Services are available to Members. The Service Area for the Dental Program includes all counties in the State of Texas, and is therefore a statewide Service Area.

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

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

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

Definition for Rate Period 1 Modified by Versions 1.1 and 1.2

Definition for Rate Period 2 Modified by Version 1.2

Definition for Rate Period 3 Modified by Version 1.2

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

**Specialty Provider** means a pediatric dentist, Endodontist, Oral Surgeon, Orthodontist, Periodontist, or Prosthodontist.

**SSA** means the Social Security Administration.

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

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

**Subcontractor** means any individual or entity, including an Affiliate, that has entered into a Subcontract with Dental Contractor.

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

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

**T.A.C.** means the Texas Administrative Code.

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

**TDI** means the Texas Department of Insurance.

**Temporary Assistance to Needy Families (TANF)** means the federally funded program that provides assistance to single parent families with children who meet the categorical requirements for aid. This program was formerly known as the Aid to Families with Dependent Children (AFDC) program.

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

**Texas Medicaid Provider Procedures Manual** means the policy and procedures manual published by or on behalf of HHSC that contains policies and procedures required of all health and dental care

providers who participate in the Texas Medicaid program.

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

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

**Third Party Liability (TPL)** means the legal responsibility of another individual or entity to pay for all or part of the services provided to Members under the Contract (see e.g., 1 TAC §354.2301 *et seq.*, relating to Third Party Resources).

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

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

**Transition Phase** includes all activities the Dental Contractor is required to perform between the Contract award and the Operational Start Date.

**Turnover Phase** includes all activities the Dental Contractor is required to perform in order to close-out the Contract and/or transition Contract activities and operations to HHSC or a subsequent contractor.

**Turnover Plan** means the written plan developed by the Dental Contractor, approved by HHSC, to be employed during the Turnover Phase. The Turnover Plan describes Dental Contractor's policies and procedures that will ensure:

- (1) The least disruption in the delivery of dental services to those Members who are enrolled with the Dental Contractor during the transition to a HHSC or subsequent contractor; and
- (2) Cooperation with HHSC and the subsequent contractor in transferring information, as well as notifying Members of the transition, as requested and in the form required and approved by HHSC.

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

Definition for Texas Medicaid Bulletin deleted by Version 1.6

Definition for Texas Medicaid Provider Procedures Manual modified by Versions 1.6 and 1.11

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

modified, is incorporated by reference into the Contract.

**Urban County** means any county with 50,000 or more residents as reported by the Texas Association of Counties at: <http://www.county.org/>.

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

**Value-added Services** or **VAS** may be actual dental services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improve dental outcomes among Members. VAS should promote oral health, healthy lifestyles, or other initiatives approved by HHSC. If approved by HHSC, VAS may also include transportation. Best practice approaches to delivering Medically Necessary Covered Dental Services are not considered VAS.

**Waste** means practices that are not cost-efficient.

### **Article 3. General Contract Terms & Conditions**

#### **Section 3.01 Contract elements.**

- (a) Contract documentation.  
The Contract between the Parties will consist of the Dental Program Contract documents and all attachments and amendments to these documents.
- (b) Order of documents.  
In the event of any conflict or contradiction between or among these documents, the documents must control in the following order of precedence:
- (1) The final executed HHSC CHIP Dental Contract document, and all amendments thereto;
  - (2) Contract **Attachment A** – “HHSC’s Dental Contract Terms and Conditions,” and all amendments thereto;
  - (3) Contract **Attachment B** – “Scope of Work/Performance Measures,” and all attachments and amendments thereto;
  - (4) The HHSC UMCM, and all attachments and amendments thereto; and
  - (5) Contract **Attachment C** – “Dental Contractor’s Proposal.”

#### **Section 3.02 Term of the Contract**

The term of the Contract will begin on the Effective Date and will conclude on the Expiration Date. The Parties may renew the Contract for a period or

periods, but the Contract Term may not exceed a total of eight (8) operational years. All reserved contract extensions beyond the Expiration Date will be subject to good faith negotiations between the Parties and mutual agreement to the extension(s).

#### **Section 3.03 Funding**

This Contract is expressly conditioned on the availability of state and federal appropriated funds. The Dental Contractor will have no right of action against HHSC in the event that HHSC is unable to perform its contractual obligations as a result of the suspension, termination, withdrawal, or failure of funding to HHSC or lack of sufficient funding of HHSC for any activities or functions contained within the scope of this Contract. If funds become unavailable, the provisions of **Article 12** (“Remedies and Disputes”) will apply. HHSC will use all reasonable efforts to ensure that such funds are available, and will negotiate in good faith with Dental Contractor to resolve any claims for payment by the Dental Contractor that represent accepted Services or Deliverables that are pending at the time funds become unavailable. HHSC will use best efforts to provide reasonable advance written notice to Dental Contractor upon learning that funding for this Contract may be unavailable.

#### **Section 3.04 Delegation of authority**

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

#### **Section 3.05 No waiver of sovereign immunity**

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

#### **Section 3.06 Force majeure**

Neither Party will be liable for any failure or delay in performing its obligations under the Contract if such failure or delay is due to a Force Majeure Event. The existence of such causes of delay or failure will extend the period of performance in the exercise of reasonable diligence until after the causes of delay or failure have been removed. Each Party must inform the other in writing with proof of receipt within five (5)

Section 3.03  
modified by  
Version 1.10

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

Business Days of the existence of a Force Majeure Event.

**Section 3.07 Publicity.**

(a) Dental Contractor may use the name of HHSC, the State of Texas, any HHS Agency, and the name of the HHSC Dental Program in any media release, public announcement, or public disclosure relating to the Contract or its subject matter only if, at least seven (7) calendar days prior to distributing the material, the Dental Contractor submits the information to HHSC for review and comment. The Dental Contractor may not use the submitted information without prior approval from HHSC. HHSC reserves the right to object to and require changes to the publication if, at HHSC's sole discretion, it determines that the publication does not accurately reflect the terms of the Contract or the Dental Contractor's performance under the Contract.

(b) Dental Contractor will provide HHSC at least three (3) copies of any information described in Subsection 3.07(a) prior to public release. Dental Contractor will provide additional copies at HHSC's request.

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

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

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

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

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

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

**Section 3.08 Assignment.**

(a) Assignment by Dental Contractor

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

(b) Assignment by HHSC

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

(c) Assumption

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

**Section 3.09 Cooperation with other vendors and prospective vendors**

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

**Section 3.10 Renegotiation and reprocurement rights**

(a) Renegotiation of Contract terms

Notwithstanding anything in the Contract to the contrary, HHSC may at any time during the term of the Contract exercise the option to notify Dental Contractor that HHSC has elected to renegotiate certain terms of the Contract. Upon Dental Contractor's receipt of any notice pursuant to this Section, Dental Contractor and HHSC will undertake good faith negotiations of the subject terms of the Contract, and may execute an amendment to the Contract in accordance with **Article 8** ("Amendments and Modifications").

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

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

(c) Termination rights upon reprocurement

Section 3.07 modified by Version 1.10

Section 3.08 modified by Version 1.10

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

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

**Section 3.11 RFP errors and omissions**

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

**Section 3.12 Attorneys’ fees**

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

**Section 3.13 Preferences under service contracts**

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

**Section 3.14 Time of the essence**

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

**Section 3.15 Notice**

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

- (1) Three (3) Business Days after the date of mailing if sent by registered or certified U.S. mail, postage prepaid, with return receipt requested;
- (2) When transmitted if sent by facsimile, provided a confirmation of transmission is produced by the sending machine; or
- (3) When delivered if delivered personally or sent by express courier service.

(b) The notices described in this Section may not be sent by electronic mail.

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

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

**Article 4. Contract Administration & Management**

**Section 4.01 Qualifications, retention and replacement of Dental Contractor employees**

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

**Section 4.02 Dental Contractor’s Key Personnel**

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

- (1) Member Services;
- (2) Management Information Systems;
- (3) Claims Processing;
- (4) Provider Network Development and Management;
- (5) Benefit Administration and Utilization and Care Management;
- (6) Quality Improvement;
- (7) Financial Functions;
- (8) Reporting;
- (9) Executive Directors, as defined in **Section 4.03** (“Executive Director”); and
- (10) Dental Director, as defined in **Section 4.04** (“Dental Director”).

(b) Support and Replacement of Key Personnel

The Dental Contractor must maintain, throughout the Contract Term, the ability to supply its Key Personnel with the required resources necessary to meet Contract requirements and comply with applicable law. The Dental Contractor must ensure project continuity by timely replacement of Key Personnel, if

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

necessary, with a sufficient number of persons having the requisite skills, experience and other qualifications. Regardless of specific personnel changes, the Dental Contractor must maintain the overall level of expertise, experience, and skill reflected in the Dental Contractor's Proposal.

(c) Notification of replacement of Key Personnel

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

**Section 4.03 Executive Director**

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

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

- (1) ensuring the Dental Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;
- (2) receiving and responding to all inquiries and requests made by HHSC related to the Contract, in the timeframes and formats specified by HHSC. Where practicable, HHSC will consult with the Dental Contractor to establish timeframes and formats reasonably acceptable to the Parties;
- (3) attending and participating in regular meetings or conference calls with HHSC;
- (4) attending and participating in regular HHSC Regional Advisory Committees (RACs) for managed care (the Executive Director may

designate key personnel to attend a RAC if the Executive Director is unable to attend);

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

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

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

**Section 4.04 Dental Director**

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

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

**Section 4.05 Responsibility for Dental Contractor personnel and Subcontractors**

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

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

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

(d) Dental Contractor agrees that any claim on behalf of any person arising out of employment or

Section 4.03  
Modified by  
Versions 1.2  
and 1.10

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

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

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

- (1) Damages incurred by Dental Contractor's employees within the scope of their duties under the Contract; and
- (2) Determination of the hours to be worked and the duties to be performed by Dental Contractor's employees.

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

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

**Section 4.06 Cooperation with HHSC and state administrative agencies**

(a) Cooperation with other HHSC Dental Contractors

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

use its best efforts to ensure that other HHSC contractors reasonably cooperate with the Dental Contractor.

(b) Cooperation with state and federal administrative agencies

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

- (1) The investigation and prosecution of fraud, abuse, and waste in the HHSC programs;
- (2) Audit, inspection, or other investigative purposes; and
- (3) Testimony in judicial or quasi-judicial proceedings relating to the Services and/or Deliverables under this Contract or other delivery of information to HHSC or other agencies' investigators or legal staff.

**Section 4.07 Conduct of Dental Contractor personnel and Subcontractors.**

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

- (1) Comply with applicable State laws, rules, and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations; and
- (2) Otherwise conduct themselves in a businesslike and professional manner.

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

- (1) Removing the employee or Subcontractor from the project;
- (2) Providing HHSC with written notice of such removal; and
- (3) Replacing the employee or Subcontractor with a similarly qualified individual or Subcontractor acceptable to HHSC.

(c) Nothing in the Contract will prevent Dental Contractor, at the request of HHSC, from replacing any personnel who are not adequately performing

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

their assigned responsibilities or who, in the reasonable opinion of HHSC's Project Manager, after consultation with Dental Contractor, are unable to work effectively with the members of HHSC's staff. In such event, Dental Contractor will provide replacement personnel with equal or greater skills and qualifications as soon as reasonably practicable. Replacement of Key Personnel will be subject to HHSC review. The Parties will work together in the event of any such replacement so as not to disrupt the overall project schedule.

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

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

**Section 4.08 Subcontractors and Agreements with Third Parties.**

Section 4.08  
Modified by  
Versions 1.2  
and 1.6

(a) Dental Contractor remains fully responsible for the obligations, services, and functions performed by its Subcontractors to the same extent as if such obligations, services, and functions were performed by Dental Contractor's employees, and for purposes of this Contract such work will be deemed work performed by Dental Contractor. HHSC reserves the right to require the replacement of any Subcontractor found by HHSC to be unacceptable and unable to meet the requirements of the Contract, and to object to the selection of a Subcontractor.

(b) Dental Contractor must:

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

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

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

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

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

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

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

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

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

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

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

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

(4) an existing Material Subcontractor changes one (1) or more of its MIS subsystems, claims processing or operational functions; or

(5) a Readiness Review is requested by HHSC.

The Dental Contractor must submit information required by HHSC for each proposed Material Subcontractor as indicated in **RFP Section 7**, "Transition Phase Requirements". Refer to **RFP Sections 8.1.2**, "Additional Readiness Reviews and Monitoring Efforts," and **8.1.12**, "Management Information System Requirements" for additional information regarding Dental Contractor Readiness Reviews during the Contract Period.

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

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

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

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

If the Dental Contractor intends to report compensation or any other payments paid to any third party (including without limitation an Affiliate) as an Allowable Expense under this Contract, and the amounts paid to the third party exceed \$200,000, or are reasonably anticipated to exceed \$200,000, in a State Fiscal Year (or in any contiguous twelve-month period), then the Dental Contractor's agreement with the third party must be in writing. The agreement must provide HHSC the right to examine the agreement and all records relating to the agreement.

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

(g) A Subcontract or any other agreement in which the Dental Contractor receives rebates, recoupments, discounts, payments, incentives, fees, free goods, bundling arrangements, retrocession payments (as described in UCM Chapter 6.1) or any other consideration from a Subcontractor or any other third party (including without limitation Affiliates) as related to this Contract must be in writing. The Dental Contractor must allow HHSC and the Office of the Attorney General to examine the Subcontract or agreement and all related records.

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

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

HHSC no later than 5 Business Days after execution or amendment.

(j) Network Provider Contracts must include the mandatory provisions included in UCM, Chapter 8.1 "Provider Contract Checklist".

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

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

**Section 4.09 *HHSC's ability to contract with Subcontractors***

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

**Section 4.10 *This Section Intentionally Left Blank***

**Section 4.11 *Prohibition Against Performance Outside the United States.***

(a) Findings.

(1) HHSC finds the following:

(i) HHSC is responsible for administering several public programs that require the collection and maintenance of information relating to persons who apply for and receive services from HHSC programs. This information consists of, among other things, personal financial and medical information and information designated "Confidential Information" under state and federal law and this Agreement. Some of this information may, within the limits of the law and this Agreement, be shared from time to time with Dental Contractor or a subcontractor for purposes of performing the Services or providing the Deliverables under this Agreement.

(ii) HHSC is legally responsible for maintaining the confidentiality and integrity of information relating to applicants and recipients of HHSC services and ensuring that any person or entity that receives such information—including Dental Contractor and

Section 4.10  
Modified by  
Version 1.2  
and deleted  
in its entirety  
by Version  
1.6

Section 4.11  
Added by  
Version 1.1  
and Modified  
by Version  
1.8

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

- any subcontractor—is similarly bound by these obligations.
- (iii) HHSC also is responsible for the development and implementation of computer software and hardware to support HHSC programs. These items are paid for, in whole or in part, with state and federal funds. The federal agencies that fund these items maintain a limited interest in the software and hardware so developed or acquired.
- (iv) Some of the software used or developed by HHSC may also be subject to statutory restrictions on the export of technology to foreign nations, including but not limited to the Export Administration Regulations, 15 C.F.R. Parts 730-774.
- (2) In view of these obligations, and to ensure accountability, integrity, and the security of the information maintained by or for HHSC and the work performed on behalf of HHSC, HHSC DETERMINES that it is necessary and appropriate to require THAT:
- (i) All work performed under this Agreement must be performed exclusively within the United States; and
- (ii) All information obtained by Dental Contractor or a subcontractor under this Agreement must be stored and maintained within the United States.
- (3) Further, HHSC finds it necessary and appropriate to forbid the performance of any work or the maintenance of any information relating or obtained pursuant to this Agreement to occur outside of the United States except as specifically authorized or approved by HHSC.
- (b) Meaning of “within the United States” and “outside the United States.”
- (1) As used in this Section 4.11, the term “within the United States” means any location inside the territorial boundaries comprising the republic of the United States of America, including of any of the 48 coterminous states in North America, the states of Alaska and Hawaii, and the District of Columbia.
- (2) Conversely, the phrase “outside the United States” means any location that is not within the territorial boundaries comprising the republic of the United States of America, including of any of the 48 coterminous states in North America, the states of Alaska and Hawaii, and the District of Columbia.
- (c) Maintenance of Confidential Information.
- (1) Dental Contractor and all subcontractors, vendors, agents, and service providers of or for Dental Contractor must not allow any Confidential Information that Dental Contractor receives from or on behalf of HHSC to be moved outside the United States by any means (physical or electronic) at any time, for any period of time, for any reason.
- (2) Dental Contractor and all subcontractors, vendors, agents, and service providers of or for Dental Contractor must not permit any person to have remote access to HHSC information, systems, or Deliverables from a location outside the United States.
- (d) Performance of Work under Agreement.
- (1) Unless otherwise approved in advance by HHSC in writing, and subject to the exceptions specified in paragraph (d) of this Section 4.11, Dental Contractor and all subcontractors, vendors, agents, and service providers of or for Dental Contractor must perform all services under the Agreement, including all tasks, functions, and responsibilities assigned and delegated to Dental Contractor under this Agreement, within the United States.
- (i) This obligation includes, but is not limited to, all Services, including but not limited to information technology services, processing, transmission, storage, archiving, data center services, disaster recovery sites and services, customer support), medical, dental, laboratory and clinical services.
- (ii) All custom software prepared for performance of this Agreement, and all modifications of custom, third party, or vendor proprietary software, must be performed within the United States.
- (2) Unless otherwise approved in advance by HHSC in writing, and subject to the exceptions specified in paragraph (d) of this Section 4.11, Dental Contractor and all subcontractors, vendors, agents, and service providers of or for Dental Contractor must not permit any person to perform work under this Agreement from a location outside the United States.
- (e) Exceptions.
- (1) COTS Software. The foregoing requirements will not preclude the acquisition or use of commercial off-the-shelf software that is developed outside the United States or hardware

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

that is generically configured outside the United States.

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

(3) HHSC Prior Approval. The foregoing requirements will not preclude Dental Contractor from performing work outside the United States that HHSC has approved in writing and that HHSC has confirmed will not involve the sharing of Confidential Information outside the United States.

(f) Disclosure.

Dental Contractor must disclose all Services and Deliverables under or related to this Agreement that Dental Contractor intends to perform or has performed outside the United States, whether directly or via subcontractors, vendors, agents, or service providers.

(g) Remedy.

(1) Dental Contractor's violation of this Section 4.11 will constitute a material breach in accordance with Article 12. Dental Contractor will be liable to HHSC for all monetary damages, in the form of actual, consequential, direct, indirect, special and/or liquidated damages in accordance with this Agreement.

(2) HHSC may terminate the Agreement with notice to Dental Contractor at least one calendar day before the effective date of such termination.

#### **Section 4.12 Employment Verification**

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

### **Article 5. Member Eligibility & Enrollment**

#### **Section 5.01 Eligibility Determination**

The HHSC Administrative Services Contractor determines Medicaid and CHIP eligibility.

#### **Section 5.02 General Information Concerning Member Enrollment & Disenrollment**

(a) HHSC or the HHSC Administrative Services Contractor will enroll and disenroll eligible individuals in the Dental Program. The HHSC Administrative Services Contractor will use HHSC's default assignment methodologies, as described in 1 Tex. Admin. Code § 353.403 and § 370.303, to enroll individuals who do not select a Dental Plan or Main Dentist. Once an eligible individual is enrolled, a file is sent to the Dental Contractor to notify the Dental Contractor that the individual is enrolled as a Medicaid or CHIP Member. The Dental Contractor is not allowed to induce or accept disenrollment from a Member. The Dental Contractor must refer the Member to the HHSC Administrative Services Contractor for information regarding enrollment or disenrollment.

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

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

#### **Section 5.03 Medicaid Member Enrollment & Disenrollment.**

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

(b) In cases where a Member loses Medicaid eligibility, if Medicaid eligibility is re-instated or re-established within 6 months from the date of loss, HHSC will retroactively restore a Member's managed care enrollment to avoid a gap in coverage. In these cases, the HHSC Administrative Services Contractor

Section 5.02  
Modified by  
Versions 1.1  
and 1.5

Section 5.03  
Modified by  
Versions 1.1,  
1.7, and 1.8

Section 4.12  
added by  
Version 1.10  
and modified  
by Version  
1.11

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

will retroactively enroll the Member into the same dental plan the Member was in before losing coverage.

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

- (1) Member misuses or loans Member's membership card to another person to obtain services.
  - (2) Member's behavior is disruptive or uncooperative to the extent that Member's continued enrollment in the Dental Contractor seriously impairs Dental Contractor's or Provider's ability to provide services to either the Member or other Members, and Member's behavior is not related to a developmental, intellectual, or physical disability or behavioral health condition.
  - (3) Member steadfastly refuses to comply with managed care restrictions. .
  - (4) Dental Contractor must take reasonable, documented measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.
- (d) HHSC must notify the Member of HHSC's decision to disenroll the Member if all reasonable measures have failed to remedy the problem.
- (e) If the Member disagrees with the decision to disenroll the Member from Dental Contractor, HHSC must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's Fair Hearing process.
- (f) Dental Contractor cannot request a disenrollment based on adverse change in the Member's health status or utilization of services that are Medically Necessary for treatment of a member's condition.
- (g) Members taken into conservatorship by the Department of Family and Protective Services (DFPS) will be disenrolled from the Dental Contractor effective the date of conservatorship, and enrolled in the STAR Health Program unless otherwise determined by DFPS.

**Section 5.04 CHIP eligibility and enrollment.**

(a) Children enrolled in the CHIP Program with incomes at or below the Medicaid eligibility threshold receive Dental Program coverage for twelve (12) months. Children enrolled in CHIP with incomes above the Medicaid eligibility threshold receive Dental Program coverage for up to 12 months and are required to verify income eligibility at month six (6) of their twelve (12) month coverage period.

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

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

**Section 5.05 Default Enrollment.**

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

(a) Special Default Enrollment Process

Prior to the Operational Start Date, HHSC's Administrative Service Contractor will notify all Dental Members and new enrollees of their choice in dental plans. The notice will provide that if the individual does not select a dental plan, HHSC will assign one.

HHSC will use the following special Default Enrollment process for the period of time described below.

- (1) If on the Operational Start Date one (1) or more CHIP dental plans have not reached a threshold of 80,000 Members or one (1) or more Medicaid dental plans have not reached a threshold of 300,000 Members, then HHSC will enroll all individuals who have not made a dental plan selection into these dental plans on a "Round Robin" basis until they reach the

Section 5.04  
Modified by  
Versions 1.1  
and 1.5

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

threshold. (Under the “Round Robin” approach, HHSC will enroll individuals who have not made a dental plan selection into these dental plans on a one-to-one (1:1) ratio.) Once the dental plan reaches the threshold, a six (6) month maintenance period will begin. During this maintenance period, if one or more dental plans’ enrollment falls below the threshold, HHSC will enroll individuals who have not made a dental plan selection into these dental plans on a Round Robin basis until they reaches the threshold again.

(2) If all dental plans reach the threshold on the Operational Start Date, then the six (6) month maintenance period will begin on the Operational Start Date. During this maintenance period, if one or more dental plans’ enrollment falls below the threshold, HHSC will enroll all individuals who have not made a dental plan selection into these dental plans on a Round Robin basis until they reach the required Member threshold again.

(3) At any point in time during the six (6) month maintenance period when all dental plans’ enrollment exceeds the required thresholds, HHSC will use the Round Robin default enrollment approach.

**(b) Standard Default Enrollment Process**

Following the expiration of the six (6) month maintenance period described in **Section 5.05(a)(2)** above, HHSC will use a Round Robin default enrollment approach.

**(c) Changing Assigned Dental Plan**

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

**Section 5.06 This Section Intentionally Left Blank**

**Article 6. Service Levels & Performance Measurement**

**Section 6.01 Performance measurement.**

Satisfactory performance of this Contract will be measured by:

- (a) Adherence to this Contract, including all representations and warranties;
- (b) Compliance with project work plans, schedules, and milestones as proposed by Dental Contractor in its Proposal and as revised by Dental Contractor and finally approved by HHSC;

- (c) Delivery of the Services and Deliverables in accordance with the Contract’s requirements;
- (d) Results of audits performed by HHSC or its representatives in accordance with **Article 9** (“Audit and Financial Compliance”);
- (e) Timeliness, completeness, and accuracy of required Deliverables; and
- (f) Achievement of contractual performance measures.

**Article 7. Governing Law & Regulations**

**Section 7.01 Governing law and venue**

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

**Section 7.02 Dental Contractor responsibility for compliance with laws and regulations**

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

- (1) Titles XIX and XXI of the Social Security Act;
- (2) Chapters 62, 63, and 109, Texas Health and Safety Code;
- (3) Chapter 531 and 533, Texas Government Code;
- (4) 42 C.F.R. Parts 417, 455, and 457, as applicable;
- (5) 45 C.F.R. Parts 74 and 92;
- (6) 48 C.F.R. Part 31 and 2 C.F.R. Part 200;
- (7) 1 T.A.C. Chapters 361, 370, 371, 391, and 392;
- (8) Consent Decree and Corrective Action Orders, *Frew, et al. v. Smith, et al.*, (applies to Medicaid only);
- (9) partial settlement agreements, *Alberto N., et al. v. Smith, et al.*, (applies to Medicaid only);
- (10) except as provided in Section 8.1.5.3 of the RFP, the Texas Dental Practice Act requiring all

Section 7.02 modified by Versions 1.1, 1.2, 1.4, 1.8, 1.10 and 1.12

Section 5.06 Deleted in its Entirety by Version 1.2

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

dental services to be provided by licensed Texas dentists and auxiliary personnel working under the supervision of licensed Texas dentists;

(11) Texas Human Resources Code Chapters 32 and 36;

(12) Texas Penal Code Chapter 35A (Medicaid Fraud);

(13) 1 Tex. Admin. Code Chapter 353;

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

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

(16) The Health Care and Education Reconciliation Act of 2010 ("HCERA"; Public Law 111-152) 42 CFR Part 455;

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

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

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

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

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

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

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

**Section 7.03 TDI licensure and solvency.**

(a) Licensure

Dental Contractor must be licensed by the TDI as an indemnity insurer or DMO that provides insurance coverage for dental care services in all counties in the State of Texas, or obtain such licensure no later than 120 days prior to the Operational Start Date.

(b) Solvency

Dental Contractor must maintain compliance with the Texas Insurance Code and rules promulgated and administered by the TDI requiring a fiscally sound operation.

Dental Contractor must have a plan and take appropriate measures to ensure adequate provision against the risk of insolvency as required by TDI. Such provision must be adequate to provide for the following in the event of insolvency:

(1) payment to unaffiliated health care providers and affiliated health care providers whose agreements do not contain member "hold harmless" clauses acceptable to TDI, and

(2) continuation of benefits for the duration of the Contract period for which HHSC has paid a Premium Payment.

Provision against the risk of insolvency must be made

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

Section 7.04  
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Version 1.4

by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI.

**Section 7.04 This Section Intentionally Left Blank**

**Section 7.05 Compliance with state and federal anti-discrimination laws.**

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

- (1) Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.);
- (2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
- (3) Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.);
- (4) Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
- (5) Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);
- (6) Food Stamp Act of 1977 (7 U.S.C. §200 et seq.); and
- (7) The HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

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

(b) Dental Contractor agrees to comply with Title VI of the Civil Rights Act of 1964, and its implementing regulations at 45 C.F.R. Part 80 or 7 C.F.R. Part 15, prohibiting a contractor from adopting and implementing policies and procedures that exclude or have the effect of excluding or limiting the participation of clients in its programs, benefits, or activities on the basis of national origin. Applicable state and federal civil rights laws require contractors to provide alternative methods for ensuring access to services for applicants and recipients who cannot express themselves fluently in English. Dental Contractor agrees to ensure that its policies do not have the effect of excluding or limiting the participation of persons in its programs, benefits, and activities on the basis of national origin. Dental Contractor also agrees to take reasonable steps to

provide services and information, both orally and in writing, in appropriate languages other than English, in order to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities.

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

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

(e) Dental Contractor must notify HHSC's Civil Rights Office of any civil rights complaints received relating to its performance under this Agreement. This notice must be delivered no more than ten (10) calendar days after receipt of a complaint. Notice provided pursuant to this section must be directed to:

HHSC Civil Rights Office  
701 W. 51st Street, Mail Code W206  
Austin, Texas 78751  
Phone Toll Free: (888) 388-6332  
Phone: (512) 438-4313  
TTY Toll Free: (877) 432-7232  
Fax: (512) 438-5885.

**Section 7.06 Environmental protection laws.**

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

(a) Pro-Children Act of 1994

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

(b) National Environmental Policy Act of 1969

Dental Contractor must comply with any applicable provisions relating to the institution of environmental quality control measures contained in the National

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

Environmental Policy Act of 1969 (42 U.S.C. §4321 *et seq.*) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality").

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

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

(d) State Clean Air Implementation Plan

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

(e) Safe Drinking Water Act of 1974

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

#### **Section 7.07 HIPAA.**

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

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

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

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

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

#### **Section 7.08 Historically Underutilized Business Participation Requirements**

(a) Definitions.

For purposes of this Section:

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

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

(b) HUB Requirements.

(1) In accordance with Attachment B-1, Section 4.2.5, the Dental Contractor must submit an HSP with its Proposal for HHSC's approval, and maintain the HSP thereafter.

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

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

(i) The Dental Contractor must submit a revised HSP to the HHSC HUB Office

Section 7.07  
is modified  
by Version  
1.7

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

when it: changes the dollar amount of, terminates, or modifies an existing Subcontract for Dental Administrative Services; or enters into a new Subcontract for Dental Administrative Services. All proposed changes to the HSP must comply with the requirements of this Agreement.

- (4) HHSC will determine if the value of Subcontracts to HUBs meet or exceed the HUB subcontracting provisions specified in the Dental Contractor's HSP. If HHSC determines that the Dental Contractor's subcontracting activity does not demonstrate a good faith effort, the Contractor may be subject to provisions in the Vendor Performance and Debarment Program ([Title 34, Part 1, Chapter 20, Subchapter C, Rule §20.105](#)), and subject to remedies for breach.

**Section 7.09 Compliance with Fraud, Waste, and Abuse requirements.**

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

Section 7.09 is added by Version 1.7

**Article 8. Amendments & Modifications**

**Section 8.01 Mutual Contract.**

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

**Section 8.02 Changes in law or contract.**

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

**Section 8.03 Modifications as a remedy**

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

**Section 8.04 Modification Process**

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

(b) Dental Contractor must respond to HHSC's proposed modification within the timeframe specified by HHSC, generally within ten (10) Business Days of receipt. Upon receipt of Dental Contractor's response to the proposed modifications, HHSC may enter into negotiations with Dental Contractor to arrive at mutually agreeable Contract amendments. In the event that HHSC determines that the Parties will be unable to reach agreement on mutually satisfactory contract modifications, then HHSC may provide written notice to Dental Contractor of its intent to terminate the Contract or not to extend the Contract beyond the Contract Term then in effect.

**Section 8.05 Modification of HHSC Uniform Managed Care Manual.**

(a) HHSC will provide Dental Contractor with at least ten (10) Business Days advance written notice before implementing a substantive and material change in the HHSC Uniform Managed Care Manual (UMCM). For purposes herein, this would refer to a change that materially and substantively alters the Dental Contractor's ability to fulfill its obligations under the Contract. The UMCM, and all modifications thereto, are incorporated by reference into this Contract. HHSC will provide Dental Contractor with a reasonable amount of time to comment on such changes, generally at least five (5) Business Days. HHSC is not required to provide advance written notice of changes that are not material and substantive in nature, such as corrections of clerical errors or policy clarifications.

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

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

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

enforce the change during the period of time between the receipt of the notice and the date of Contract termination.

**Section 8.06 Required compliance with amendment and modification procedures**

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

**Article 9. Audit & Financial Compliance**

**Section 9.01 Record retention and audit.**

Dental Contractor agrees to maintain, and require its Subcontractors to maintain, records, books, documents, and information (collectively "records") that are adequate to ensure that the services provided and are made payments in accordance with the requirements of this Contract, including applicable Federal and State requirements (e.g., 45 CFR §74.53). Such records must be retained by Dental Contractor or its Subcontractors for a period of five (5) years after the Contract Expiration Date or until the resolution of all litigation, claim, financial management review or audit pertaining to this Contract, whichever is longer.

**Section 9.02 Access to records, books, and documents.**

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

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

- (1) Examination;
- (2) Audit;
- (3) Investigation;
- (4) Contract administration; or
- (5) The making of copies, excerpts, or transcripts.

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

- (1) The United States Department of Health and Human Services or its designee;
- (2) The Comptroller General of the United States or its designee;
- (3) Dental Program personnel from HHSC or its designee, including HHSC's independent auditor;
- (4) The Office of Inspector General;
- (5) The Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;
- (6) Any independent verification and validation contractor or quality assurance contractor acting on behalf of HHSC;
- (7) The Office of the State Auditor of Texas or its designee;
- (8) A State or Federal law enforcement agency;
- (9) A special or general investigating committee of the Texas Legislature or its designee; and
- (10) Any other State or Federal entity identified by HHSC, or any other entity engaged by HHSC.

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

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

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

**Section 9.03 Audits of Services, Deliverables and inspections.**

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

Section 9.02  
modified by  
Version 1.4

Section 9.03  
modified by  
Version 1.12

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

- (1) service locations, facilities, or installations;
- (2) records; and
- (3) Software and Equipment.

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

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

- (1) Dental Contractor's capacity to bear the risk of potential financial losses;
  - (2) The Services and Deliverables provided;
  - (3) A determination of the amounts payable under this Contract;
- (4) A determination of the allowability of costs reported under this Contract;
- (5) An examination of Subcontract terms and/or transactions;
- (6) An assessment of financial results under this Contract;
- (7) Detection of fraud, waste and/or abuse;
  - (8) Other purposes HHSC deems necessary to perform its regulatory function and/or enforce the provisions of this Contract.

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

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

hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

**Section 9.04 SAO Audit**

The Dental Contractor understands that acceptance of funds under this Contract acts as acceptance of the authority of the State Auditor's Office ("SAO"), or any successor agency, to conduct an investigation in connection with those funds. The Dental Contractor further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested at no cost. The Dental Contractor will ensure that this clause concerning the authority to audit funds and the requirement to cooperate is included in any Subcontract, and in any third party agreements described in **Section 4.10** "Dental Contractor Agreements with Third Parties".

**Section 9.05 Response/compliance with audit or inspection findings**

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

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

- (1) Required by Texas or Federal law, regulation, rule, court order, or other audit requirement relating to Dental Contractor's business;
- (2) Performed by Dental Contractor as part of the Scope of Work; or
- (3) Necessary due to Dental Contractor's noncompliance with any law, regulation, rule, court order, or audit requirement imposed on Dental Contractor.

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

Section 9.04  
modified by  
Version 1.4

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

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

The Dental Contractor must notify HHSC of all proceedings, actions, and events as specified in UCMCM, Chapter 5.8, "Report of Legal and Other Proceedings, and Related Events."

**Article 10. Terms & Conditions of Payment**

**Section 10.01 Calculation of monthly Premium Payment**

Section 10.01 modified by Version 1.6

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

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

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

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

- (1) an amount for the dental services performed during the month;
- (2) an amount for administering the program, and
- (3) an amount for the Dental Contractor's risk margin.

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

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

**Section 10.02 Time and Manner of Payment.**

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

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

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

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

- (1) equitably adjust the Premium Payments for all participating Dental Contractors, and reduce scope of service requirements as appropriate in accordance with **Article 8** "Amendments and Modifications", or
- (2) terminate the Contract in accordance with **Article 12** "Remedies and Disputes".

**Section 10.03 Certification of Premium Rates.**

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

**Section 10.04 Modification of Premium Rates.**

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

Section 10.02 modified by Version 1.6

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

terminate the Contract in accordance with **Article 12** "Remedies and Disputes".

**Section 10.05 CHIP Premium Rates Structure.**

(a) CHIP Rate Cells.

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

- (1) under age one (1);
- (2) ages one (1) through five (5);
- (3) ages six (6) through fourteen (14); and
- (4) ages fifteen (15) through eighteen (18).

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

(b) CHIP Premium Rates for Rate Period1.

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

(c) CHIP Premium Rate development.

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

(d) Acuity adjustment.

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

(e) Value-Added Services

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

**Section 10.06 Medicaid Premium Rates Structure.**

(a) Medicaid Rate Cells.

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

- (1) under age one (1);
- (2) ages one (1) through five (5);
- (3) ages six (6) through fourteen (14); and
- (4) ages fifteen (15) through twenty (20).

(b) Medicaid Premium Rates for Rate Period1.

The Medicaid Premium Rates for Rate Period 1 are included in the negotiated HHSC Dental Program Contract.

(c) Medicaid Premium Rate development: Rate Periods 1 and 2.

HHSC will establish base Premium Rates for Rate Periods 1 and 2 by analyzing Fee-for-Service claims data for the Service Area. This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information. HHSC may modify the base Premium Rates using diagnosis based risk adjusters to yield the final Premium Rates.

(d) Medicaid Premium Rate development: Rate Periods Following Rate Period 2.

HHSC will establish base Premium Rates for the Rate Periods following Rate Period 2 by analyzing historical Medicaid Encounter Data and financial data. This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information. HHSC may modify the base Premium Rates using diagnosis based risk adjusters to yield the final Premium Rates.

(e) Acuity adjustment.

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

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

(f) Value-Added Services

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

**Section 10.07 Adjustments to Premium Payments**

(a) Adjustment.

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

- (1) a Member's eligibility status or program type is changed, corrected as a result of error, or is retroactively adjusted;
- (2) the Member is enrolled into the Dental Contractor in error;
- (3) the Member moves outside the United States;
- (4) the Member dies before the first day of the month for which the payment was made; or
- (5) the payment has been denied by the CMS in accordance with the requirements of 42 C.F.R. §438.730.

(b) Appeal of adjustment.

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

**Section 10.08 Experience Rebate.**

(a) Dental Contractor's duty to pay.

At the end of each FSR Reporting Period beginning with FSR Reporting Period 12/13, the Dental Contractor must pay an Experience Rebate for the Program to HHSC as detailed in Section 10.08, Subsection b. The Net Income Before Taxes and total Revenues are as measured by the Financial-Statistical Report (FSR) as reviewed and confirmed by HHSC. The final amount used in the calculation of the percentage may be impacted by the Loss Carry Forward; see Section 10.08, Subsection (d).

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

(b) Graduated Experience Rebate Sharing Method.

<u>Pre-Tax Income as a % of Revenues</u>	<u>Dental Contractor Share</u>	<u>HHSC Share</u>
≤ 3%	100%	0%
> 3% and ≤ 5%	80%	20%
> 5% and ≤ 7%	60%	40%
> 7% and ≤ 9%	40%	60%
> 9% and ≤ 12%	20%	80%
> 12%	0%	100%

HHSC and the Dental Contractor will share the Net Income Before Taxes for the Program as follows:

(1) The Dental Contractor will retain all Net Income Before Taxes that is equal to or less than 3% of the total Revenues received by the Dental Contractor.

(2) HHSC and the Dental Contractor will share that portion of the Net Income Before Taxes that is over 3% but less than or equal to 5% of the total Revenues received, with 80% to the Dental Contractor and 20% to HHSC.

(3) HHSC and the Dental Contractor will share that portion of the Net Income Before Taxes that is over 5% but less than or equal to 7% of the total Revenues received, with 60% to the Dental Contractor and 40% to HHSC.

(4) HHSC and the Dental Contractor will share that portion of the Net Income Before Taxes that is over 7% but less than or equal to 9% of the total Revenues received, with 40% to the Dental Contractor and 60% to HHSC.

(5) HHSC and the Dental Contractor will share that portion of the Net Income Before Taxes that is over 9% but less than or equal to 12% of the total Revenues received, with 20% to the Dental Contractor and 80% to HHSC.

(6) HHSC will be paid the entire portion of the Net Income Before Taxes that exceeds 12% of the total Revenues.

(c) Net income Before taxes.

(1) The Dental Contractor must compute the Net Income Before Taxes in accordance with the HHSC UCMCM's "Cost Principles for Expenses" and "FSR Instructions for Completion" and applicable federal regulations. The Net Income Before Taxes will be confirmed by HHSC or its agent for the FSR Reporting Period relating to all Revenues and

Section 10.07 modified by Version 1.6

Section 10.08 modified by Versions 1.2, 1.6, 1.8, and 1.10

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

Allowable Expenses incurred pursuant to the Contract. HHSC reserves the right to modify the “Cost Principles for Expenses” and “FSR Instructions for Completion” found in HHSC’s UMCM, in accordance with Section 8.05, “Modification of the HHSC Uniform Managed Care Manual.”

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

- (i) the payment of an Experience Rebate;
- (ii) any interest expense associated with late or underpayment of the Experience Rebate;
- (iii) any financial incentives, and
- (iv) any financial disincentives, including without limitation any incentives described in Attachment B-1, Section 6.2.4; and
- (v) the liquidated damages, and any interest expense associated, as described in Attachment B-5.

See UMCM Chapter 6.1 “Cost Principles for Expenses”.

(3) Financial incentives will not be reduced by potential increased Experience Rebate payments. Financial disincentives will not be offset in whole or in part by potential decreases in Experience Rebate payments.

(4) For FSR reporting purposes, any financial incentives incurred must not be reported as an increase in Revenues or as an offset to costs, and any award of such will not increase reported income. Any financial disincentives incurred must not be included as reported expenses, and must not reduce reported income. The reporting or recording of any of these incurred items will be done on a memo basis, which is below the income line, and will be listed as separate items.

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

(1) General

Losses incurred on a Consolidated Basis by the Dental Contractor for one FSR Reporting Period may be carried forward to the next FSR Reporting Period and applied as an offset against pre-tax net income. Prior losses may be carried forward for up to two contiguous FSR Reporting Periods.

When a loss in a given FSR Reporting Period is carried forward and applied against profits in both of the next two FSR Reporting Periods, the loss must first be applied against the first subsequent FSR

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

The Admin Cap may impact losses carried forward. See Section 10.09 (f).

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

(2) Basis of consolidation.

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

(e) Settlements for payment.

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

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

(2) The next scheduled payment will be an adjustment to the Primary Settlement, if required, and will be paid on the same day that the 334-day FSR Report is submitted to HHSC, if the adjustment is a payment from the Dental Contractor to HHSC. Section 10.05(f) describes the interest expenses

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

---

associated with any such payment after the Primary Settlement.

The Dental Contractor may make non-scheduled payments at any time to reduce the accumulation of interest under Section 10.05(f). For any nonscheduled payments prior to the 334-day FSR, the Dental Contractor is not required to submit a revised FSR, but is required to submit an Experience Rebate calculation form and an adjusted summary page of the FSR. The FSR summary page is labeled "Summary Income Statements (Dollars), All Coverage Groups Combined (FSR, Part I)."

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

- (i) The date of the management representation letter resulting from the audit; or
- (ii) The date of any invoice issued by HHSC.

Payment within this 30-day timeframe will not relieve the Dental Contractor of any interest payment obligation that may exist under Section 10.05(f).

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

(f) Interest on Experience Rebate.

(1) Interest on any Experience Rebate owed to HHSC will be charged beginning 35 days after the due date of the Primary Settlement, as described in Section 10.05(e)(1). Thus, any Experience Rebate due or paid on or after the Primary Settlement will accrue interest starting at 35 days after the due date for the 90-day FSR Report. For example, any Experience Rebate payment(s) made in conjunction with the 334-day FSR, or as a result of audit findings,

will accrue interest back to 35 days after the due-date for submission of the 90-day FSR.

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

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

(3) Any interest obligations that are incurred pursuant to Section 10.05 that are not timely paid will be subject to accumulation of interest as well, at the same rate as applicable to the underlying Experience Rebate.

(4) All interest assessed pursuant to Section 10.05 will continue to accrue until such point as a payment is received by HHSC, at which point interest on the amount received will stop accruing. If a balance remains at that point that is subject to interest, then the balance will continue to accrue interest. If interim payments are made, then any interest that may be due will only be charged on amounts for the time period during which they remained unpaid.

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

The accrual of interest as defined under Section 10.05(f) will not stop during any period of dispute. If a dispute is resolved in the Dental Contractor's favor, then interest will only be assessed on the revised unpaid amount.

(5) If the Dental Contractor incurs an interest obligation pursuant to Section 10.05, HHSC will assess such interest at 12% per annum, compounded daily. If any interest rate stipulated hereunder is found by a court of competent jurisdiction to be outside the range deemed legal and enforceable, then in such specific case the rate hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

(6) Any such interest expense incurred pursuant to Section 10.05 is not an Allowable Expense for reporting purposes on the FSR.

**Section 10.09 Federal Disallowance**

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

**Section 10.10 Payment by Members.**

(a) The Dental Contractor, Network Providers, and Out-of-Network Providers are prohibited from billing or collecting any amount from a Member for Covered Services, except that CHIP Network Providers and Out-of-Network Providers may collect copayments authorized in the CHIP State Plan from CHIP Members for Covered Services.

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

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

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

**Section 10.11 Restriction on assignment of fees**

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

**Section 10.12 Liability for taxes**

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

Dental Contractor or any taxes levied on employee wages.

**Section 10.13 Liability for employment-related charges and benefits**

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

**Section 10.14 No additional consideration**

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

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

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

**Section 10.15 Payment/Adjustment to Capitation in Consideration of the ACA Section 9010 Health Insurance Providers Fee**

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

Beginning in calendar year 2014, the PPACA requires the Dental Contractor to pay the HIP Fee no later than September 30th (as applicable to each relevant year, the "HIP Fee Year") with respect to premiums paid to the Dental Contractor in the preceding calendar year (as applicable to each relevant year, the "HIP Data Year"), and continuing similarly in each successive

Section 10.10.1 added and removed by Version 1.4

Section 10.15 added by Version 1.9

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

year. In order to satisfy the requirement for actuarial soundness set forth in 42 C.F.R. § 438.6(c) with respect to amounts paid by HHSC under this Agreement, the parties agree that HHSC will make a retroactive adjustment to capitation to the Dental Contractor for the full amount of the HIP Fee allocable to this Agreement, as follows:

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

- The amount of the HIP Fee attributable to this Agreement;
- The federal income tax liability, if any, that the Dental Contractor incurs as a result of receiving HHSC's payment for the amount of the HIP Fee attributable to this Agreement; and
- Any Texas state premium tax attributable to the capitation adjustment.

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

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

*Documentation Requirements:* HHSC will pay the Dental Contractor after it receives sufficient documentation, as determined by HHSC, detailing the Dental Contractor's Texas Medicaid and CHIP-specific liability for the HIP Fee. The Dental Contractor will provide documentation that includes the following:

- The preliminary and final versions of the IRS Form 8963;

- Texas Medicaid/CHIP-specific premiums included in the premiums reported on Form 8963; and
- The preliminary and final versions of the Fee statement provided by the IRS.

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

This provision will survive the termination of the Agreement.

#### **Article 11. Disclosure & Confidentiality of Information**

##### **Section 11.01 Confidentiality.**

(a) Dental Contractor and all Subcontractors, consultants, or agents must treat all information that is obtained through performance of the Services under the Contract, including information relating to applicants or recipients of Dental Program as Confidential Information to the extent that confidential treatment is provided under state and federal law, rules, and regulations.

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

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

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

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

Section  
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Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

operations, or Dental Contractor's performance of the Contract.

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

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

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

- (1) Already known to the Receiving Party without restrictions at the time of its disclosure by the Furnishing Party;
- (2) Independently developed by the Receiving Party without reference to the Furnishing Party's Confidential Information;
- (3) Rightfully obtained by the Receiving Party without restriction from a third party after its disclosure to a third party by the Furnishing Party;
- (4) Publicly available other than through the fault or negligence of the Receiving Party; or
- (5) Lawfully released without restriction to anyone.

#### **Section 11.02 Disclosure of HHSC's Confidential Information**

(a) Dental Contractor will immediately report to HHSC any and all unauthorized disclosures or uses of HHSC's Confidential Information of which it or its Subcontractors, consultants, or agents is aware or has knowledge. Dental Contractor acknowledges that any publication or disclosure of HHSC's Confidential Information to others may cause immediate and irreparable harm to HHSC and may constitute a violation of State or federal laws. If Dental Contractor, its Subcontractors, consultants, or agents should publish or disclose such Confidential Information to others without authorization, HHSC will immediately be entitled to injunctive relief or any other remedies to which it is entitled under law or equity. HHSC will have the right to recover from Dental

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

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

#### **Section 11.03 Member Records**

(a) Dental Contractor must comply with the requirements of state and federal laws, including the HIPAA requirements set forth in **Section 7.07**, "HIPAA," regarding the transfer of Member Records.

(b) If at any time during the Contract Term this Contract is terminated, HHSC may require the transfer of Member Records, upon written notice to Dental Contractor, to another entity, as consistent with federal and state laws and applicable releases.

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

#### **Section 11.04 Requests for public information**

(a) When the Dental Contractor produces reports or other forms of information that the Dental Contractor believes consist of proprietary or otherwise confidential information, the Dental Contractor must clearly mark such information as confidential information or provide written notice to HHSC that it considers the information confidential.

(b) If HHSC receives a request, filed in accordance with the Texas Public Information Act ("Act,") seeking information that has been identified by the Dental Contractor as proprietary or otherwise confidential, HHSC will deliver a copy of the request for public information to Dental Contractor, in accordance with the requirements of the Act.

(c) With respect to any information that is the subject of a request for disclosure, Dental Contractor is required to demonstrate to the Texas Office of Attorney General the specific reasons why the requested information is confidential or otherwise

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

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excepted from required public disclosure under law. Dental Contractor will provide HHSC with copies of all such communications.

**Section 11.05 Privileged Work Product**

(a) Dental Contractor acknowledges that HHSC asserts that privileged work product may be prepared in anticipation of litigation and that Dental Contractor is performing the Services with respect to privileged work product as an agent of HHSC, and that all matters related thereto are protected from disclosure by the Texas Rules of Civil Procedure, Texas Rules of Evidence, Federal Rules of Civil Procedure, or Federal Rules of Evidence.

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

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

- (1) Immediately notify HHSC; and
- (2) Use all reasonable efforts to resist providing such access.

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

- (1) Represent Dental Contractor in such resistance;
- (2) Retain counsel to represent Dental Contractor; or
- (3) Reimburse Dental Contractor for reasonable attorneys' fees and expenses incurred in resisting such access.

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

**Section 11.06 Unauthorized acts**

Each Party agrees to:

- (1) Notify the other Party promptly of any unauthorized possession, use, or knowledge, or attempt thereof, by any person or entity that may become known to it, of any HHSC Confidential Information or any information identified by the Dental Contractor as confidential or proprietary;
- (2) Promptly furnish to the other Party full details of the unauthorized possession, use, or knowledge, or attempt thereof, and use reasonable efforts to assist the other Party in investigating or preventing the reoccurrence of any unauthorized possession, use, or knowledge, or attempt thereof, of Confidential Information;
- (3) Cooperate with the other Party in any litigation and investigation against third Parties deemed necessary by such Party to protect its proprietary rights; and
- (4) Promptly prevent a reoccurrence of any such unauthorized possession, use, or knowledge such information.

**Section 11.07 Legal action.**

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

**Section 11.08 Information Security**

- (a) The Dental Contractor and all Subcontractors, consultants, or agents under the Agreement must comply with the following:
- (1) Health and Human Services Enterprise Information Security Standards and Guidelines; and
  - (2) Title 1, Sections 202.1 and 202.3 through 202.28, Texas Administrative Code.
- (b) The Dental Contractor must comply with the following, as applicable:
- (1) The Federal Information Security Management Act of 2002 (FISMA);
  - (2) The Health Insurance Portability and Accountability Act of 1996 (HIPAA);
  - (3) The Health Information Technology for Economic and Clinical Health Act (HITECH Act);

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

(4) Publication 1075 – Tax Information Security Guidelines for Federal, State and Local Agencies;

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

(6) NIST Special Publication 800-53 Revision 3 – Recommended Security Controls for Federal Information Systems and Organizations; and

(7) NIST Special Publication 800-47 – Security Guide for Interconnecting Information Technology Systems.

(c) In addition to the requirements expressly stated in this Section, the Dental Contractor must comply with any other State or Federal law, regulation, or administrative rule relating to the Dental Program.

(d) Upon reasonable notice, the Dental Contractor must provide, and cause its Subcontractors and agents to provide, HHSC or its designee, prompt, reasonable, and adequate access to any information security records, books, documents, and papers that are directly pertinent to the performance of the Scope of Work including, but not limited to:

- (1) Dental Contractor information security policies;
- (2) Dental Contractor information security procedures;
- (3) Dental Contractor information security standards;
- (4) Dental Contractor information security guidelines;
- (5) Dental Contractor security plan in compliance with NIST Special Publication 800-53 Revision 3;
- (6) Dental Contractor security violation reports;
- (7) Dental Contractor employee security acknowledgement agreements; and
- (8) Lists of Dental Contractor's employees with authorized access to HHSC confidential information.

Items (1) through (5) above are subject to HHSC's review and approval. Neither HHSC's review or approval, nor its fail to review or approve, will relieve, waive or satisfy any of the Dental Contractor's obligations under this Agreement.

(e) The Dental Contractor will provide, and will cause its Subcontractors and agents to provide, to HHSC periodic written certifications of compliance with controls and provisions relating to information security, including but not limited, those related to confidential data transfers and the handling and disposal of Protected Health Information (PHI), Electronic Protected Health Information (EPHI), and Personally Identifiable Information (PII). Acceptable forms of written compliance may be, but are not limited to:

- (1) Statement on Auditing Standards No.70, Service Organizations (SAS-70) Report;
- (2) General Security Controls Audit;
- (3) Application Controls Audit;
- (4) Vulnerability Assessment; and
- (5) Network/Systems Penetration Test.

**SECTION 11.09 Dental Contractor's Breach Notice, Reporting and Correction Requirements**

**Section 11.09.1. Notification to HHSC.**

- (A) Dental Contractor will cooperate fully with HHSC in investigating, mitigating to the extent practicable and issuing notifications directed by HHSC, for any unauthorized disclosure or suspected disclosure of Confidential Information to the extent and in the manner determined by HHSC.
- (B) Dental Contractor's obligation begins at discovery of unauthorized disclosure or suspected disclosure and continues as long as related activity continues, until all effects of the incident are mitigated to HHSC's satisfaction (the "incident response period").
- (C) Dental Contractor will require that its subcontractors and providers comply with all of the following breach notice requirements.
- (D) Breach Notice:
  1. Initial Notice.
    - a. For federal information, including without limitation, Federal Tax Information, Social Security Administration Data, and Medicaid Member Information, within the first, consecutive clock hour of discovery, and for all other types of Confidential Information not more than 24 hours after discovery, **or in a timeframe otherwise approved by HHSC in writing**, initially

Section 11.09 added by Version 1.12

Section 11.09.1 added by Version 1.12

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

- report to HHSC's Privacy and Security Officers via email at: [privacy@HHSCC.state.tx.us](mailto:privacy@HHSCC.state.tx.us) and to the HHSC division responsible for this UMCC;
- b. Report all information reasonably available to Dental Contractor about the privacy or security incident; and
  - c. Name, and provide contact information to HHSC for, Dental Contractor's single point of contact who will communicate with HHSC both on and off business hours during the incident response period.
2. 48-Hour Formal Notice. No later than 48 consecutive clock hours after discovery, or a time within which discovery reasonably should have been made by Dental Contractor, provide formal notification to HHSC, including all reasonably available information about the incident or breach, and Dental Contractor's investigation, including without limitation and to the extent available:
- a. The date the incident or breach occurred;
  - b. The date of Dental Contractor's and, if applicable, subcontractor's discovery;
  - c. A brief description of the incident or breach; including how it occurred and who is responsible (or hypotheses, if not yet determined);
  - d. A brief description of Dental Contractor's investigation and the status of the investigation;
  - e. A description of the types and amount of Confidential Information involved;
  - f. Identification of and number of all individuals reasonably believed to be affected, including first and last name of the individual and if applicable the, legally authorized representative, last known address, age, telephone number, and email address if it is a preferred contact method, to the extent known or can be reasonably determined by Dental Contractor at that time;
  - g. Dental Contractor's initial risk assessment of the incident or breach demonstrating whether individual or other notices are required by applicable law or this DUA for HHSC approval, including an analysis of whether there is a low probability of compromise of the Confidential Information or whether any legal exceptions to notification apply;
- h. Dental Contractor's recommendation for HHSC's approval as to the steps individuals and/or Dental Contractor on behalf of Individuals, should take to protect the Individuals from potential harm, including without limitation Dental Contractor's provision of notifications, credit protection, claims monitoring, and any specific protections for a legally authorized representative to take on behalf of an Individual with special capacity or circumstances;
    - i. The steps Dental Contractor has taken to mitigate the harm or potential harm caused (including without limitation the provision of sufficient resources to mitigate);
    - j. The steps Dental Contractor has taken, or will take, to prevent or reduce the likelihood of recurrence;
    - k. Identify, describe or estimate of the persons, workforce, subcontractor, or individuals and any law enforcement that may be involved in the incident or breach;
    - l. A reasonable schedule for Dental Contractor to provide regular updates to the foregoing in the future for response to the incident or breach, but no less than every three (3) business days or as otherwise directed by HHSC, including information about risk estimations, reporting, notification, if any, mitigation, corrective action, root cause analysis and when such activities are expected to be completed; and
    - m. Any reasonably available, pertinent information, documents or reports related to an incident or breach that HHSC requests following discovery.
- Section 11.09.2 Investigation, Response and Mitigation.**
- (A) Dental Contractor will immediately conduct a full and complete investigation, respond to the incident or breach, commit necessary and appropriate staff and resources to expeditiously

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Version  
1.12

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

respond, and report as required to and by HHSC for incident response purposes and for purposes of HHSC's compliance with report and notification requirements, to the satisfaction of HHSC.

- (B) Dental Contractor will complete or participate in a risk assessment as directed by HHSC following an incident or breach, and provide the final assessment, corrective actions and mitigations to HHSC for review and approval.
- (C) Dental Contractor will fully cooperate with HHSC to respond to inquiries and/or proceedings by state and federal authorities, persons and/or incident about the incident or breach.
- (D) Dental Contractor will fully cooperate with HHSC's efforts to seek appropriate injunctive relief or otherwise prevent or curtail such incident or breach, or to recover or protect any Confidential Information, including complying with reasonable corrective action or measures, as specified by HHSC in a Corrective Action Plan if directed by HHSC under the UCCM.

**Section 11.09.3 Breach Notification to Individuals and Reporting to Authorities.**

- (A) HHSC may direct Dental Contractor to provide breach notification to individuals, regulators or third-parties, as specified by HHSC following a breach.
- (B) Dental Contractor must obtain HHSC's prior written approval of the time, manner and content of any notification to individuals, regulators or third-parties, or any notice required by other state or federal authorities. Notice letters will be in Dental Contractor's name and on Dental Contractor's letterhead, unless otherwise directed by HHSC, and will contain contact information, including the name and title of Dental Contractor's representative, an email address and a toll-free telephone number, for the Individual to obtain additional information.
- (C) Dental Contractor will provide HHSC with copies of distributed and approved communications.
- (D) Dental Contractor will have the burden of demonstrating to the satisfaction of HHSC that any notification required by HHSC was timely made. If there are delays outside of Dental Contractor's control, Dental Contractor will provide written documentation of the reasons for the delay.

If HHSC delegates notice requirements to Dental Contractor, HHSC shall, in the time and manner reasonably requested by Dental Contractor,

cooperate and assist with Dental Contractor's information requests in order to make such notifications and reports.

**Article 12. Remedies & Disputes**

**Section 12.01 Understanding and expectations**

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

**Section 12.02 Tailored remedies**

- (a) Understanding of the Parties.

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

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

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

- (2) Dental Contractor will, within five (5) Business Days (or another date approved by HHSC) of receipt of written notice of a non-material deficiency, provide HHSC a written response that:

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

Section 11.09.3 added by Version 1.12

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

- or
- (ii) If Dental Contractor disagrees with HHSC's findings, its reasons for disagreeing with HHSC's findings.
- (3) Dental Contractor's proposed cure of a non-material deficiency is subject to the approval of HHSC. Dental Contractor's repeated commission of non-material deficiencies or repeated failure to resolve any such deficiencies may be regarded by HHSC as a material deficiency and entitle HHSC to pursue any other remedy provided in the Contract or any other appropriate remedy HHSC may have at law or equity.
- (c) Corrective Action Plan.
- (1) At its option, HHSC may require Dental Contractor to submit to HHSC a written Corrective Action Plan to correct or resolve a material breach of this Contract, as determined by HHSC.
- (2) The Corrective Action Plan must provide:
- (i) A detailed explanation of the reasons for the cited deficiency;
- (ii) Dental Contractor's assessment or diagnosis of the cause; and
- (iii) A specific proposal to cure or resolve the deficiency.
- (3) The Corrective Action Plan must be submitted by the deadline set forth in HHSC's request for a Corrective Action Plan. The Corrective Action Plan is subject to approval by HHSC, which will not unreasonably be withheld.
- (4) HHSC will notify Dental Contractor in writing of HHSC's final disposition of HHSC's concerns. If HHSC accepts Dental Contractor's proposed Corrective Action Plan, HHSC may:
- (i) Condition such approval on completion of tasks in the order or priority that HHSC may reasonably prescribe;
- (ii) Disapprove portions of Dental Contractor's proposed Corrective Action Plan; or
- (iii) Require additional or different corrective action(s).
- Notwithstanding the submission and acceptance of a Corrective Action Plan, Dental Contractor remains responsible for achieving all written performance criteria.
- (5) HHSC's acceptance of a Corrective Action Plan under this Section will not:
- (i) Excuse Dental Contractor's prior substandard performance;
- (ii) Relieve Dental Contractor of its duty to comply with performance standards; or
- (iii) Prohibit HHSC from assessing additional tailored remedies or pursuing other appropriate remedies for continued substandard performance.
- (d) Administrative remedies.
- (1) At its discretion, HHSC may impose one or more of the following remedies for each item of material noncompliance and will determine the scope and severity of the remedy on a case-by-case basis:
- (i) Assess liquidated damages in accordance with **Attachment C** to the **HHSC Dental Contract**, "Liquidated Damages Matrix;"
- (ii) Conduct accelerated monitoring of the Dental Contractor. Accelerated monitoring includes more frequent or more extensive monitoring by HHSC or its agent;
- (iii) Require additional, more detailed, financial and/or programmatic reports to be submitted by Dental Contractor;
- (iv) Decline to renew or extend the Contract;
- (v) Appoint temporary management under the circumstances described in 42 C.F.R. §438.706;
- (vi) Initiate disenrollment of a Member or Members;
- (vii) Suspend enrollment of Members;
- (viii) Withhold or recoup payment to Dental Contractor;
- (ix) Require forfeiture of all or part of the Dental Contractor's bond; or
- (x) Terminate the Contract in accordance with **Section 12.03**, ("Termination by HHSC").
- (2) For purposes of the Contract, an item of material noncompliance means a specific action of Dental Contractor that:
- (i) Violates a material provision of the Contract;
- (ii) Fails to meet an agreed measure of performance; or
- (iii) Represents a failure of Dental Contractor to be reasonably responsive to a

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

reasonable request of HHSC for information, assistance, or support relating to the Services or Deliverables within the timeframe specified by HHSC.

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

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

(e) Damages.

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

(2) The liquidated damages prescribed in this Section are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of HHSC's projected financial loss and

damage resulting from the Dental Contractor's nonperformance, including financial loss as a result of project delays. Accordingly, in the event Dental Contractor fails to perform in accordance with the Contract, HHSC may assess liquidated damages as provided in this Section.

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

(4) HHSC may elect to collect liquidated damages:

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

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

(f) Equitable Remedies

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

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

(g) Suspension of Contract

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

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

(ii) HHSC has reason to believe that Dental Contractor has committed, assisted in the commission of Fraud, Abuse, Waste,

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

malfeasance, misfeasance, or nonfeasance by any party concerning the Contract;

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

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

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

(i) Be delivered in writing to Dental Contractor;

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

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

**Section 12.03 Termination by HHSC.**

This Contract will terminate upon the Expiration Date. In addition, prior to completion of the Contract Term, all or a part of this Contract may be terminated for any of the following reasons:

(a) Termination in the best interest of HHSC.

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

(b) Termination for cause.

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

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

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

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

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

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

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

HHSC may terminate this Contract if a court of competent jurisdiction finds Dental Contractor failed to adhere to any laws, ordinances, rules, regulations or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of Dental Contractor's duties under this Contract. HHSC will provide at least thirty (30) days advance written notice of such termination.

(3) Breach of confidentiality.

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

(4) Failure to maintain adequate personnel or resources.

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

(5) Termination for gifts and gratuities.

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

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

Section 12.03 modified by Version 1.5

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

behalf.

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

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

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

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

(6) Termination for non-appropriation of funds.

Notwithstanding any other provision of this Contract, if funds for the continued fulfillment of this Contract by HHSC are at any time not forthcoming or are insufficient, through failure of any entity to appropriate funds or otherwise, then HHSC will have the right to terminate this Contract at no additional cost and with no penalty whatsoever by giving prior written notice documenting the lack of funding. HHSC will provide at least thirty (30) days advance written notice of such termination. HHSC will use reasonable efforts to ensure appropriated funds are available.

(7) Judgment and execution.

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

(a) Discharge the judgment or provide for its discharge in accordance with the terms of the judgment;

(b) Procure a stay of execution of the judgment within thirty (30) days from the date of entry thereof; or

(c) Perfect an appeal of such judgment and cause the execution of such judgment to be stayed during the appeal, providing such financial reserves as may be required under generally accepted accounting

principles.

(ii) If a writ or warrant of attachment or any similar process is issued by any court against all or any material portion of the property of Dental Contractor, and such writ or warrant of attachment or any similar process is not released or bonded within thirty (30) days after its entry, HHSC may terminate the Contract in accordance with this Section.

(8) Termination for Criminal Conviction

HHSC will have the right to terminate the Contract in whole or in part, or require the replacement of a Material Subcontractor, if the Dental Contractor or a Material Subcontractor is convicted of a criminal offense in a state or federal court:

(i) Related to the delivery of an item or service;

(ii) Related to the neglect or abuse of patients in connection with the delivery of an item or service;

(iii) Consisting of a felony related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct, or

(iv) resulting in a penalty or fine in the amount of \$500,000 or more in a state or federal administrative proceeding.

(9) Termination for Dental Contractor's material breach of the Contract.

HHSC will have the right to terminate the Contract in whole or in part if HHSC determines, at its sole discretion, that Dental Contractor has materially breached the Contract. HHSC will provide at least thirty (30) days advance written notice of such termination, unless HHSC in its reasonable determination finds that a shorter notice period is warranted.

#### **Section 12.04 Termination by Dental Contractor.**

(a) Failure to pay.

Dental Contractor may terminate this Contract if HHSC fails to pay the Dental Contractor undisputed charges when due as required under this Contract. Retaining premium, recoupment, sanctions, or penalties that are allowed under this Contract or that result from the Dental Contractor's failure to perform or the Dental Contractor's default under the terms of this Contract is not cause for termination. Termination for failure to pay does not release HHSC from the obligation to pay undisputed charges for services provided prior to the termination date.

If HHSC fails to pay undisputed charges when due, then the Dental Contractor may submit a notice of

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

intent to terminate for failure to pay in accordance with the requirements of **Subsection 12.04(d)**. If HHSC pays all undisputed amounts then due within thirty (30)-days after receiving the notice of intent to terminate, the Dental Contractor cannot proceed with termination of the Contract under this Section.

(b) Change to HHSC Uniform Managed Care Manual.

Dental Contractor may terminate this agreement if the Parties are unable to resolve a dispute concerning a material and substantive change to the HHSC UMCM (a change that materially and substantively alters the Dental Contractor's ability to fulfill its obligations under the Contract). Dental Contractor must submit a notice of intent to terminate due to a material and substantive change in the HHSC UMCM no later than thirty (30) days after the effective date of the policy change. HHSC will not enforce the policy change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(c) Change to Premium Rate.

If HHSC proposes a modification to the Premium Rate that is unacceptable to the Dental Contractor, the Dental Contractor may terminate the Contract. Dental Contractor must submit a written notice of intent to terminate due to a change in the Premium Rate no later than thirty (30) days after HHSC's notice of the proposed change. HHSC will not enforce the rate change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(d) Notice of intent to terminate.

In order to terminate the Contract pursuant to this Section, Dental Contractor must give HHSC at least ninety (90) days written notice of intent to terminate. The termination date will be calculated as the last day of the month following ninety (90) days from the date the notice of intent to terminate is received by HHSC.

#### **Section 12.05 Termination by mutual agreement**

This Contract may be terminated by mutual written agreement of the Parties.

#### **Section 12.06 Effective date of termination**

Except as otherwise provided in this Contract, termination will be effective as of the date specified in the notice of termination.

#### **Section 12.07 Extension of termination effective date**

The Parties may extend the effective date of termination one or more times by mutual written agreement.

#### **Section 12.08 Payment and other provisions at Contract termination**

(a) In the event of termination pursuant to this Article, HHSC will pay the Premium Payment for Services and Deliverables rendered through the effective date of termination. All pertinent provisions of the Contract will form the basis of settlement.

(b) Dental Contractor must provide HHSC all reasonable access to records, facilities, and documentation as is required to efficiently and expeditiously close out the Services and Deliverables provided under this Contract.

(c) Dental Contractor must prepare a Turnover Plan, which is acceptable to and approved by HHSC. The Turnover Plan will be implemented during the time period between receipt of notice and the termination date.

#### **Section 12.09 Modification of Contract in the event of remedies.**

HHSC may propose a modification of this Contract in response to the imposition of a remedy under this Article. Any modifications under this Section must be reasonable, limited to the matters causing the exercise of a remedy, in writing, and executed in accordance with **Article 8** ("Amendments and Modifications"). Dental Contractor must negotiate such proposed modifications in good faith.

#### **Section 12.10 Turnover assistance**

Upon receipt of notice of termination of the Contract by HHSC, Dental Contractor will provide any turnover assistance reasonably necessary to enable HHSC or its designee to effectively close out the Contract and move the work to another vendor or to perform the work itself.

#### **Section 12.11 Rights upon termination or expiration of Contract**

In the event that the Contract is terminated for any reason, or upon its expiration, HHSC will, at HHSC's discretion, retain ownership of any and all associated work products, Deliverables and/or documentation in whatever form that they exist.

#### **Section 12.12 Dental Contractor responsibility for associated costs**

If HHSC terminates the Contract for Cause, the Dental Contractor will be responsible to HHSC for all

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

reasonable costs incurred by HHSC, the State of Texas, or any of its administrative agencies to replace the Dental Contractor. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation that is reasonably attributable to Dental Contractor's failure to perform any Service in accordance with the terms of the Contract

**Section 12.13 Dispute resolution.**

(a) General Contract of the Parties

The Parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the Parties employ all reasonable and informal means to resolve any dispute under this Contract. The Parties express their mutual commitment to using all reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this Section.

(b) Duty to negotiate in good faith

Any dispute that in the judgment of any Party to this Contract may materially or substantially affect the performance of any Party will be reduced to writing and delivered to the other Party. The Parties must then negotiate in good faith and use every reasonable effort to resolve such dispute and the Parties must not resort to any formal proceedings unless they have reasonably determined that a negotiated resolution is not possible. The resolution of any dispute disposed of by Contract between the Parties must be reduced to writing and delivered to all Parties within ten (10) Business Days.

(c) Claims for breach of Contract

(1) General requirement. Dental Contractor's claim for breach of this Contract will be resolved in accordance with the dispute resolution process established by HHSC in accordance with Chapter 2260, Texas Government Code.

(2) Negotiation of claims. The Parties expressly agree that the Dental Contractor's claim for breach of this Contract that the Parties cannot resolve in the ordinary course of business or through the use of all reasonable and informal means will be submitted to the negotiation process provided in Chapter 2260, Subchapter B, Texas Government Code.

(i) To initiate the process, Dental Contractor must submit written notice to HHSC that specifically states that Dental Contractor invokes the provisions of Chapter 2260, Subchapter B, Texas Government Code. The notice must comply with the requirements of

Title 1, Chapter 392, Subchapter B of the Texas Administrative Code.

(ii) The Parties expressly agree that the Dental Contractor's compliance with Chapter 2260, Subchapter B, Texas Government Code, will be a condition precedent to the filing of a contested case proceeding under Chapter 2260, Subchapter C, of the Texas Government Code.

(3) Contested case proceedings. The contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be Dental Contractor's sole and exclusive process for seeking a remedy for any and all alleged breaches of contract by HHSC if the Parties are unable to resolve their disputes under Subsection(c)(2) of this Section.

The Parties expressly agree that compliance with the contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be a condition precedent to seeking consent to sue from the Texas Legislature under Chapter 107, Civil Practices & Remedies Code. Neither the execution of this Contract by HHSC nor any other conduct of any representative of HHSC relating to this Contract must be considered a waiver of HHSC's sovereign immunity to suit.

(4) *HHSC rules.* The submission, processing and resolution of Dental Contractor's claim is governed by the rules adopted by HHSC pursuant to Chapter 2260, Texas Government Code, found at Title 1, Chapter 392, Subchapter B of the Texas Administrative Code.

(5) *Dental Contractor's duty to perform.* Neither the occurrence of an event constituting an alleged breach of contract nor the pending status of any claim for breach of contract is grounds for the suspension of performance, in whole or in part, by Dental Contractor of any duty or obligation with respect to the performance of this Contract. Any changes to the Contract as a result of a dispute resolution will be implemented in accordance with **Article 8** ("Amendments and Modifications").

**Section 12.14 Liability of Dental Contractor.**

(a) Dental Contractor bears all risk of loss or damage due to:

(1) Defects in products, Services or Deliverables;

(2) Unfitness or obsolescence of products, Services or Deliverables; or

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

(3) The negligence or intentional misconduct of Dental Contractor or its employees, agents, Subcontractors, or representatives.

(b) Dental Contractor must, at the Dental Contractor's own expense, defend with counsel approved by HHSC, indemnify, and hold harmless HHSC and State employees, officers, directors, contractors and agents from and against any losses, liabilities, damages, penalties, costs, fees, and expenses from any claim or action for property damage, bodily injury or death, to the extent caused by or arising from the negligence or intentional misconduct of the Dental Contractor and its employees, officers, agents, or Subcontractors. HHSC will not unreasonably withhold approval of counsel selected by Dental Contractor.

(c) Dental Contractor will not be liable to HHSC for any loss, damages or liabilities attributable to or arising from the failure of HHSC or any state agency to perform a service or activity in connection with this Contract.

**Section 12.15 Pre-termination Process.**

The following process will apply when HHSC terminates the Agreement for any reason set forth in Section 12.03(b), "Termination for Cause," other than Subpart 6, "Termination for Non-appropriation of Funds." HHSC will provide the Dental Contractor with reasonable advance written notice of the proposed termination, as it deems appropriate under the circumstances. The notice will include the reason for the proposed termination, the proposed effective date of the termination, and the time and place where the parties will meet regarding the proposed termination. During this meeting, the Dental Contractor may present written information explaining why HHSC should not affirm the proposed termination. HHSC's Associate Commissioner for Medicaid and CHIP will consider the written information, if any, and will provide the Dental Contractor with a written notice of HHSC's final decision affirming or reversing the termination. An affirming decision will include the effective date of termination.

The pre-termination process described herein will not limit or otherwise reduce the parties' rights and responsibilities under Section 12.13, "Dispute Resolution;" however, HHSC's final decision to terminate is binding and is not subject to review by the State Office of Administrative Hearings under Chapter 2260, Texas Government Code.

**Article 13. Assurances & Certifications**

**Section 13.01 Proposal certifications.**

Dental Contractor acknowledges its continuing obligation to comply with the requirements of the certifications contained in its Proposal, and will immediately notify HHSC of any changes in circumstances affecting the certifications.

Section 13.01 modified by Version 1.4

**Section 13.02 Conflicts of interest.**

(a) Representation.

Dental Contractor agrees to comply with applicable state and federal laws, including 41 U.S.C. § 423, rules, and regulations regarding conflicts of interest in the performance of its duties under this Contract. Dental Contractor warrants that it has no interest and will not acquire any direct or indirect interest that would conflict in any manner or degree with its performance under this Contract.

Section 13.02 modified by Version 1.6

(b) General duty regarding conflicts of interest.

Dental Contractor will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain. Dental Contractor will operate with complete independence and objectivity without actual, potential or apparent conflict of interest with respect to the activities conducted under this Contract.

**Section 13.03 Organizational conflicts of interest.**

(a) Definition.

An organizational conflict of interest is a set of facts or circumstances, a relationship, or other situation under which the Dental Contractor or a Subcontractor has past, present, or currently planned personal or financial activities or interests that either directly or indirectly:

(1) Impairs or diminishes the Dental Contractor's or Subcontractor's ability to render impartial or objective assistance or advice to HHSC; or

(2) Provides the Dental Contractor or Subcontractor an unfair competitive advantage in future HHSC procurements (excluding the award of this Contract).

(b) Warranty.

Except as otherwise disclosed and approved by HHSC prior to the Effective Date of the Contract, Dental Contractor warrants that, as of the Effective Date and to the best of its knowledge and belief, there are no relevant facts or circumstances that could give rise to an organizational conflict of interest affecting

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

this Contract. Dental Contractor affirms that it has neither given, nor intends to give, at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, at any time during the procurement process or in connection with the procurement process except as allowed under relevant state and federal law.

(c) Continuing duty to disclose.

(1) Dental Contractor agrees that, if after the Effective Date, Dental Contractor discovers or is made aware of an organizational conflict of interest, Dental Contractor will immediately and fully disclose such interest in writing to the HHSC project manager. In addition, Dental Contractor must promptly disclose any relationship that might be perceived or represented as a conflict after its discovery by Dental Contractor or by HHSC as a potential conflict. HHSC reserves the right to make a final determination regarding the existence of conflicts of interest, and Dental Contractor agrees to abide by HHSC's decision.

(2) The disclosure will include a description of the actions that Dental Contractor has taken or proposes to take to avoid or mitigate such conflicts.

(d) Remedy.

If HHSC determines that an organizational conflict of interest exists, HHSC may, at its discretion, terminate the Contract pursuant to **Subsection 12.03(b)(9)**. If HHSC determines that Dental Contractor was aware of an organizational conflict of interest before the award of this Contract and did not disclose the conflict to the contracting officer, such nondisclosure will be considered a material breach of the Contract. Furthermore, such breach may be submitted to the Office of the Attorney General, Texas Ethics Commission, or appropriate State or Federal law enforcement officials for further action.

(e) Flow down obligation.

Dental Contractor must include the provisions of this Section in all Subcontracts for work to be performed similar to the service provided by Dental Contractor, and the terms "Contract," "Dental Contractor," and "project manager" modified appropriately to preserve the State's rights.

**Section 13.04 HHSC personnel recruitment prohibition.**

Dental Contractor has not retained or promised to retain any person or company, or utilized or promised to utilize a consultant that participated in HHSC's

development of specific criteria of the RFP or who participated in the selection of the Dental Contractor for this Contract.

Unless authorized in writing by HHSC, Dental Contractor will not recruit or employ any HHSC personnel who have worked on projects relating to the subject matter of this Contract, or who have had any influence on decisions affecting the subject matter of this Contract, for two (2) years following the completion of this Contract.

**Section 13.05 Anti-kickback provision**

Dental Contractor certifies that it will comply with the Anti-Kickback Act of 1986, 41 U.S.C. §51-58 and Federal Acquisition Regulation 52.203-7, to the extent applicable.

**Section 13.06 Debt or back taxes owed to State of Texas**

In accordance with Section 403.055 of the Texas Government Code, Dental Contractor agrees that any payments due to Dental Contractor under the Contract will be first applied toward any debt and/or back taxes Dental Contractor owes State of Texas. Dental Contractor further agrees that payments will be so applied until such debts and back taxes are paid in full.

**Section 13.07 Outstanding debts and judgments**

Dental Contractor certifies that it is not presently indebted to the State of Texas, and that Dental Contractor is not subject to an outstanding judgment in a suit by State of Texas against Dental Contractor for collection of the balance. For purposes of this Section, an indebtedness is any sum of money that is past due, and owed to the State of Texas and is not currently under dispute. A false statement regarding Dental Contractor's status will be treated as a material breach of this Contract and may be grounds for termination at the option of HHSC.

**Article 14. Representations & Warranties**

**Section 14.01 Authorization.**

(a) The execution, delivery and performance of this Contract has been duly authorized by Dental Contractor and no additional approval, authorization or consent of any governmental or regulatory agency is required to be obtained in order for Dental Contractor to enter into this Contract and perform its obligations under this Contract.

(b) Dental Contractor has obtained, or will obtain by the deadlines set forth in this Contract, all licenses, certifications, permits, and authorizations necessary to perform the Services under this Contract and

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

currently is in good standing with all regulatory agencies that regulate any or all aspects of Dental Contractor's performance of this Contract. Dental Contractor will maintain all required certifications, licenses, permits, and authorizations during the term of this Contract.

**Section 14.02 Ability to perform**

Dental Contractor warrants that it has the financial resources to fund the capital expenditures required under the Contract without advances by HHSC or assignment of any payments by HHSC to a financing source.

**Section 14.03 Minimum Net Worth**

The Dental Contractor has and will maintain throughout the life of this Contract, minimum net worth that complies with standards adopted by TDI. Minimum net worth means the excess total admitted assets over total liabilities, excluding liability for subordinated debt issued in compliance with Chapter 843 of the Texas Insurance Code.

**Section 14.04 Insurer solvency.**

(a) The Dental Contractor must be and remain in full compliance with all applicable state and federal solvency requirements for basic-service indemnity insurance providers or DMOs, including but not limited to, all reserve requirements, net worth standards, debt-to-equity ratios, or other debt limitations. In the event the Dental Contractor fails to maintain such compliance, HHSC, without limiting any other rights it may have by law or under the Contract, may terminate the Contract.

(b) If the Dental Contractor becomes aware of any impending changes to its financial or business structure that could adversely impact its compliance with the requirements of the Contract or its ability to pay its debts as they come due, the Dental Contractor must notify HHSC immediately in writing.

(c) The Dental Contractor must have a plan and take appropriate measures to ensure adequate provision against the risk of insolvency as required by TDI. Such provision must be adequate to provide for the following in the event of insolvency:

- (1) payments to unaffiliated dental providers and affiliated dental providers whose Contracts do not contain Member "hold harmless" clauses acceptable to the TDI;
- (2) continuation of Medically Necessary Covered Dental Services for the duration of the Contract Period for which a premium has been paid for a Member;

(3) provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI and the Contract.

Should TDI determine that there is an immediate risk of insolvency or the Dental Contractor is unable to provide Medically Necessary Covered Dental Services to its Members, HHSC, without limiting any other rights it may have by law, or under the Contract, may terminate the Contract.

**Section 14.05 Workmanship and performance.**

(a) All Services and Deliverables provided under this Contract will be provided in a manner consistent with the standards of quality and integrity as outlined in the Contract.

(b) All Services and Deliverables must meet or exceed the required levels of performance specified in or pursuant to this Contract.

(c) Dental Contractor will perform the Services and provide the Deliverables in a workmanlike manner, in accordance with best practices and high professional standards used in well-managed operations performing services similar to the Services described in this Contract.

**Section 14.06 Warranty of deliverables.**

Dental Contractor warrants that Deliverables developed and delivered under this Contract will meet in all material respects the specifications as described in the Contract during the period following its acceptance by HHSC, through the term of the Contract, including any subsequently negotiated by Dental Contractor and HHSC. Dental Contractor will promptly repair or replace any such Deliverables not in compliance with this warranty at no charge to HHSC.

**Section 14.07 Compliance with Contract**

Dental Contractor will not take any action substantially or materially inconsistent with any of the terms and conditions set forth in this Contract without the express written approval of HHSC.

**Section 14.08 Technology Access**

All technological solutions offered by the Dental Contractor must comply with the requirements of Texas Government Code §531.0162. This includes providing technological solutions that meet federal accessibility standards for persons with disabilities, as applicable.

Section  
14.08  
modified by  
Version 1.4

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

**Section 14.09 Electronic & Information Resources  
Accessibility Standards**

(a) Applicability.

The following Electronic and Information Resources (EIR) requirements apply to the Contract because the Dental Contractor performs services that include EIR that: (i) HHSC employees are required or permitted to access; or (ii) members of the public are required or permitted to access. This Section does not apply to incidental uses of EIR in the performance of a Contract, unless the Parties agree that the EIR will become property of the State or will be used by the HHSC's clients or recipients after completion of the Contract. Nothing in this section is intended to prescribe the use of particular designs or technologies or to prevent the use of alternative technologies, provided they result in substantially equivalent or greater access to and use of a Product.

(b) Definitions.

For purposes of this Section:

**“Accessibility Standards”** means the Electronic and Information Resources Accessibility Standards and the Web Site Accessibility Standards/Specifications.

**“Electronic and Information Resources”** means information resources, including information resources technologies, and any equipment or interconnected system of equipment that is used in the creation, conversion, duplication, or delivery of data or information. The term includes, but is not limited to, telephones and other telecommunications products, information kiosks, transaction machines, Internet websites, multimedia resources, and office equipment, including copy machines and fax machines.

**“Electronic and Information Resources Accessibility Standards”** means the accessibility standards for electronic and information resources contained in Volume 1 Texas Administrative Code Chapter 213.

**“Web Site Accessibility Standards/Specifications”** means standards contained in Volume 1 Texas Administrative Code Chapter 206.

**“Product”** means information resources technology that is, or is related to, EIR.

(c) Accessibility Requirements.

Under Texas Government Code Chapter 2054, Subchapter M, and implementing rules of the Texas Department of Information Resources, HHSC must procure Products that comply with the Accessibility Standards when such Products are available in the

commercial marketplace or when such Products are developed in response to a procurement solicitation. Accordingly, Dental Contractor must provide electronic and information resources and associated Product documentation and technical support that comply with the Accessibility Standards.

(d) Evaluation, Testing, and Monitoring.

(1) HHSC may review, test, evaluate and monitor Dental Contractor's Products and associated documentation and technical support for compliance with the Accessibility Standards. Review, testing, evaluation and monitoring may be conducted before and after the award of a contract. Testing and monitoring may include user acceptance testing.

Neither (1) the review, testing (including acceptance testing), evaluation or monitoring of any Product, nor (2) the absence of such review, testing, evaluation or monitoring, will result in a waiver of the State's right to contest the Dental Contractor's assertion of compliance with the Accessibility Standards.

(2) Dental Contractor agrees to cooperate fully and provide HHSC and its representatives timely access to Products, records, and other items and information needed to conduct such review, evaluation, testing and monitoring.

(e) Representations and Warranties.

(1) Dental Contractor represents and warrants that: (i) as of the Effective Date of the Contract, the Products and associated documentation and technical support comply with the Accessibility Standards as they exist at the time of entering the Contract, unless and to the extent the Parties otherwise expressly agree in writing; and (ii) if the Products will be in the custody of the state or an HHS Agency's client or recipient after the Contract expiration or termination, the Products will continue to comply with such Accessibility Standards after the expiration or termination of the Contract Term, unless HHSC and/or its clients or recipients, as applicable, use the Products in a manner that renders it noncompliant.

(2) In the event Dental Contractor should have known, becomes aware, or is notified that the Product and associated documentation and technical support do not comply with the Accessibility Standards, Dental Contractor represents and warrants that it will, in a timely manner and at no cost to HHSC, perform all necessary steps to satisfy the Accessibility Standards, including but not limited to remediation, replacement, and upgrading of the Product, or providing a suitable substitute.

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

(3) Dental Contractor acknowledges and agrees that these representations and warranties are essential inducements on which HHSC relies in awarding this Contract.

(4) Dental Contractor's representations and warranties under this subsection will survive the termination or expiration of the Contract and will remain in full force and effect throughout the useful life of the Product.

(f) Remedies.

(1) Pursuant to Texas Government Code Sec. 2054.465, neither Dental Contractor nor any other person has cause of action against HHSC for a claim of a failure to comply with Texas Government Code Chapter 2054, Subchapter M, and rules of the Department of Information Resources.

(2) In the event of a breach of Dental Contractor's representations and warranties, Dental Contractor will be liable for direct, consequential, indirect, special, and/or liquidated damages and any other remedies to which HHSC may be entitled under this Contract and other applicable law. This remedy is cumulative of any and all other remedies to which HHSC may be entitled under this Contract and other applicable law.

#### **Article 15. Intellectual Property**

##### **Section 15.01 Infringement and misappropriation.**

(a) Dental Contractor warrants that all Deliverables provided by Dental Contractor will not infringe or misappropriate any right of, and will be free of any claim of, any third person or entity based on copyright, patent, trade secret, or other intellectual property rights.

(b) Dental Contractor will, at its expense, defend with counsel approved by HHSC, indemnify, and hold harmless HHSC, its employees, officers, directors, contractors, and agents from and against any losses, liabilities, damages, penalties, costs, and fees from any claim or action against HHSC that is based on a claim of breach of the warranty set forth in the preceding paragraph. HHSC will promptly notify Dental Contractor in writing of the claim, provide Dental Contractor a copy of all information received by HHSC with respect to the claim, and cooperate with Dental Contractor in defending or settling the claim. HHSC will not unreasonably withhold, delay or condition approval of counsel selected by the Dental Contractor.

(c) In case the Deliverables, or any one or part thereof, is in such action held to constitute an infringement or misappropriation, or the use thereof is enjoined or restricted or if a proceeding appears to

Dental Contractor to be likely to be brought, Dental Contractor will, at its own expense, either:

- (1) Procure for HHSC the right to continue using the Deliverables; or
- (2) Modify or replace the Deliverables to comply with the Specifications and to not violate any intellectual property rights.

If neither of the alternatives set forth in (1) or (2) above are available to the Dental Contractor on commercially reasonable terms, Dental Contractor may require that HHSC return the allegedly infringing Deliverable(s) in which case Dental Contractor will refund all amounts paid for all such Deliverables.

##### **Section 15.02 Exceptions.**

Dental Contractor is not responsible for any claimed breaches of the warranties set forth in Section 15.01 to the extent caused by:

- (a) Modifications made to the item in question by anyone other than Dental Contractor or its Subcontractors, or modifications made by HHSC or its contractors working at Dental Contractor's direction or in accordance with the specifications; or
- (b) The combination, operation, or use of the item with other items if Dental Contractor did not supply or approve for use with the item; or
- (c) HHSC's failure to use any new or corrected versions of the item made available by Dental Contractor.

##### **Section 15.03 Ownership and Licenses**

(a) Definitions.

For purposes of this Section 15.03, the following terms have the meanings set forth below:

(1) "**Custom Software**" means any software developed by the Dental Contractor for HHSC; in connection with the Contract; and with funds received from HHSC. The term does not include Dental Contractor Proprietary Software or Third Party Software.

(2) "**Dental Contractor Proprietary Software**" means software: (i) developed by the Dental Contractor prior to the Effective Date of the Contract, or (ii) software developed by the Dental Contractor after the Effective Date of the Contract that is not developed for HHSC; in connection with the Contract; and with funds received from HHSC.

(3) "**Third Party Software**" means software that is: developed for general commercial use; available to the public; or not

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

developed for HHSC. Third Party Software includes without limitation: commercial off-the-shelf software; operating system software; and application software, tools, and utilities.

(b) Deliverables.

The Parties agree that any Deliverable, including without limitation the Custom Software, will be the exclusive property of HHSC.

(c) Ownership rights.

(1) HHSC will own all right, title, and interest in and to its Confidential Information and the Deliverables provided by the Dental Contractor, including without limitation the Custom Software and associated documentation. For purposes of this Section 15.03, the Deliverables will not include Dental Contractor Proprietary Software or Third Party Software. Dental Contractor will take all actions necessary and transfer ownership of the Deliverables to HHSC, including, without limitation, the Custom Software and associated documentation prior to Contract termination.

(2) Dental Contractor will furnish such Deliverables, upon request of HHSC, in accordance with applicable State law. All Deliverables, in whole and in part, will be deemed works made for hire of HHSC for all purposes of copyright law, and copyright will belong solely to HHSC. To the extent that any such Deliverable does not qualify as a work for hire under applicable law, and to the extent that the Deliverable includes materials subject to copyright, patent, trade secret, or other proprietary right protection, Dental Contractor agrees to assign, and hereby assigns, all right, title, and interest in and to Deliverables, including without limitation all copyrights, inventions, patents, trade secrets, and other proprietary rights therein (including renewals thereof) to HHSC.

(3) Dental Contractor will, at the expense of HHSC, assist HHSC or its nominees to obtain copyrights, trademarks, or patents for all such Deliverables in the United States and any other countries. Dental Contractor agrees to execute all papers and to give all facts known to it necessary to secure United States or foreign country copyrights and patents, and to transfer or cause to transfer to HHSC all the right, title, and interest in and to such Deliverables. Dental Contractor also agrees not to assert any moral rights under applicable copyright law with regard to such Deliverables.

(d) License Rights

HHSC will have a royalty-free and non-exclusive license to access the Dental Contractor Proprietary Software and associated documentation during the term of the Contract. HHSC will also have ownership and unlimited rights to use, disclose, duplicate, or publish all information and data developed, derived, documented, or furnished by Dental Contractor under or resulting from the Contract. Such data will include all results, technical information, and materials developed for and/or obtained by HHSC from Dental Contractor in the performance of the Services hereunder, including but not limited to all reports, surveys, plans, charts, recordings (video and/or sound), pictures, drawings, analyses, graphic representations, computer printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the Services performed as a result of the Contract.

(e) Proprietary Notices

Dental Contractor will reproduce and include HHSC's copyright and other proprietary notices and product identifications provided by Dental Contractor on such copies, in whole or in part, or on any form of the Deliverables.

(f) State and Federal Governments

In accordance with 45 C.F.R. §95.617, all appropriate State and Federal agencies will have a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, translate, or otherwise use, and to authorize others to use for Federal Government purposes all materials, the Custom Software and modifications thereof, and associated documentation designed, developed, or installed with federal financial participation under the Contract, including but not limited to those materials covered by copyright, all software source and object code, instructions, files, and documentation.

## **Article 16. Liability**

### **Section 16.01 Property damage.**

(a) Dental Contractor will protect HHSC's real and personal property from damage arising from Dental Contractor's, its agent's, employees' and Subcontractors' performance of the Contract, and Dental Contractor will be responsible for any loss, destruction, or damage to HHSC's property that results from or is caused by Dental Contractor's, its agents', employees' or Subcontractors' negligent or wrongful acts or omissions. Upon the loss of, destruction of, or damage to any property of HHSC, Dental Contractor will notify the HHSC Project

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

Manager thereof and, subject to direction from the Project Manager or her or his designee, will take all reasonable steps to protect that property from further damage.

(b) Dental Contractor agrees to observe and encourage its employees and agents to observe safety measures and proper operating procedures at HHSC sites at all times.

(c) Dental Contractor will distribute a policy statement to all of its employees and agents that directs the employee or agent to promptly report to HHSC or to Dental Contractor any special defect or unsafe condition encountered while on HHSC premises. Dental Contractor will promptly report to HHSC any special defect or an unsafe condition it encounters or otherwise learns about.

**Section 16.02 Risk of Loss.**

During the period Deliverables are in transit and in possession of Dental Contractor, its carriers or HHSC prior to being accepted by HHSC, Dental Contractor will bear the risk of loss or damage thereto, unless such loss or damage is caused by the negligence or intentional misconduct of HHSC. After HHSC accepts a Deliverable, the risk of loss or damage to the Deliverable will be borne by HHSC, except loss or damage attributable to the negligence or intentional misconduct of Dental Contractor's agents, employees or Subcontractors.

**Section 16.03 Limitation of HHSC's Liability**

HHSC WILL NOT BE LIABLE FOR ANY INCIDENTAL, INDIRECT, SPECIAL, OR CONSEQUENTIAL DAMAGES UNDER CONTRACT, TORT (INCLUDING NEGLIGENCE), OR OTHER LEGAL THEORY. THIS WILL APPLY REGARDLESS OF THE CAUSE OF ACTION AND EVEN IF HHSC HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

HHSC'S LIABILITY TO THE DENTAL CONTRACTOR UNDER THE CONTRACT WILL NOT EXCEED THE TOTAL CHARGES TO BE PAID BY HHSC TO THE DENTAL CONTRACTOR UNDER THE CONTRACT, INCLUDING CHANGE ORDER PRICES AGREED TO BY THE PARTIES OR OTHERWISE ADJUDICATED.

**Article 17. Insurance & Bonding**

**Section 17.01 Insurance Coverage**

(a) Statutory and General Coverage.

Dental Contractor will maintain, at Dental Contractor's own expense, during the Term of the Contract and until final acceptance of all Services and Deliverables,

the following insurance coverage. Dental Contractor will provide HHSC with proof of the following insurance coverage on or before the Contract Effective Date:

(1) Business Automobile Liability Insurance for all owned, non-owned, and hired vehicles, for bodily injury and property damage;

(2) Comprehensive General Liability insurance of at least \$1,000,000.00 per occurrence and \$5,000,000.00 in the aggregate (including Bodily injury coverage of \$100,000.00 per each occurrence and Property Damage Coverage of \$25,000.00 per occurrence; and

(3) If Dental Contractor's current Comprehensive General Liability insurance coverage does not meet the above stated requirements, Dental Contractor will obtain Umbrella Liability insurance to compensate for the difference in the coverage amounts. If Umbrella Liability insurance is provided it must follow the form of the primary coverage.

(b) Professional Liability Coverage.

Dental Contractor must maintain at its own expense, or cause its Network Providers to maintain, during the Term of the Contract and until final acceptance of all Services and Deliverables, the following insurance coverage:

(1) Professional Liability Insurance for each Network Provider of \$100,000.00 per occurrence and \$300,000.00 in the aggregate. Dental Contractor must provide proof of such coverage upon request to HHSC.

(2) An Excess Professional Liability (Errors and Omissions) Insurance Policy for the greater of \$3,000,000.00 or an amount (rounded to the nearest \$100,000.00) that represents the number of Members enrolled in the Dental Contractor in the first month of the applicable Contract Year multiplied by \$150.00, not to exceed \$10,000,000.00. Dental Contractor will provide HHSC with proof of this insurance coverage on or before the Contract Effective Date.

(c) General Requirements for All Insurance Coverage

(1) Except as provided herein, all exceptions to the Contract's insurance requirements must be approved in writing by HHSC. HHSC's written approval is not required in the following situation:

The Dental Contractor or a Network Provider is not required to obtain insurance coverage

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

---

described in Section 17.01 if the Dental Provider or Network Provider qualifies as a state governmental unit or municipality under the Texas Tort Claims Act, and is required to comply with, and are subject to, the provision of the Texas Tort Claims Act.

(2) Dental Contractor or the Network Provider is responsible for any and all deductibles stated in the policies.

(3) Insurance coverage will be issued by insurance companies authorized by applicable law to conduct business in the State of Texas, and

(4) Insurance coverage must name HHSC as an additional insured, with the exception of Professional Liability insurance maintained by Network Providers. Insurance coverage must name HHSC as a loss payee, with the exception of Professional Liability insurance maintained by Network Providers and Business Automobile Liability insurance.

(5) Insurance coverage kept by the Dental Contractor must be maintained in full force at all times during the Term of the Contract, and until HHSC's final acceptance of all Services and Deliverables. Failure to maintain such insurance coverage will constitute a material breach of this contract.

(6) With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must have an extended reporting period of two (2) years. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, the Contract Effective Date.

(7) With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must provide that prior written notice to be given to HHSC at least thirty (30) calendar days before coverage is reduced below minimum HHSC contractual requirements, canceled, or non-renewed. Dental Contractor must submit a new coverage binder to HHSC to ensure no break in coverage. Each policy must include the following provision: "It is a condition of this policy that the company must furnish written notice to HHSC's designated contact at least thirty (30) calendar days in advance of any reduction in cancellation, or non-renewal of this policy."

(8) The Parties expressly understand and agree that any insurance coverages and limits furnished by Dental Contractor will in no way expand or limit Dental Contractor's liabilities and responsibilities specified within the Contract documents or by applicable law.

(9) Dental Contractor expressly understands and agrees that any insurance maintained by HHSC will apply in excess of and not contribute to insurance provided by Dental Contractor under this contract.

(10) If Dental Contractor or its Network Providers, desire additional coverage, higher limits of liability, or other modifications for its own protection, Dental Contractor or its Network Providers will be responsible for the acquisition and cost of such additional protection. Such additional protection will not be an Allowable Expense under this Contract.

(11) Dental Contractor will require all insurers to waive their rights of subrogation against HHSC.

(d) Proof of Insurance Coverage

(1) Except as provided in Section 17.01(d)(2), Dental Contractor must furnish HHSC original Certificates of Insurance evidencing the required insurance coverage on or before the Effective Date of the Contract. If insurance coverage is renewed during the term of the Contract, the Dental Contractor must furnish HHSC renewal certificates of insurance, or such similar evidence within five (5) Business Days of renewal. Dental Contractor will submit evidence of insurance prior to Contract award. The failure of HHSC to obtain such evidence from Dental Contractor before permitting Dental Contractor to commence work will not be deemed to be a waiver by HHSC and Dental Contractor will remain under continuing obligation to maintain and provide proof of the insurance coverage.

(2) The insurance specified above will be carried until all Services and Deliverables required under the terms of the Contract are satisfactorily completed. Failure to carry or keep such insurance in force will constitute a violation of the Contract.

**Section 17.02 Performance Bond.**

Beginning on the Effective Date of the Contract, and each year thereafter, the Dental Contractor must obtain a performance bond with a one (1) year term. The performance bond must be renewable, and renewal must occur no later than the first day of each subsequent State Fiscal Year. The performance bond must continue to be in effect for one (1) year following the expiration of the final renewal period. Dental Contractor must obtain and maintain the annual performance bonds in the form prescribed by HHSC and approved by TDI, naming HHSC as Obligee, securing Dental Contractor's faithful performance of the terms and conditions of this Contract. The annual performance bond(s) must be issued in the amount of \$100,000.00. Performance bonds must be issued by a surety licensed by TDI, and specify cash payment

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment A – Medicaid/CHIP Dental Services Terms & Conditions**

Version 1.12

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as the sole remedy. Dental Contractor must deliver the initial performance bond to HHSC prior to or on the Effective Date of the Contract, and each renewal prior to the first day of the State Fiscal Year.

**Section 17.03 TDI Fidelity Bond**

The Dental Contractor will secure and maintain throughout the life of the Contract a fidelity bond as required by the Texas Department of Insurance. The Dental Contractor must promptly provide HHSC with copies of the bond and any amendments or renewals thereto.

## DOCUMENT HISTORY LOG

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Baseline	n/a	September 1, 2011	Initial version of Attachment B-1, RFP Section 6, "Incentives & Disincentives."
Revision	1.1	March 1, 2012	Contract amendment did not revise Attachment B-1, RFP Section 6, "Incentives & Disincentives."
Revision	1.2	September 1, 2012	Section 6.2.4.4 is modified to replace the reference to the Procurement Library with a UMCM reference.
Revision	1.3	March 1, 2013	All references to the previous Executive Commissioner Suehs are changed to his successor, Executive Commissioner Janek.
Revision	1.4	September 1, 2013	Section 6.2.3.2 is modified to provide HHSC more flexibility to implement reward-based assignment methodologies. Section 6.2.4.1 is modified to add the word "Program" to the section title. Section 6.2.4.2 is renamed "Performance Based Incentive Program". Subsection 6.2.4.2.1 "Quality Challenge Award" is renamed "Quality Challenge Award Program" and to add clarifying language. Subsection 6.2.4.2.2 State-Dental Contractor Shared Savings Program is added.
Revision	1.5	January 1, 2014	Contract amendment did not revise Attachment B-1, RFP Section 6, "Incentives & Disincentives."
Revision	1.6	February 1, 2014	Section 6.2.4.2.2 is renamed "Other Incentive Programs" and updated.
Revision	1.7	September 1, 2014	Contract amendment did not revise Attachment B-1, RFP Section 6, "Incentives & Disincentives."
Revision	1.8	March 1, 2015	In each contract section, after the first appearance of the term, "Uniform Managed Care Manual" is changed to "UMCM." Section 6.2.4.1 is modified to change the name from "Performance-Based Capitation Rate Program (5%-at-risk)" to "Pay for Quality (P4Q) Program" and to clarify the P4Q program requirements. Section 6.2.4.2 "Performance Based Incentive Program" is deleted in its entirety.

**DOCUMENT HISTORY LOG**

<b>STATUS<sup>1</sup></b>	<b>DOCUMENT REVISION<sup>2</sup></b>	<b>EFFECTIVE DATE</b>	<b>DESCRIPTION<sup>3</sup></b>
			<p>Section 6.2.4.2.1 “Quality Challenge Award Program” is deleted in its entirety.</p> <p>Section 6.2.4.2.2 “Other Incentive Programs” is deleted in its entirety.</p> <p>Section 6.2.4.5 is modified to include additional methodologies.</p>
Revision	1.9	May 1, 2015	Contract amendment did not revise Attachment B-1, RFP Section 6, “Incentives & Disincentives.”
Revision	1.10	September 1, 2015	<p>Section 6.2.4.1 is modified to correct a typo and to clarify the requirements.</p> <p>Section 6.2.4.5 is modified to correct a typo.</p>
Revision	1.11	March 1, 2016	<p>All references to the previous Executive Commissioner Janek are changed to his successor, Executive Commissioner Traylor.</p> <p>Section 6.2.4.1 is modified to correct UMCM chapter references.</p>
Revision	1.12	September 1, 2016	All references to the previous Executive Commissioner Traylor are changed to his successor, Executive Commissioner Smith.
<p><sup>1</sup> Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.</p> <p><sup>2</sup> Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.</p> <p><sup>3</sup> Brief description of the changes to the document made in the revision.</p>			

## Table of Contents

<b>6. Incentives &amp; Disincentives.....</b>	<b>4</b>
6.1 Premium Rate Development .....	4
6.2 Financial Payment Structure and Provisions.....	4
6.2.1 Premium Payments .....	5
6.2.2 Performance Incentives and Disincentives .....	5
6.2.3 Non Financial Incentives .....	5
6.2.4 Financial Incentives and Disincentives.....	6

## **6. Incentives & Disincentives**

This section describes performance incentives and disincentives related to HHSC’s value-based purchasing approach. For further information, refer to **Attachment A**, “HHSC Dental Contract Terms and Conditions.”

Under the Contract, dental care coverage for Members will be provided on a fully insured basis. The Dental Contractor must provide the Services and Deliverables, including Dental Administrative Services and Medically Necessary Covered Dental Services to enrolled Members, in order for monthly Premium Payments to be paid by HHSC.

### **6.1 Premium Rate Development**

Refer to the **Attachment A**, “HHSC Dental Contract Terms & Conditions,” for information concerning Premium Rate development.

### **6.2 Financial Payment Structure and Provisions**

HHSC will pay the Dental Contractor monthly Premium Payments based on the number of eligible and enrolled Members. HHSC will calculate the monthly Premium Payments by multiplying the number of Member Months by the applicable monthly Premium Rate by Member Rate Cell.

The Dental Contractor must understand and expressly assume the risks associated with the performance of the duties and responsibilities under the Contract, including the failure, termination, or suspension of funding to HHSC, delays or denials of required approvals, cost of claims incorrectly paid by the Dental Contractor, and cost overruns not reasonably attributable to HHSC. The Dental Contractor must further agree that no other charges for tasks, functions, or activities that are incidental or ancillary to the delivery of the Services and Deliverables will be sought from HHSC or any other state agency, nor will the failure of HHSC or any other party to pay for such incidental or ancillary services entitle the Dental Contractor to withhold Services or Deliverables due under the Contract.

### **6.2.1 Premium Payments**

The Dental Contractor must refer to the **Attachment A**, “HHSC Dental Contract Terms & Conditions,” for information and Contract requirements on the:

1. Time and manner of payment;
2. Adjustments to Premium Payments; and
3. Experience Rebate.

### **6.2.2 Performance Incentives and Disincentives**

The Contract includes several financial and non-financial performance incentives and disincentives. These incentives and disincentives are subject to change by HHSC over the course of the Contract Period. The methodologies required to implement these strategies may be refined by HHSC after collaboration with the Dental Contractor. HHSC does not anticipate that any changes to the incentives/disincentives would be made during the first Rate Period, or during any subsequent Rate Period once the rates are established for that period. The Dental Contractor is prohibited from passing down financial disincentives and/or sanctions imposed on the Dental Contractor to dental providers, except on an individual basis and related to the individual dental provider’s inadequate performance.

### **6.2.3 Non Financial Incentives**

#### **6.2.3.1 Performance Profiling**

HHSC may distribute information on key performance indicators to the Dental Contractors on a regular basis, identifying the Dental Contractor’s performance, and comparing that performance to other Dental Contractors and to HHSC standards and/or external benchmarks. HHSC may recognize when a Dental Contractor obtains superior performance and/or improvement by publicizing the Dental Contractor’s achievements. For example, HHSC may post information concerning exceptional performance on its website, where it will be available to both stakeholders and members of the public. Likewise, HHSC may post its final determination regarding poor performance or peer group performance comparisons on its website, where it will be available to both stakeholders and members of the public.

### **6.2.3.2 Auto-assignment Methodology for Dental Contractors**

Section  
6.2.3.2  
modified by  
Version 1.4

HHSC may revise its auto-assignment methodology during the Contract Period for enrollees who do not select a Dental Contractor. The new assignment methodology would reward those Dental Contractors that demonstrate superior performance or improvement on one or more key dimensions of performance (see 1 Tex. Admin. Code § 353.403(d)(3)(B for Medicaid).

HHSC will invite Dental Contractors to comment on potential approaches prior to implementation of a performance-based auto-assignment algorithm.

### **6.2.4 Financial Incentives and Disincentives**

#### **6.2.4.1 Pay for Quality (P4Q) Program**

Section  
6.2.4.1  
modified by  
Versions  
1.4, 1.8,  
1.10, and  
1.11

Under the P4Q program, HHSC will place each Dental Contractor at risk for 4% of the Premium Payments for the Medicaid and CHIP Programs. HHSC retains the right to reduce the percentage of the Capitation Payment placed at risk in a given Rate Period.

HHSC will pay the Dental Contractor the full monthly Premium Payments as described in **Section 6.2.1**. Then, at the end of the P4Q data collection period, HHSC will evaluate the Dental Contractor's performance and assign points and dollar amounts using the methodology set out in UMCM, Chapter 6.2.13, "Texas Medicaid/CHIP Dental Pay for Quality (P4Q) Program Methodology." HHSC's objective is that all Dental Contractors achieve performance levels that enable them to retain the full at-risk amount.

Specific contractual requirements, including performance measures, and program details will be set forth in Uniform Managed Care Manual (UMCM), Chapters 6.2.7, "Medicaid Dental Pay for Quality (P4Q) Program Measures," 6.2.8, "CHIP Dental Pay for Quality (P4Q) Program Measures," and 6.2.13, "Texas Medicaid/CHIP Dental Pay for Quality (P4Q) Program Methodology."

Failure to timely provide HHSC with necessary data related to the calculation of the P4Q performance indicators will result in HHSC's assignment of a zero percent (0%) performance rate for each related performance indicator.

Dental Contractors will report actual Premium Payments received on the Financial Statistical Report (FSR) during the Rate Period that is at risk (i.e., the Dental Contractor will *not* report 96% of the payments received, leaving four percent (4%) 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 UMCM, Chapter 5.3.1, “Financial Statistical Report and Instructions”).

HHSC will evaluate the P4Q program methodology annually in consultation with Dental Contractors. HHSC may then modify the methodology as it deems necessary and appropriate, in order to motivate, recognize, and reward Dental Contractors for superior performance.

Section 6.2.4.2 added by Version 1.4 and removed in its entirety by Version 1.8

**6.2.4.2 This Section Intentionally Left Blank**

Section 6.2.4.2.1 modified by Version 1.4 and removed in its entirety by Version 1.8

**6.2.4.2.1 This Section Intentionally Left Blank**

**6.2.4.2.2 This Section Intentionally Left Blank**

Section 6.2.4.2.2 added by Version 1.4; modified by Version 1.6; and removed in its entirety by Version 1.8

**6.2.4.3 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 B-3**, “Deliverables/Liquidated Damages Matrix, for performance standards that carry liquidated damage values.

**6.2.4.4 Few 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.

Section 6.2.4.4 modified by Versions 1.2, 1.3 and 1.12

The incentives and disincentives and corresponding methodology are set forth in UMCM, Chapter 12 “Frew.”

#### **6.2.4.5 Additional Incentives and Disincentives**

HHSC will evaluate performance-based incentive and disincentive methodologies annually and in consultation with the Dental Contractors and DSHS Dental Program Management. HHSC may then add to or modify the methodologies as needed, or develop additional methodologies, as funds become available, or as mandated by court decree, statute, or rule in an effort to motivate, recognize, and reward the Dental Contractors for performance.

Information about the data collection period to be used, performance indicators selected or developed, and Dental Contractor ranking methodologies for any specific period will be found in the UMCM.

Section  
6.2.4.5  
modified by  
Versions  
1.8 and  
1.10

**DOCUMENT HISTORY LOG**

<b>STATUS<sup>1</sup></b>	<b>DOCUMENT REVISION<sup>2</sup></b>	<b>EFFECTIVE DATE</b>	<b>DESCRIPTION<sup>3</sup></b>
Baseline	n/a	September 1, 2011	Initial version of Attachment B-1, RFP Section 7, "Transition Phase Requirements."
Revision	1.1	March 1, 2012	Section 7.1 is modified to add termination of the contract to the list of remedies for failure to timely satisfy Readiness Review requirements.
Revision	1.2	September 1, 2012	Contract amendment did not revise Attachment B-1, Section 7, "Transition Phase Requirements."
Revision	1.3	March 1, 2013	Contract amendment did not revise Attachment B-1, Section 7, "Transition Phase Requirements."
Revision	1.4	September 1, 2013	Section 7.2.8.1 is modified for clarification and to comply with requirements of SB 7, 83R.
Revision	1.5	January 1, 2014	Contract amendment did not revise Attachment B-1, Section 7, "Transition Phase Requirements."
Revision	1.6	February 1, 2014	Contract amendment did not revise Attachment B-1, Section 7, "Transition Phase Requirements."
Revision	1.7	September 1, 2014	Section 7.2.7 is modified to update SAS70 to SSAE16.
Revision	1.8	March 1, 2015	After the first appearance of the term, "Uniform Managed Care Manual" is changed to "UMCM."
Revision	1.9	May 1, 2015	Contract amendment did not revise Attachment B-1, Section 7, "Transition Phase Requirements."
Revision	1.10	September 1, 2015	Contract amendment did not revise Attachment B-1, Section 7, "Transition Phase Requirements."
Revision	1.11	March 1, 2016	All references to "Fraud and Abuse" are changed to "Fraud, Waste, and Abuse"
Revision	1.12	September 1, 2016	Contract amendment did not revise Attachment B-1, Section 7, "Transition Phase Requirements."
<p><sup>1</sup> Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.</p> <p><sup>2</sup> Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.</p> <p><sup>3</sup> Brief description of the changes to the document made in the revision.</p>			

## Table of Contents

7.	Transition Phase Requirements.....	3
7.1	Introduction.....	3
7.2	Transition Phase Schedule and Tasks.....	4
7.2.1	Contract Start-Up and Planning .....	4
7.2.2	Administration and Key Dental Contractor Personnel.....	5
7.2.3	Organizational Readiness Review .....	5
7.2.4	Financial Readiness Review .....	6
7.2.5	System Testing and Transfer of Data.....	7
7.2.6	System Readiness Review .....	8
7.2.7	Demonstration and Assessment of System Readiness .....	9
7.2.8	Operations Readiness .....	10
7.2.9	Assurance of System and Operational Readiness .....	13
7.2.10	TDI Licensure, Certification or Approval.....	14
7.2.11	Post-Transition.....	14

## 7. Transition Phase Requirements

### 7.1 Introduction

This Section presents the scope of work for the Transition Phase of the Contract, which includes those activities that must take place between the time of Contract award and the Operational Start Date.

The Transition Phase will include all activities that must be completed successfully prior to the Dental Contractor's Operational Start Date, including all Readiness Review activities. HHSC will conduct Readiness Reviews to determine whether the Dental Contractor has implemented all systems and processes necessary to begin serving Members. Dental Contractors must satisfy all Readiness Review requirements no later than 60 days prior to the Operational Start Date. HHSC may, at its discretion, terminate the Contract, postpone the Dental Contractor's Operational Start Date and/or assess contractual remedies if a Dental Contractor fails to timely correct all Readiness Review deficiencies within a reasonable cure period, as determined by HHSC. Refer to **Attachment A**, "Dental Contract Terms and Conditions" and the **Attachment B-3**, "Deliverables/Liquidated Damages Matrix" for additional information.

The Dental Contractor is required to promptly provide a Corrective Action Plan and/or Risk Mitigation Plan as requested by HHSC in response to Transition Phase deficiencies identified by the Dental Contractor, HHSC, or its agent. The Dental Contractor must promptly alert HHSC of deficiencies, and must correct a deficiency or provide a Corrective Action Plan and/or Risk Mitigation Plan no later than ten (10) calendar days after HHSC's notification of deficiencies. If the Contractor documents to HHSC's satisfaction that the deficiency has been corrected within ten (10) calendar days of such deficiency notification by HHSC, no Corrective Action Plan is required.

Section 7.1  
Modified by  
Version 1.1

## **7.2 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.

### **7.2.1 Contract Start-Up and Planning**

HHSC and the Dental Contractor will work together during the initial Contract start-up phase to:

- define project management and reporting standards;
- establish communication protocols between HHSC and the Dental Contractor;
- establish contacts with other HHSC contractors;
- establish a schedule for key activities and milestones;
- develop a comprehensive plan for exchanging information on CHIP benefit limitations with HHSC and other Dental Contractors; and
- clarify expectations for the content and format of Contract Deliverables.

The Dental Contractor will be responsible for developing a written work plan, referred to as the Transition/Implementation Plan, which will be used to monitor progress throughout the Transition Phase. The Dental Contractor must update the Transition/Implementation Plan provided with its proposal no later than 90 days prior to the Operational Start Date, then provide monthly implementation progress reports through the sixth month of Program operations. HHSC may require more frequent reporting as it determines necessary.

## 7.2.2 Administration and Key Dental Contractor Personnel

No later than the Effective Date of the Contract, the Dental Contractor must designate and identify Key Dental Contractor Personnel that meet the requirements in **Attachment A**, “Dental Contract Terms and Conditions,” **Article 4**, “Contract Administration and Management.” The Dental Contractor will supply HHSC with resumes of each Key Dental Contractor Personnel as well as organizational information that has changed relative to the Dental Contractor’s Proposal, such as updated job descriptions and updated organizational charts, (including updated Management Information System (MIS) job descriptions and an updated MIS staff organizational chart), if applicable. If the Dental Contractor is using Material Subcontractors, the Dental Contractor must also provide the organizational chart for such Material Subcontractors.

## 7.2.3 Organizational Readiness Review

In order to complete an organizational review and assess the most current corporate environment, the Dental Contractor must submit an Organization Update Report no later than 60 days prior to the Operational Start Date that updates the organizational information submitted in its proposal (see **Section 4.2**, “Business Specifications”). For each of the numbered items below, the report must describe whether the information provided in Dental Contractor’s Proposal has changed. If so, the report must include relevant portions of the proposal with changes highlighted.

1. Respondent identification and information, **Section 4.2.2**.
2. Corporate background and experience:
  - a. Item #1, concerning publicly-funded managed care contracts, under **Section 4.2.3**;
  - b. Item # 2, concerning regulatory actions, sanctions, and/or fines, under **Section 4.2.3**;
  - c. **Section 4.2.3.1**, concerning organizational charts; and
  - d. **Section 4.2.3.2**, concerning resumes.
3. Material Subcontractor information, **Section 4.2.4**.

## 7.2.4 Financial Readiness Review

To complete a financial review, the Dental Contractor must submit a Financial Update Report no later than 60 days prior to the Operational Start Date. At a minimum, the report must include the following:

1. Material change in financial condition.

For both the Dental Contractor and its ultimate parent, the report must identify whether either entity has experienced any material financial deterioration following proposal submission. The report must identify and briefly describe any changes to the financial statements, including changes to net worth; cash flow; loss of contracts; credit, audit, regulatory, and/or legal issues; major contingencies, etc. The report must also describe any known potential issues, and any issues with respect to change of ownership or control.

2. Updated financial statements.

The report must include the most recently updated financial statements, which should be more current than those provided in the proposal. The updated financial statements should include the most recent quarterly (or monthly) internal financial statements, the most-recently completed annual statements, and the most-recent audited statements. The statements should generally include the notes, management discussion, and where appropriate, the audit letter. Internal most-recent-month statements are not expected to include these items.

The report must include any of the following new or updated reports (as referenced under **Sections 4.2.3.3** and **4.2.3.4**) that have become available since proposal submission: TDI financial examination report (or similar report from another state); Form B Registration statement filing; IRS Form 990; and bond or debt rating analysis. It is not necessary to submit updated SEC 10-K or 10-Q filings with the report.

In addition to the Financial Update Report, the Dental Contractor must submit documentation demonstrating it has secured all required bonds in accordance with TDI requirements, **Section 8**

“Operations Phase Requirements,” and **Attachment A**, “Dental Terms and Conditions,” **Article 17**. Such documentation is due no later than ten (10) business days after the Contract Effective Date.

#### **7.2.4.1 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 Uniform Managed Care Manual (UMCM), Chapter 6.1, “Cost Principles for Expenses.”

#### **7.2.5 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 all MIS systems and subsystems identified in **Section 8.1.12** “Management Information System Requirements.” For example, the Dental Contractor’s MIS system must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as indicated in **Section 8.1.12.4** “HIPAA Compliance.”

During this Readiness Review task, the Dental Contractor will accept into its system any and all necessary data files and information available from HHSC or its contractors. The Dental Contractor will install and test all hardware, software, and telecommunications required to

support the Contract. The Dental Contractor will define and test modifications to the Dental Contractor's system(s) required to support the business functions of the Contract.

The Dental Contractor will produce data extracts and receive all electronic data transfers and transmissions.

If any errors or deficiencies are evident, the Dental Contractor will develop resolution procedures to address problems identified. The Dental Contractor will 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 Members and any necessary connections to the HHSC Administrative Services Contractor. The HHSC Administrative Services Contractor will provide enrollment test files to new Dental Contractors that do not have previous HHSC enrollment files. The Dental Contractor will demonstrate its system capabilities and adherence to Contract specifications during readiness review.

## **7.2.6 System Readiness Review**

The Dental Contractor must ensure that systems services are not disrupted or interrupted during the Operations Phase of the Contract. The Dental Contractor must coordinate with HHSC and other contractors to ensure the business and systems continuity for the processing of all health care claims and data as required under this Contract.

The Dental Contractor must submit descriptions of interface and data and process flow for each key business processes described in **Section 8.1.12.3** "System-wide Functions".

The Dental Contractor must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. No later than 120 days prior to the Operational Start Date, a new Dental Contractor must develop, or an incumbent Dental Contractor must update, the following plans:

1. Disaster Recovery Plan\*
2. Business Continuity Plan\*

3. Security Plan
4. Joint Interface Plan.
5. Risk Management Plan, and
6. Systems Quality Assurance Plan.

\* The Business Continuity Plan and the Disaster Recovery Plan may be combined into one document.

## **7.2.7 Demonstration and Assessment of System Readiness**

Section  
7.2.7 is  
modified by  
Version 1.7

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 also 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 SSAE16 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 prior to the Operational Start Date of the Contract. The Dental Contractor must be prepared to assure and demonstrate system readiness. The Dental Contractor must execute system readiness test cycles to include all external data interfaces, including those with Material Subcontractors.

HHSC, or its agents, may independently test whether the Dental Contractor's MIS has the capacity to administer the Dental Program. This Readiness Review may include a desk review and/or an onsite review. HHSC may request additional documentation to support the provision of Dental Program Services. Based in part on the Dental Contractor's assurances of systems readiness, information contained in the Proposal, additional documentation submitted by the Dental Contractor, and any review conducted by HHSC or its agents, 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.

## **7.2.8 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 Medicaid and CHIP Dental Services, including coordination with Subcontractors and HHSC’s contractors. The Dental Contractor will be responsible for developing and documenting its approach to quality assurance.

### **7.2.8.1 Readiness Review**

At a minimum, the Dental Contractor must:

1. Develop new, or revise existing, operations procedures and associated documentation to support the Dental Contractor’s proposed approach to conducting operations activities in compliance with the contracted Scope of Work.
2. Submit a comprehensive plan for Network adequacy that includes a list of all contracted and credentialed Providers, in an HHSC-approved format. The plan must include a description of additional contracting and credentialing activities scheduled to be completed before the Operational Start Date.
3. Inform all Network Providers about the information required to submit a claim at least 30 days prior to the Operational Start Date and as a provision within the Network Provider agreement.
4. Prepare and implement a Member Services staff training curriculum and a Provider training curriculum.
5. Prepare a Coordination Plan documenting how the Dental Contractor will coordinate its business activities with those activities performed by HHSC’s contractors and the Dental

Section  
7.2.8.1  
modified by  
Version 1.4

Contractor's Material Subcontractors, if any. The Coordination Plan will include identification of coordinated activities and protocols for the Transition Phase.

6. Develop and submit to HHSC the draft Medicaid and CHIP Member Handbooks, draft Provider Manuals, draft Provider Directories, and draft Member Identification Cards for HHSC's review and approval. The materials must at a minimum meet the requirements specified in **Section 8.1.6**, "Member Services" and include the Critical Elements defined in UCM, Chapter 3, "Critical Elements".
7. Develop and submit to HHSC the Dental Contractor's proposed Member Complaint and Appeals processes for the Medicaid and CHIP Programs.
8. Provide sufficient copies of the final Provider Directories to the HHSC Administrative Services Contractor in sufficient time to meet the enrollment schedule.
9. Demonstrate toll-free telephone systems and reporting capabilities for the Member Services Hotline and the Provider Services Hotline.
10. No later than 30 days after the Contract Effective Date, new Dental Contractors must develop, and incumbent Dental Contractors must update, their written Fraud, Waste, and Abuse Compliance Plans. See **Section 8.1.13**, "Fraud, Waste, and Abuse" for the requirements of the plan, including new requirements for special investigation units. As part of the Fraud, Waste, and Abuse Compliance Plan, the Dental Contractor must:
11. Designate executive and essential personnel to attend mandatory training in Fraud, Waste, and Abuse detection, prevention and reporting. Executive and essential Fraud, Waste, and Abuse personnel means Dental Contractor staff persons who (1) are directly involved in the decision-making and administration of the Fraud, Waste, and Abuse detection program within the Dental Contractor, and (2) who supervise staff in the following areas: data collection, provider enrollment or disenrollment, Encounter Data, claims processing, Utilization Review, Appeals or Grievances, quality assurance and Marketing. The training will be conducted by the Office of Inspector General, Health and Human Services Commission, and will be provided free of charge. The Dental Contractor must schedule and complete training no later than 90 days after the Contract's Effective Date.

12. Designate an officer or director within the organization responsible for carrying out the provisions of the Fraud, Waste, and Abuse Compliance Plan.

If this function is subcontracted to another entity, the Subcontractor also meets all the requirements in this section and the Fraud, Waste, and Abuse section as stated in **Section 8**, "Operations Phase Requirements".

13. The Dental Contractor must submit a copy of each Material Subcontract to HHSC in accordance with the timeframes identified in **Attachment A**, "Dental Contract Terms and Conditions," **Section 4.08**, "Subcontractors."
14. No later than 10 Business Days after the Contract Effective Date, the Dental Contractor must submit documentation demonstrating that it has secured all required insurance, in accordance with TDI requirements and **Section 8**, "Operations Phase Requirements," and **Attachment A**, "Dental Contract Terms and Conditions," **Article 17**.
15. The Dental Contractor must post the Contractor's provider recruiting information to its website and make the Network Provider contract available for downloading no later than ten (10) Business Days from initial approval from HHSC.

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, expands into a new Program or Service Area, or implements a major systems change after the Contract's Effective Date.

During the Readiness Review, HHSC may request additional information, including more detailed or updated information regarding the Dental Contractor's operating procedures and documentation. HHSC will assess 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 the Proposal, and in Transition Phase documentation submitted by the Dental Contractor.

### **7.2.8.2 Value-Added Services**

The Dental Contractor must use HHSC's template for submitting proposed Value-added Services (see UCM Chapter 4.4). Once approved by HHSC, this document is incorporated by reference into the Contract.

During the Transition Phase, HHSC will offer a one-time opportunity for the Dental Contractor to propose two (2) additional Value-added Services to its list of current, approved Value-added Services. HHSC will establish the requirements and the timeframes for submitting the two (2) additional proposed Value-added Services.

During this HHSC-designated opportunity, the Dental Contractor may propose either to add new Value-added Services or to enhance its approved Value-added Services. The Dental Contractor may propose two (2) additional Value-added Services for both the Medicaid and CHIP Programs, which will be effective on the Operational Start Date. The services do not have to be the same for each Program. The Contract will be amended to include any additional Value-added Services approved by HHSC.

The Dental Contractor is not required to add Value-added Services during the HHSC-designated opportunity, but this will be the only time during the Transition Phase for the Dental Contractor to add Value-added Services. At no time during the Transition Phase will the Dental Contractor be allowed to delete, limit, or restrict any of its approved Value-added Services.

### **7.2.9 Assurance of System and Operational Readiness**

In addition to successfully providing the Deliverables described in **Section 7.2.5**, the Dental Contractor must ensure HHSC that all processes, MIS systems, and staffed functions are ready and able to successfully assume responsibilities for operations prior to the Operational Start Date. In particular, the Dental Contractor must ensure that Key Dental Contractor Personnel, Member Services staff, Provider Services staff, and MIS staff are hired and trained, MIS systems and interfaces are in place and functioning properly, communications procedures are in

place, Provider Manuals have been distributed, and that Provider training sessions have occurred according to an HHSC-approved schedule.

### **7.2.10 TDI Licensure, Certification or Approval**

The Dental Contractor must receive TDI licensure or approval for all zip codes in Texas no later than 120 days prior to the Operational Start Date. If the Dental Contractor fails to receive TDI licensure by this deadline, then HHSC may terminate the contract. The Dental Contractor must indemnify HHSC for all costs incurred by HHSC or its authorized representatives relating to such termination. Such costs include, without limitation, the cost of securing a replacement vendor, as well as the cost of any claim or litigation that is reasonably attributable to the Dental Contractor's failure to receive the requisite approval.

### **7.2.11 Post-Transition**

The Dental Contractor will work with HHSC, Providers, and Members to promptly identify and resolve problems identified after the Operational Start Date and to communicate to HHSC, Providers, and Members, as applicable, the steps the Dental Contractor is taking to resolve the problems.

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Baseline	n/a	September 1, 2011	Initial version of Attachment B-1, RFP Section 8, "Operations Phase Requirements."
Revision	1.1	March 1, 2012	<p>Section 8.1.4.1 is revised to include continuity of care language.</p> <p>Section 8.1.5.8 is modified to clarify that Provider Hotline must have an automated response that provides the Member's eligibility for the current month, not their enrollment start and end dates of coverage.</p> <p>Section 8.1.6.5 is modified to require the Dental Contractors to include a link to financial literacy information on the OCCC web page as required by HB 2615.</p> <p>Section 8.1.11 is modified to remove the requirement to submit an accounting policy manual.</p> <p>Section 8.1.11.1 "Financial Disclosure Report" is renamed "MCO Disclosure Statement" and the submission date is updated.</p> <p>Section 8.1.12.5 is modified to require Dental Contractors to maintain a mechanism to receive claims in addition to the HHSC claims portal and to provide a web portal that supports Batch Processing.</p> <p>Section 8.1.19 is modified to outline the process and timeframes for responding to the OIG, to add the 90 day timeline for submitting the annual plan, correct a cross reference, and to require Dental Contractors to ensure their subcontractors receiving or making annual Medicaid payments of at least \$5 million comply with 1902(a)(68)(A) of the Social Security Act.</p> <p>Section 8.1.15 is modified to conform to the payment requirements in the Uniform Managed Care Contract.</p> <p>Section 8.1.16.1 is revised to clarify that that CHIP copayments do not apply to preventive services and copayment amounts are capped at the Dental Contractor's cost.</p> <p>Section 8.2.1 is modified to clarify orthodontic treatment requirements.</p> <p>Section 8.2.2.1.2 is modified to require Dental Contractors to use standard Texas Health Steps</p>

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>language in their Member Materials as provided in the UMCM.</p> <p>Section 8.2.2.3 is amended to add “Texas Health Steps environmental lead investigation (ELI)”. Remainder of list is renumbered.</p> <p>Section 8.2.3.2 is modified to add a reference to Gov’t Code §533.005(a)(19).</p> <p>Section 8.2.6 is modified to add the phrase “unless an exception applies under federal law” to the first sentence.</p>
Revision	1.2	September 1, 2012	<p>Section 8.1.1.1 is modified to conform to the timelines in the UMCM.</p> <p>Section 8.1.4.1 is modified to require Main Dental Home Providers to provide services in accordance with the AAPD recommendations for both Medicaid and CHIP Members.</p> <p>Section 8.1.5.4 is modified to require Main Dental Home Providers to provide services in accordance with the AAPD recommendations for both Medicaid and CHIP Members.</p> <p>Section 8.1.5.7 is modified to require HHSC review of all provider materials relating to Medicaid managed care or CHIP.</p> <p>Section 8.1.5.9 is modified to clarify the applicable federal regulations.</p> <p>Section 8.1.6.1 is modified to prohibit the MCOs from including any language in their member materials which limits the members’ ability to contest or appeal denial of a benefit.</p> <p>Section 8.1.13 is modified to update the time frames for responding to the OIG and to add language regarding Credible Allegation of Fraud notices.</p> <p>Section 8.1.14.2(j), (k), (l), (m), and (n) is modified to correct the names of the Frew Dental Reports and to add UMCM Chapter numbers.</p> <p>Section 8.1.15 is modified to require payment of full encounter rates to the FQHC at the time the claim is paid for both Medicaid and CHIP.</p> <p>Section 8.2.6 is modified to clarify the pay and chase requirements for prenatal and preventative care, and recoveries in the context of state child</p>

## DOCUMENT HISTORY LOG

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			support enforcement actions (SSA §1902(a)(25)(E) and (F)); and to correct contract cross reference.
Revision	1.3	March 1, 2013	<p>All references to the previous Executive Commissioner Suehs are changed to his successor, Executive Commissioner Janek.</p> <p>Section 8.1.3.1 is modified to add language regarding reducing or deleting Value-added services.</p> <p>Section 8.1.5.1 is modified to include a provision for termination of a Significant Traditional Provider.</p> <p>Section 8.1.5.11 "Provider Advisory Groups" is added.</p> <p>Section 8.1.6.10 "Member Advisory Groups" is added.</p> <p>Section 8.1.12.5 is modified to add new language modeled off of insurance code requirements.</p>
Revision	1.4	September 1, 2013	<p>Section 8.1.1.1 is modified to remove references to overarching goals and to clarify that HHSC will provide the PIP topics.</p> <p>Section 8.1.1.2 is modified to clarify the language.</p> <p>Section 8.1.3.1 is modified to clarify that MCOs may not charge copayments for Value-added Services, but may offer discounts for non-covered services as Value-added Services as required by SB 632.</p> <p>Section 8.1.4.2 is revised to align more closely with HHSC's standards for Health Care MCOs.</p> <p>Section 8.1.4.3 is revised to align more closely with HHSC's standards for Health Care MCOs.</p> <p>Section 8.1.5.3 is modified for clarification and to comply with requirements of SB 1401, 83R.</p> <p>Section 8.1.5.5 is modified to add timeframes for completing the credentialing process and to comply with requirements of SB 365, 83R.</p> <p>Section 8.1.5.9 is modified to clarify the MCO's obligations for payment and Network Provider agreements and to comply with requirements of SB 7, 83R.</p> <p>Section 8.1.5.5 is modified to allow MCOs to offer provider search functionality on their websites instead of PDF versions of the Provider Directory. In addition, duplicative language is removed.</p>

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>Section 8.1.5.12 “Provider Incentives” is added.</p> <p>Section 8.1.6.10 Member Advisory Groups is deleted in its entirety.</p> <p>Section 8.1.9.1 “Compliance with State and Federal Prior Authorization Requirements” is added as required by SB1216, 83R.</p> <p>Section 8.1.12.1 is modified to require MCO Provider Agreements to comply with Texas Gov’t. Code regarding reimbursement of claims based on orders or referrals by supervising providers.</p> <p>Section 8.1.14 is modified for clarification that records must be provided “at no cost.”</p> <p>Section 8.1.14.1 is modified to correct the name to which the acronym HEDIS refers.</p> <p>Section 8.2.3.2 is modified for clarification and to comply with requirements of SB 7, 83R.</p>
Revision	1.5	January 1, 2014	<p>Section 8.1.5.5 is modified to clarify the timeframes for completing the credentialing process.</p> <p>Section 8.1.5.13 Provider Protection Plan is added as required by SB 1150, 83R.</p> <p>Section 8.2.2.1.2 is modified to conform to the Uniform Managed Care Contract.</p>
Revision	1.6	February 1, 2014	<p>Section 8.1.1.1 is modified to clarify that absent HHSC’s direction the Dental Contractor may choose to collaborate with other Dental Contractors in the Service Area on one PIP per year.</p> <p>Section 8.1.1.1.1 “Dental Contractor Report Cards” is added.</p> <p>Section 8.1.5 is modified to clarify licensure or certification requirements for all providers. In addition, Nursing Facility Services, Local Authorities, Hospice Services, and Mental Health Rehabilitative Services are added.</p> <p>Section 8.1.5.5 is modified to add a sub-section heading for 8.1.5.5.1 Expedited Credentialing Process.</p> <p>Section 8.1.9 is modified to add that compensation to individuals or entities conducting UM activities cannot be structured to provide incentives for the individual or entity to deny, limit, or discontinue</p>

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>medically necessary services as required by 42 C.F.R. 438.210(e).</p> <p>Section 8.1.12.5 is modified to add timeframes for Nursing Facility claims and to clarify the Dental Contractor must provide a web portal at no cost to the Provider and its functionality.</p> <p>Section 8.1.13 is modified to require the Dental Contractors to meet all requirements in Texas Government Code § 531.105.</p> <p>Section 8.2.1 is modified to clarify timeframes for prior authorizations for transitioning Members.</p> <p>Section 8.2.2.3 is modified to remove the reference to the Texas Medicaid Bulletins.</p>
Revision	1.7	September 1, 2014	<p>Section 8.1.1.1 is modified to change the due date for PIP projects and to require the Dental Contractors to complete a mid-year review process.</p> <p>Section 8.1.5.5.1 is modified to conform to language in the Uniform Managed Care Contract.</p> <p>Section 8.1.5.9 is modified to include language requiring compliance with Tex. Ins. Code § 1458.051 and §§ 1458.101-102.</p> <p>Section 8.1.5.12 is modified to change the name from “Provider Incentives” to “Dental Contractor Value Based Contracting.” In addition, the language is clarified.</p> <p>Section 8.1.5.13 is modified to include notice requirements for changes to the prior authorization process.</p> <p>Section 8.1.6.8 is modified to remove reference to Section 7.</p> <p>Section 8.1.12 is revised to define major systems changes and to outline notice requirements.</p> <p>Section 8.1.12.4 is revised to clarify notice requirements.</p> <p>Section 8.1.12.5 is modified to clarify notice requirements.</p> <p>Section 8.1.13 is modified to include language related to requirements regarding a provider in the Dental Contractor’s network who is under investigation by HHSC OIG.</p>

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>Section 8.1.16.1 is modified to conform to language in the Uniform Managed Care Contract.</p> <p>Section 8.2.3.2 is revised to include a requirement for the physician resolving the claims dispute.</p>
Revision	1.8	March 1, 2015	<p>In each contract section, after the first appearance of the term, "Uniform Managed Care Manual" is changed to "UMCM."</p> <p>Section 8.1.1.1 is modified to remove the references to "annual"</p> <p>Section 8.1.3.1 is modified to require Dental Contractors to clarify restrictions and limitations to their VAS and notification process when deleting a VAS.</p> <p>Section 8.1.5.5 is modified to add language regarding credentialing for new providers from Section 8.1.4.4 and to move the last sentence of the section to the end of the second paragraph.</p> <p>Section 8.1.5.5.1 is modified to move language regarding credentialing for new providers to Section 8.1.4.4</p> <p>Section 8.1.5.7 is modified to clarify language and require Provider training on the claims appeal and recoupment processes. This section is also modified to clarify that if HHSC has not approved Provider Materials within 15 days, the Dental Contractor may use them only after first notifying HHSC of its intent to use.</p> <p>Section 8.1.5.9 is modified to include language requiring compliance with Tex. Ins. Code § 1458.051 and §§ 1458.101-102 and to clarify requirements for requesting an across-the-board rate reduction.</p> <p>Section 8.1.5.12 Dental Contractor Value-Based Contracting (Expansion of Alternative Payment Structures for Providers) is deleted in its entirety and the requirements added as Section 8.1.8.6.2.</p> <p>Section 8.1.6.1 is modified to clarify approval requirements for Member Materials.</p> <p>Section 8.1.6.4 is modified to clarify the format for submission to the HHSC Administrative Services Contractor.</p>

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>Section 8.1.6.5 is revised to refer to UMCM chapters that set out general and pharmacy website requirements.</p> <p>Section 8.1.6.8 is modified to clarify that Dental Contractors are responsible for reimbursing Providers for language services.</p> <p>Section 8.1.8.6.1 Dental Contractor Value-Based Contracting is added prior to the last two paragraphs in Section 8.1.8.6.</p> <p>Sub-Section 8.1.8.6.2 Provider and Stakeholder Meetings is added prior to the last two paragraphs in Section 8.1.8.6.</p> <p>Section 8.1.9.2 is added to require that Dental Contractors offer a toll-free fax line for service authorizations.</p> <p>Section 8.1.11.1 is modified to remove unintentional language differences between the UMCC and the other contracts.</p> <p>Section 8.1.12.5 is modified to clarify claims processing and payment requirements.</p> <p>Section 8.1.13 is modified to add Waste to the section header and some additional OIG commonly requested information to the current list.</p> <p>Section 8.1.14.2 is modified to add the Enrollment/Credentialing Denial Report.</p> <p>Section 8.2.5.1 is modified to clarify disenrollment requirements.</p>
Revision	1.9	May 1, 2015	Contract amendment did not revise Attachment B-1, Section 8 “Operations Phase Requirements”.
Revision	1.10	September 1, 2015	<p>Section 8.1.1.1 is modified to clarify the requirements for collaboration.</p> <p>Section 8.1.3.1 is modified to change the due dates.</p> <p>Section 8.1.4.4 is modified to add requirements for a mandatory survey of Providers.</p> <p>Section 8.1.5.5 is modified to clarify the requirement and to add applicability to LTSS providers.</p> <p>Section 8.1.5.7 is modified to qualify the cultural competency training requirement.</p>

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>Section 8.1.5.10 is modified to require the MCOs to notify HHSC when a Provider termination impacts more than 10% of its Members.</p> <p>Section 8.1.6.5 is revised to correct the UMCM chapter number for the MMC/CHIP Website Critical Elements.</p> <p>Section 8.1.6.8 is modified to require the MCOs to update the plan within 60 days if directed by HHSC.</p> <p>Section 8.1.8.5 is modified to change the section name to “Provider Credentialing and Profiling” and to add credentialing requirements.</p> <p>Section 8.1.12.1 is modified to clarify the language and to add requirements for the Quarterly Encounter Reconciliation Report.</p> <p>Section 8.1.13 is modified to address issues of material misrepresentation. In addition, sub-section headings are added and the section is reorganized for clarity.</p> <p>Section 8.1.14.1 is modified to change the section name from “Healthcare Effectiveness Data and Information Set (HEDIS) and Other Statistical Performance Measures” to “Performance Measurement” and to remove unnecessary language.</p> <p>Section 8.2.6 is amended to clarify requirement.</p>
Revision	1.11	March 1, 2016	<p>All references to the previous Executive Commissioner Janek are changed to his successor, Executive Commissioner Traylor.</p> <p>All references to “Fraud and Abuse” are changed to “Fraud, Waste, and Abuse.”</p> <p>Section 8.1.2 is modified to require the Dental Contractor to allow HHSC access for remote monitoring.</p> <p>Section 8.1.3 is modified to require Dental Contractors to monitor claims data for delivery of prior authorized dental services and to require the Dental Contractors to utilize evidence based medical policies.</p> <p>Section 8.1.5.10 is modified to clarify the timeframe.</p> <p>Section 8.1.7 is modified to correct the UMCM reference.</p>

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>Section 8.1.9 is modified to require that the individuals who supervise and finalize preauthorizations and concurrent review decisions are Texas licensed Dentists.</p> <p>Section 8.1.14.2 (o) is modified to remove the designation of "Medicaid only" for the Out-of-Network Utilization reports.</p> <p>Section 8.2.2.1.2 is modified to require the Dental Contractors to cooperate and coordinate with the THSteps outreach unit to ensure prompt delivery of services to Members who miss dental checkups.</p> <p>Section 8.2.5.2 is modified to require that the individuals who make decisions on Appeals are Texas licensed Dentists.</p> <p>Section 8.2.5.4 is modified to require Dental Contractors to ensure appropriate staff attends all Fair Hearings as scheduled.</p>
Revision	1.12	September 1, 2016	<p>All references to the previous Executive Commissioner Traylor are changed to his successor, Executive Commissioner Smith.</p> <p>Section 8.1.3 is modified to remove language added in error in the previous amendment.</p> <p>Section 8.1.4.1 is modified to add FQHCs and RHCs as Main Dental Home Providers.</p> <p>Section 8.1.5.2 is modified to require the Dental Contractors to provide each provider with a copy of the executed provider contract within 45 days of execution.</p> <p>Section 8.1.5.5.1 is modified to add provider types for which the Dental Contractor s must expedite credentialing.</p> <p>Section 8.1.5.7 is modified to clarify item 7; and to remove item 16 "requirements of the <i>Frew v. Traylor</i> Consent Decree and Corrective Action Orders".</p> <p>Section 8.1.5.9 is modified to align the contract language with the Texas Government Code.</p> <p>Section 8.1.5.10 is modified to clarify the reporting requirement.</p> <p>Section 8.1.6.1 is modified to clarify delivery of hard copies of the Provider Directories.</p> <p>Section 8.1.6.4 is modified to clarify the requirements and to add Subsections 8.1.6.4.1 Hard</p>

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>Copy Provider Directory and 8.1.6.4.2 Online Provider Directory</p> <p>Section 8.1.6.5 is modified to add a reference to the Online Provider Directory and to add requirements for mobile device use.</p> <p>Section 8.1.13 is modified to clarify Dental Contractor level of cooperation and assistance.</p> <p>Section 8.1.13.2 is modified to clarify and provide support to the Deliverables/Liquidated Damages Matrix.</p> <p>Section 8.1.14.2 is modified to update the requirements for items (d) (e) (f) and (h); to delete items (g) (k) and (l); and re-letter all subsequent items.</p> <p>Section 8.2.2.1.3 is modified to clarify item 1 and to remove the requirement for the Dental Contractor to educate and train Providers regarding the requirements of the <i>Frew v. Traylor</i> Consent Decree and Corrective Action Orders.</p>
<p><sup>1</sup> Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.</p> <p><sup>2</sup> Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.</p> <p><sup>3</sup> Brief description of the changes to the document made in the revision.</p>			

**Table of Contents**

**8. OPERATIONS PHASE REQUIREMENTS ..... 12**

8.1 Scope of Work ..... 12

8.1.1 Administration and Contract Management ..... 12

8.1.2 Additional Readiness Reviews and Monitoring Efforts ..... 14

8.1.3 Medically Necessary Covered Dental Services ..... 15

8.1.4 Access to Care ..... 20

8.1.5 Provider Network Requirements ..... 25

8.1.6 Member Services ..... 38

8.1.7 Marketing and Prohibited Practices ..... 48

8.1.8 Quality Assessment and Performance Improvement ..... 49

8.1.9 Utilization Management (UM) ..... 53

8.1.10 Financial Requirements for Medically Necessary Covered Dental Services ..... 55

8.1.11 Accounting and Financial Reporting Requirements ..... 56

8.1.12 Management Information System (MIS) Requirements ..... 63

8.1.13 Fraud, Waste, and Abuse ..... 72

8.1.14 General Reporting Requirements ..... 78

8.1.15 Federally Qualified Health Centers (FQHCs) ..... 82

8.1.16 Payment by Members ..... 83

8.2 Additional Medicaid Scope of Work ..... 85

8.2.1 Continuity of Care and Out-of-Network Providers ..... 85

8.2.2 Provisions Related to Medically Necessary Covered Dental Services for Medicaid Members ..... 87

8.2.3 Provider Complaints and Appeals ..... 89

8.2.4 Member Rights and Responsibilities ..... 91

8.2.5 Medicaid Member Complaints and Appeals System ..... 91

8.2.6 Third Party Liability and Recovery and Coordination of Benefits ..... 102

8.2.7 SSI Members ..... 103

8.3 Additional CHIP Scope of Work ..... 103

8.3.1 CHIP Provider Complaint and Appeals ..... 104

8.3.2 CHIP Member Complaint and Appeal Process ..... 105

8.3.3 Third Party Liability and Recovery and Coordination of Benefits ..... 105

## **8. OPERATIONS PHASE REQUIREMENTS**

This Section describes scope of work requirements for the Operations Phase of the Contract.

This Section does not include all of the Dental Program requirements, such as the timeframe and format for some of the reporting requirements. HHSC has included supplemental information in Attachment A, “Dental Contract Terms and Conditions” and the Uniform Managed Care Manual (UMCM). HHSC reserves the right to modify these documents as it deems necessary using the procedures set forth in Attachment A, “Dental Contract Terms and Conditions.”

### **8.1 Scope of Work**

This section presents the operational requirements for the Texas Dental Program. Coverage for benefits will be available to enrolled Members effective on the March 1, 2012 Operational Start Date.

#### **8.1.1 Administration and Contract Management**

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 and/or waiver requirements.

##### **8.1.1.1 Performance Improvement Projects**

HHSC will provide the Dental Contractor with two Performance Improvement Project (PIP) topics per Program. The Dental Contractor must develop one PIP per topic. The Dental Contractor must conduct one PIP per program in collaboration with other Dental Contractors, MCOs, participants in Delivery System Reform Incentive Payment (DSRIP) projects established under the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, or the NorthSTAR behavioral health organization (as appropriate) in the Service Area. HHSC will update the PIP topics as it determines it to be necessary, and the Dental Contractor must complete each PIP template in accordance with UMCM Chapter 10.2.4. Each Dental Contractor must also complete progress reports as outlined in UMCM Chapter 10.2.9. PIPs will follow CMS protocol, as described below. The purpose of health care quality PIPs is to assess and improve processes, and thereby outcomes, of care. In order for these projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner.

Section 8.1.1.1 is modified by Versions 1.7, 1.8, and 1.10

PIPs will follow CMS protocol, as described below. The purpose of PIPs is to assess and improve processes, and thereby outcomes, of care. In order for these projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner.

Dental Contractors must use the following ten (10) step CMS protocol when conducting PIPs:

1. Select the study topic(s);
2. Define the study question(s);
3. Select the study indicator(s);
4. Use a representative and generalizable study population;
5. Use sound sampling techniques (if sampling is used);
6. Collect reliable data;
7. Implement intervention and improvement strategies;
8. Analyze data and interpret study results;
9. Plan for real improvement; and
10. Achieve sustained improvement.

(See UCM Chapter 10.2.4, “Performance Improvement Project Submission Instructions” and 10.2.5, “Performance Improvement Project Template”).

The Dental Contractor must participate in semi-annual Contract Status Meetings (CSMs) with HHSC for the primary purpose of reviewing progress toward the achievement of PIPs and Contract requirements. HHSC may request additional CSMs, as it deems necessary to address areas of noncompliance. HHSC will provide the Dental Contractor with reasonable advance notice of additional CSMs, generally at least five (5) Business Days.

The Dental Contractor must provide to HHSC, no later than 14 Business Days prior to each semi-annual CSM, one (1) electronic copy of a written update detailing and documenting the Dental Contractor’s progress toward and any barriers in meeting the PIPs.

#### **8.1.1.1.1 Dental Contractor Report Cards**

Texas Government Code § 536.051 requires HHSC to provide information to Medicaid and CHIP Members regarding Dental Contractor performance on outcome and process measures during

the enrollment process. To comply with this requirement, HHSC will develop annual Dental Contractor report cards. HHSC will develop a separate report card for each Program Service Area to allow enrollees to easily compare the Dental Contractors on quality measures. HHSC may publish the report cards on its website, and include them in the enrollment packets. HHSC will provide a copy of the report card to the Dental Contractor before publication and the Dental Contractor will have the opportunity to review and provide comments. However, HHSC reserves the right to publish the results while awaiting Dental Contractor feedback.

HHSC may charge the Dental Contractor any costs related to recalculating the report card measures if the EQRO determines the original data was valid.

#### **8.1.1.2 Performance Indicator Dashboard**

HHSC will track Dental Contractor performance on PIPs. It will also track other key facets of Dental Contractor performance through the use of a Performance Indicator Dashboard for Quality Measures (see UMCM Chapter 10.1.7). HHSC will compile the Performance Indicator Dashboard based on Dental Contractor submissions, data from the EQRO, and other data available to HHSC. HHSC will share the Performance Indicator Dashboard with the Dental Contractor on an annual basis.

Section  
8.1.1.2  
modified by  
Version 1.4

#### **8.1.2 Additional Readiness Reviews and Monitoring Efforts**

During the Operations Phase, HHSC may conduct desk and/or onsite reviews as part of its normal Contract monitoring efforts. Additionally, a Dental Contractor that chooses to make a change to any operational system or undergo any major transition may be subject to additional Readiness Reviews. HHSC will determine whether the proposed changes require a desk review and/or an onsite review. The Dental Contractor is responsible for all reasonable 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, "reasonable travel costs" 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. This provision does not limit HHSC's ability to collect other costs as damages in accordance with **Attachment A**, Section 12.02(e), "Damages."

Section  
8.1.2  
modified by  
Version  
1.11

The Dental Contractor must provide HHSC secure access rights as an authorized or guest user to all Provider access points, including but not limited to its Provider portal and call monitoring system, for remote monitoring capability.

In addition, the Dental Contractor must provide HHSC secure access rights as an authorized or guest user to all Member access points, including but not limited to its Member portal and call monitoring system, for remote monitoring capability.

Refer to **Section 7** “Transition Phase Requirements” and **Section 8.1.12**, “Management Information System Requirements” for additional information regarding Readiness Reviews. Refer to **Attachment A, Section 4.08(c)**, “HHSC Dental Contract Terms and Conditions” for information regarding Readiness Reviews of the Dental Contractor’s Material Subcontractors.

### **8.1.3 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 the Contract. The Dental Contractor must provide Medically Necessary Covered Dental Services, subject to the HHSC-prescribed benefit limitations.

Section 8.1.3 modified by Versions 1.11 and 1.12

**Attachment B-2.1**, “CHIP Medically Necessary Covered Dental Services, includes a comprehensive list of Medically Necessary Covered Dental Services for CHIP, including preventive, diagnostic, restorative, endodontic, periodontal, prosthodontic, and oral and maxillofacial surgery and orthodontic benefits (limited to pre- and post-surgical orthodontic services to treat craniofacial anomalies requiring surgical intervention). HHSC has not yet determined the annual benefit limit(s) for these services, but will amend **Attachment B-2.1** to include such limit(s) once available.

**Attachment B-2**, “Medicaid Medically Necessary Covered Dental Services,” includes a list of Medically Necessary Covered Dental Services for Medicaid, including diagnostic, preventive, therapeutic, restorative, endodontic, periodontal, prosthodontic (removable and fixed), implant and oral and maxillofacial surgery services, and adjunctive general services. Refer to the Texas Medicaid Provider Procedures Manual for a comprehensive list of all dental Medically Necessary Covered Dental Services for Medicaid.

Medically Necessary Covered Dental Services for both the Medicaid and CHIP Programs are subject to change due to changes in federal and state laws, rules and regulations, and changes in dental practice, protocols, or technology.

The Dental Contractor must begin providing Medically Necessary Covered Dental Services to a Member beginning on the Member's date of enrollment regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior health care services. The Dental Contractor must not impose any pre-existing condition limitations or exclusions, or require evidence of insurability, to provide coverage to any Member.

The Dental Contractor must not practice discriminatory selection, or encourage segregation among the total group of eligible Members by excluding, seeking to exclude, or otherwise discriminating against any group or class of individuals.

The Dental Contractor is responsible for paying for or reimbursing for all Medically Necessary Covered Dental Services provided to Medicaid and CHIP Members, up to maximum benefit amounts. Members who receive Medically Necessary Covered Dental Services are not responsible for paying the costs of such services (other than any authorized cost-sharing in CHIP), unless they have exhausted applicable maximum benefit limits. Thus, with the exception of authorized CHIP cost-sharing amounts, neither Medicaid nor CHIP Members pay for Medically Necessary Covered Dental Services within the annual benefit limit prescribed by HHSC.

Certain services are benefits of the CHIP or Medicaid Dental Program, 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 **Sections 8.1.3.3** and **8.2.2.3**. The Dental Contractor is responsible for educating Members about the availability of Non-Capitated Services, and referring Members to and helping coordinate care for Non-Capitated Services.

#### **8.1.3.1 Value-Added Services**

"Value-Added Services" (VAS) are additional services and benefits beyond those specified in **Attachment B-2.1**, "CHIP Medically Necessary Covered Dental Services" and **Attachment B-2**, "Medicaid Medically Necessary Covered Dental Services." VAS may be actual Dental Services,

benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improve dental outcomes among Members. VAS should promote oral health, healthy lifestyles, or other initiatives approved by HHSC. If approved by HHSC, VAS may also include transportation. Best practice approaches to delivering Medically Necessary Covered Dental Services are not considered VAS.

If offered, VAS must be offered to all Members of an identified group or category of Members. VAS that are approved by HHSC during the contracting process will be included in the Contract's scope of services.

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 medical or administrative expenses, and therefore are not factored into the rate setting process. In addition, the Dental Contractor must not pass on the cost of the VAS to Members or Providers.

The Dental Contractor may offer discounts on non-covered benefits to Members as VAS, provided that the Dental Contractor complies with Texas Insurance Code § 1451.155 and § 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 Contractor's Member Handbook. The Dental Contractor must also include a disclaimer in its Marketing Materials and Provider Directory indicating that restrictions and limitations may apply.

During the Operations Phase, VAS can be added or removed only by written amendment of the Contract. The Dental Contractor will be given the opportunity to add or enhance VAS twice per SFY, with changes to be effective September 1 and March 1. The Dental Contractor will also be given the opportunity to delete or reduce VAS once per 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's request to add, enhance, delete, or reduce a VAS must be submitted to HHSC by March 15 of each year to be effective September 1 for the following contract period. The Dental Contractor cannot reduce or

delete any VAS until September 1 of the next SFY. A second request to add or enhance VAS must be submitted to HHSC by September 15 of each year to be effective March 1. The Dental Contractor must use HHSC's template for submitting proposed VAS. When the Dental Contractor requests deletion of a VAS, the Dental Contractor must include information regarding the processes by which the Dental Contractor will notify Members and revise materials. (See UCM Chapter 4.4). Once approved by HHSC, this document is incorporated by reference into the Contract.

The Dental Contractor's request to add a VAS must:

1. Define and describe the proposed VAS;
2. Identify the category or group of Members eligible to receive the VAS if it is a type of service that is not appropriate for all Members;
3. Note 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 administrative data (Encounter Data) and/or in its Financial Statistical Report (FSR), as applicable;
6. Propose how and when the Dental Contractor will notify Providers and Members about the availability of such VAS;
7. Describe the process by which a Member may obtain or access the VAS, including any action required by the Member, as appropriate; and
8. Include a statement that the Dental Contractor will provide such VAS for at least 12 months from the September 1 effective date.

The Dental Contractor cannot include a VAS in any material distributed to Members or prospective Members until the Parties have amended the Contract to include that VAS. If a VAS is deleted by amendment, the Dental Contractor must notify each Member that the service is no longer available through the Dental Contractor. The Dental Contractor must also revise all materials distributed to prospective Members to reflect the change in VAS. Materials are subject to review and approval by HHSC.

#### **8.1.3.2 Case-by-Case Added Services**

Subject to HHSC prior written approval, the Dental Contractor may offer additional benefits that are outside the scope of services to individual Members on a case-by-case basis, based on

Member need, cost-effectiveness, the wishes of the Member/Member's family, and the potential for improved dental health status of the Member.

### **8.1.3.3 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 health plans. 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.

For 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 (fee-for-service) 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.

Although the Dental Contractor is not responsible for coverage or payment of emergency dental services and other Non-Capitated Services (see **Section 8.2.2.3** for additional Medicaid services), it must educate Members and Providers about the availability of, and how to access, Non-Capitated emergency dental services. The Dental Contractor must refer Members to Non-Capitated Service providers, and provide coordination of care for Non-Capitated Services. This coordination of care must include:

- (1) identifying providers of Medically Necessary dental services; and
- (2) helping the Member access needed Medically Necessary dental services to the extent they are available to the Member.

The Dental Contractor's coordination of care efforts for Medically Necessary dental services should include protocols for working with Medicaid and CHIP health plans (for Members enrolled in CHIP, STAR, or STAR+PLUS), and HHSC's Claims Administrator (for Members enrolled in Traditional Medicaid and Primary Care Case Management), as well as protocols for reciprocal referral and communication of data and clinical information regarding the Member.

The Dental Contractor is responsible for informing Providers that bills for all Non-capitated Services must be submitted to the CHIP or Medicaid health plans or HHSC's Claims Administrator, as appropriate.

#### **8.1.4 Access to Care**

All Medically Necessary Covered Dental Services must be available to Members on a timely basis in accordance with appropriate dental guidelines, consistent with generally accepted practice parameters, and the Contract's requirements.

Unless otherwise specified in the Contract, HHSC will apply the access requirements established by TDI for health maintenance organizations (see [28 T.A.C. §11.1607](#)), to the Dental Contractor, even if the Dental Contractor is licensed as an indemnity insurer.

The Dental Contractors must provide the Medically Necessary Covered Dental Services outlined in **Attachment B-2.1**, "CHIP Medically Necessary Covered Dental Services" and **Attachment B-2**, "Medicaid Medically Necessary Covered Dental Services." If the Medically Necessary Covered Dental Services are not available through Network Providers, the Dental Contractor must, upon the request of a Network Provider or the Member, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five (5) Business Days after receipt of reasonably requested documentation, allow a referral to a non-network provider. The Dental Contractor must fully reimburse the non-network provider in accordance with the Out-of-Network methodology for Medicaid as defined by HHSC in [1 TAC 353.4](#), and for CHIP, at the usual and customary rate defined by TDI in [28 T.A.C. Section 11.506](#).

The Dental Contractor must include provisions in its Network Provider agreements that prohibit Providers from charging Medicaid Members for Medically Necessary Covered Dental Services. The Network Provider agreements must also prohibit Providers from charging CHIP Members for

Medically Necessary Covered Dental Services in excess of authorized CHIP cost-sharing amounts, unless the Member has reached the benefit limit for the 12-month enrollment period. HHSC will amend **Attachment B-2.1** to include information concerning authorized cost-sharing amounts for CHIP (there are no cost-sharing amounts for Medicaid children) and benefit limits for both Medicaid and CHIP.

The Dental Contractor must have a mechanism in place to allow Members with Special Health Care Needs to have direct access to a specialist as appropriate for the Member's condition and identified needs, such as a standing referral to a specialty provider.

#### **8.1.4.1 Main Dental Home**

Section  
8.1.4.1  
modified by  
Versions  
1.1, 1.2 and  
1.12

Based on the American Academy of Pediatric Dentistry's (AAPD) definition, Texas Medicaid defines a Main Dental Home as the dental provider who supports an ongoing relationship with the client that includes all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a client's Main Dental Home begins no later than six (6) months of age and includes referrals to dental specialists when appropriate.

The Dental Contractor must develop a network of Main Dental Home Providers, consisting of general dentists, pediatric dentists, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs), who will provide preventative care and refer members to specialty care as needed.

The Dental Contractor must require Main Dental Home Providers, through contract provisions or Provider Manual, to provide children enrolled in CHIP (birth through age 18) and Medicaid (birth through age 20) with diagnostic and preventive services in accordance with the American Academy of Pediatric Dentistry (AAPD) recommendations. The Dental Contractor must make best efforts to ensure that Main Dental Home Providers follow these periodicity dental requirements for children. Best efforts must include, but not be limited to, Provider education, Provider profiling, monitoring, and feedback activities.

The Dental Contractor must require Main Dental Home Providers, through contract provisions or Provider Manual, to assess the dental needs of Members for referral to specialty care providers

and provide referrals as needed. Main Dental Home Providers must coordinate Members' care with specialty care providers after referral. The Dental Contractor must make best efforts to ensure that Main Dental Home Providers assess Member needs for referrals and make such referrals. Best efforts must include, but not be limited to, Provider education activities and review of Provider referral patterns.

The Dental Contractor must allow Main Dental Home Providers to request Member to be reassigned to another Main Dental Home Provider for any of the following reasons:

- The Member is not included in the Main Dental Home Provider's scope of practice.
- The Member is noncompliant with dental advice.
- The Member consistently displays unacceptable office decorum.
- The Member/Main Dental Home Provider relationship is not mutually agreeable.

The Dental Contractor must assist the Member in selecting a Main Dental Home within 30 days of enrollment in the Dental Contractor's dental plan. If the Member has not selected a Main Dental Home within 30 days of enrollment, the Dental Contractor must use an HHSC-approved default process for assigning a Main Dental Home. This default process should include the basis for assigning a Member to a particular MDH, such as recent encounter history with a provider, the number of prior encounters with a provider, proximity to Member's home or work address and other relevant factors.

#### **8.1.4.2 Waiting Times for Appointments**

Through its Provider Network composition and management, the Dental Contractor must ensure that the following standards are met. In all cases below, "day" is defined as a calendar day, and the standards are measured from the date of presentation or request, whichever occurs first.

1. Urgent care, including urgent specialty care, must be provided within 24 hours;
2. Therapeutic and diagnostic care must be provided within 14 days;
3. Main Dentists must make referrals for specialty care on a timely basis, based on the urgency of the Member's medical condition, but no later than 30 days;
4. Preventive dental services for children should be offered to CHIP Members in accordance with American Academy of Pediatric Dentistry (AAPD) periodicity schedule, and to Medicaid Members in accordance with the Texas Health Steps periodicity schedule.
5. Non-urgent specialty care must be provided within 60 days of authorization.

Section  
8.1.4.2  
modified by  
Version 1.4

### **8.1.4.3 Access to Network Providers**

The Dental Contractor’s Network must have general and pediatric dental Providers in sufficient numbers, and with sufficient capacity, to provide timely access to dental care to all Members in accordance with the waiting times for appointments in **Section 8.1.4.2**, “Waiting Times for Appointments.”

Section  
8.1.4.3  
modified by  
Version 1.4

The Dental Contractor’s Network must comply with the accessibility standards set forth in 1 Tex. Admin. Code § 353.411(b-d). At least 95 percent of Members must have access to two or more Main Dentists with an Open Practice within 30 miles of the Member’s residence in urban counties and 75 miles of the Member’s residence in rural counties. This may include arranging for services from Providers who are able to accommodate the Member’s special needs.

The Dental Contractor also must ensure that 90 percent of all Members have access to at least one specialty providers within 75 miles of the Member’s residence.

HHSC will consider requests for exceptions to the distance standards for all provider types under limited circumstances. Each exception request must be supported by information and documentation as specified in HHSC’s exception request template.

Providers must retain the authority to control the number of Members they accept into their practice. The Dental Contractor cannot require a Provider to maintain an open or closed practice.

### **8.1.4.4 Monitoring Access**

The Dental Contractor must systematically and regularly 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 8.1.4.2**, “Waiting Times for Appointments,” and **Section 8.1.4.3**, “Access to Network Providers.”

Section  
8.1.4.4  
modified by  
Version 1.10

The Dental Contractor is required to design, develop, and implement a mandatory challenge survey to verify Provider information and monitor adherence to Provider requirements. The Dental Contractor must design the survey so that on a periodic, randomized basis, a Provider’s input is required before accessing the Dental Contractor Provider portal functionalities. At a minimum, the challenge survey must include verification of the following elements:

- 1) Provider Name;
- 2) Address;
- 3) Phone Number;
- 4) Office Hours;
- 5) Days of Operation;
- 6) Practice Limitations;
- 7) Languages Spoken;
- 8) Provider Type / Provider Specialty; and
- 9) Length of time a patient must wait between scheduling an appointment and receiving treatment and;
- 10) Accepting new patients.

The Dental Contractor must collect, analyze, and submit survey results as specified in UCMCM Chapter 5.4.1.10, "Provider Network Examination."

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.

#### **8.1.4.5 First Dental Home Initiative for Medicaid Members**

In addition to establishing a Network of Main Dental Home Providers (see **Section 8.1.4.1**), the Dental Contractor must implement a "First Dental Home Initiative" for Medicaid Members. This initiative will enhance dental providers' the ability to assist Members and their primary caregivers in obtaining optimum oral health care through First Dental Home visits. The First Dental Home visit can be initiated as early as six (6) months of age and must include, but is not limited to, the following:

- Comprehensive oral examination;
- Oral hygiene instruction with primary caregiver;
- Dental prophylaxis, if appropriate;
- Topical fluoride varnish application when teeth are present;
- Caries risk assessment; and
- Dental anticipatory guidance.

Medicaid Members from six (6) through 35 months of age may be seen for dental checkups by a certified First Dental Home Initiative provider as frequently as every three (3) months if Medically Necessary.

To become a First Dental Home Initiative Provider, the dentist must complete either the online module or an in-person training and submit registration information. The Texas Health Steps online First Dental Home Module is available at

<http://www.txhealthsteps.com/catalog/coursedetails.asp?crd=1772> or accessed through [www.txhealthsteps.com](http://www.txhealthsteps.com).

#### **8.1.4.6 Texas Best Practices**

The Dental Contractor must implement practices consistent with the Texas best practices as identified by the CMS in the State of Texas Dental Review, October 2010, (see the **Procurement Library**) as well as other state best practices identified by the CMS.

#### **8.1.5 Provider Network Requirements**

The Dental Contractor must enter into written contracts with properly credentialed Providers as described in this Section. The Provider contracts must comply with the UMCM's requirements.

Section  
8.1.5  
modified by  
Version 1.6

The Dental Contractor must maintain a Provider Network sufficient to provide all Members a choice of providers and 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 current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations related to the Contract.

The Provider Network must be responsive to the linguistic, cultural, and other unique needs of any minority or disabled individuals, or other special population in the Dental Program. This includes the capacity to communicate with Members in languages other than English, when necessary, as well as with those who are deaf or hearing impaired.

The Dental Contractor must seek to obtain the participation in its Provider Network of qualified providers currently serving the Medicaid and CHIP Members. Dental Contractors utilizing Out-of-Network providers to render services to their Medicaid Members must not exceed the Medicaid utilization standards established in 1 T.A.C. §353.4. HHSC may modify this requirement for

Medicaid Dental Contractors that demonstrate good cause for noncompliance, as set forth in § 353.4(e)(3).

The Dental Contractor must also seek participation in its Provider Network from the following types of entities that may serve American Indian and Alaskan Native children:

- Health clinics operated by a federally-recognized tribe in Texas;
- Federally Qualified Health Centers (FQHC) operated by a federally-recognized tribe in Texas; and
- Urban Indian organizations in Texas.

If licensure or certification is required to provide a Covered Service, then a Network Provider must be licensed or certified in Texas, except as provided in **Section, 8.1.5.3**. Network Providers cannot be under sanction or excluded from participation in the Medicare, Medicaid, or CHIP Programs. A Provider must have a National Provider Identifier (NPI) in accordance with the timelines established in [45 C.F.R. Part 162, Subpart D](#). The Dental Contractor must require tax identification numbers from all participating Dental Providers.

#### **8.1.5.1 Significant Traditional Providers**

In the first three (3) years following the Operational Start Date, the Dental Contractor must seek to enroll Significant Traditional Providers (STPs), as identified by HHSC, in its Provider Network. STPs are dental providers who are currently contracted to provide CHIP dental services or are enrolled as a Medicaid dental provider. HHSC will provide the Dental Contractor with a list of STP providers. In addition, the Dental Contractor must refer providers who believe they qualify as STPs to HHSC for consideration for STP status.

The Dental Contractor must give STPs the opportunity to participate in its Network for the three-year period beginning on the Operational Start Date. However, the STP providers must:

1. Agree to accept the Dental Contractor's reimbursement rates; and
2. Meet the Dental Contractor's standard credentialing requirements, provided that lack of board certification or board eligibility is not the sole grounds for exclusion from the Provider Network.

The Dental Contractor may terminate a Network Provider agreement with an STP after demonstrating, to the satisfaction of HHSC, good cause for the termination. Good cause may include evidence of provider fraud, waste, or abuse.

During that time, providers who believe they meet the STP requirements may contact HHSC to request HHSC's consideration for STP status.

### **8.1.5.2 Provider Contract Requirements**

Section  
8.1.5.2  
modified by  
Version  
1.12

The Dental Contractor must enter into written contracts with licensed Dental Providers. Providers serving Medicaid Members must be enrolled in the Texas Medicaid Program. While the Dental Contractor's initial base of Network Providers may consist primarily of Providers currently participating in Medicaid and/or the CHIP Dental Network, the Dental Contractor must also recruit other dental providers, particularly in Medically Underserved Areas (MUA).

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 Network participation. The Dental Contractor may not enter into a capitated (per-member-per-month) payment arrangement with a provider, or any payment arrangement whereby a provider is placed at financial risk for services rendered.

The Dental Contractor's Network Provider agreements must be in writing, must comply with applicable federal and state laws and regulations, and must include minimum requirements specified in the RFP, Attachment A "HHSC Dental Contract Terms and Conditions," and UCM Chapter 8.1, "Provider Contract Checklist." The Dental Contractor must give each Provider a copy of this executed contract within 45 days of execution. For an executed contract, the Provider needs to be credentialed, and the Provider and Dental Contractor must both sign the contract.

The Dental Contractor's Network Provider agreement must specify that program violations arising out of performance of the contract are subject to administrative enforcement by the Health and Human Services Commission Office of Inspector General (OIG) as specified in 1 Tex. Admin. Code Chapter 371, Subchapter G.

The Dental Contractor must submit model Network Provider agreements to HHSC for review during Readiness Review, and any substantive revisions thereafter. HHSC retains the right to

reject or require changes to any Network Provider agreement that does not comply with Dental Program requirements or this Contract.

### **8.1.5.3 Out-of-State Providers**

To participate in Medicaid, the provider also must be enrolled with HHSC as a Medicaid provider. The Dental Contractor may enroll out-of-state providers in its Medicaid and CHIP Networks in accordance with 1 Tex. Admin. Code § 352.17.

Section  
8.1.5.3  
modified by  
Version 1.4

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.

### **8.1.5.4 After-hour Access to Providers**

The following are acceptable telephone arrangements for contacting Main Dental Home Dental Providers after their normal business hours.

Section  
8.1.5.4  
modified by  
Version 1.2

#### **Acceptable after-hours coverage:**

1. The office telephone is answered after-hours by an answering service that meets language requirements of the Major Population Groups and that can contact the Main Dental Home Provider or another designated Dental Provider in emergency situations. The answering service and/or the Main Dental Home Provider or his or her designee must be able to provide the Member instructions on accessing emergency services. For calls regarding non-emergent conditions received by an answering service, the Main Dental Home Provider or his or her designee must respond within four (4) 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 Major Population Groups served, directing the Member to call another number to reach the Main Dental Home Provider or another Dental Provider designated by the Main Dental Home Provider. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
3. The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the Main Dental Home Provider or another designated Dental Provider who can return the call within four (4) hours after normal business operations resume.

**Unacceptable after-hours coverage:**

1. The office telephone is only answered during office hours;
2. The office telephone is answered after-hours by a recording that tells patients to leave a message;
3. The office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed; and
4. Returning after-hours calls more than four (4) hours after normal business hours resume.

The Dental Contractor must require Dental Providers, through contract provisions or the Dental Contractor's Provider Manual, to provide CHIP and Medicaid Members with diagnostic and preventive services in accordance with the American Academy of Pediatric Dentistry (AAPD) recommendations. The Dental Contractor must make best efforts to ensure that Providers follow these periodicity requirements for children. Best efforts must include, but not be limited to, Provider education, Provider profiling, monitoring, and feedback activities.

The Dental Contractor must require Main Dental Home Providers, through contract provisions or the Provider Manual, to assess the dental needs of Members for referral to specialty care providers and provide referrals as needed. 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. Main Dental Home Providers must coordinate such Members' care with specialty care providers after referral. The Dental Contractor should address specialty care, conduct Provider education activities, and review of Provider referral patterns.

**8.1.5.5 Provider Credentialing and Re-credentialing**

At least once every three years, the Dental Contractor must review and approve the credentials of all participating licensed and unlicensed Providers who participate in the Dental Contractor Provider Network. If the Dental Contractor subcontracts with another entity to perform credentialing activities, the delegated credentialing must comply with the standards set forth in [28 Tex Admin Code §11.1902](#) (HHSC will apply the TDI standard that is applicable to health maintenance organizations to the Dental Contractor, even if the Dental Contractor is licensed as an indemnity insurer), and any comparable requirements defined by HHSC.

Section 8.1.5.5 modified by Versions 1.4, 1.5, 1.6, 1.7, 1.8, and 1.10

At a minimum, the scope and structure of the Dental Contractor’s credentialing and re-credentialing processes must be consistent with recognized industry standards and relevant state and federal regulations. HHSC will apply the standards set forth in 28 Tex. Admin. Code §§ 11.1902 and 11.1402(c), relating to credentialing of providers in managed care organizations, to the Dental Contractor. For the Medicaid Program, the Dental Contractor must also comply with [42 C.F.R. §438.12](#) and [§438.214\(b-e\)](#). 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 claim systems must be able to recognize the provider as a Network 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 provide the provider written notice of all missing information no later than 5 Business Days after receipt.

The Dental Contractor may not discriminate in 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 Medicaid or CHIP Dental Programs.

#### **8.1.5.5.1 Expedited Credentialing Process**

Dental Contractors must provide expedited credentialing and payment to dental providers, including dentists and dental specialists (dentists and physicians providing dental specialty care), who have joined established groups or professional practices that are already contracted with the Dental Contractor. Dental Contractors are subject to the same credentialing and payment requirements that are imposed on managed care organizations by Texas Government Code § 533.0064. A Member who receives services from a dental provider undergoing expedited credentialing is not responsible and will be held harmless for services rendered by that, even if the provider is ultimately ineligible for credentialing by the Dental Contractor.

Section 8.1.5.5.1 subheading added by Version 1.6 and modified by Versions 1.7, 1.8, and 1.12

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.

#### **8.1.5.6 Board Eligibility and 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 Provider Network. The Dental Contractor must make information on the percentage of board-eligible and board-certified pediatric dentists in the Provider Network and the percentage of board-eligible and board-certified specialty providers, by specialty, available to HHSC upon request.

#### **8.1.5.7 Provider Manual, Materials and Training**

The Dental Contractor must prepare a Provider Manual for the Dental Program and issue the manual to all existing Network Providers. For newly contracted Network Providers, the Dental Contractor must issue copies of the Provider Manuals no later than five (5) Business Days after inclusion in the Network. Upon request, the Dental Contractor must provide a copy of the Provider Manual to potential Network providers during the contracting process. The Provider Manual must contain the critical elements defined in UCM Chapter 3.18, "Dental Provider Manual Critical Elements."

Section  
8.1.5.7  
modified by  
Versions  
1.2, 1.3, 1.8,  
1.10 and  
1.12

The Provider Manual must state that balance billing is not allowed in the Dental Program. HHSC rules prohibit providers from balance billing Members (see [1 TAC §§354.1005](#) and [370.453](#)). Specifically, HHSC rules require providers to accept payment received from the Dental Contractor for Medically Necessary Covered Dental Services provided to Members as payment in full, unless the Members have exhausted their benefit limits. HHSC balance billing rules apply to Network Providers and Out-of-Network providers.

HHSC's initial review of the Provider Manual is part of the Operational Readiness Review described in **Section 7**, "Transition Phase Requirements." Following Operational Readiness Review, HHSC must review and approve any substantive revisions to the Provider Manual before the Dental Contractor publishes or distributes it to Providers.

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 Members. The Dental Contractor must complete Dental Program training within thirty (30) days of placing a newly contracted Provider on active status. As described below, the Dental Contractor must provide ongoing training to new and existing Providers. The Dental Contractor must maintain, and make available upon request, enrollment or attendance rosters dated and signed by each attendee or other written evidence of training of each Provider and their staff.

The Dental Contractor must establish ongoing Provider training that includes, but is not limited to, the following issues:

1. Relevant requirements of this Contract;
2. Medically Necessary Covered Dental Services and the Provider's responsibilities for providing and/or coordinating such services;
3. The Dental Contractor's quality assurance and performance improvement program (QAPI) and the Provider's role in such a program;
4. The Dental Contractor's policies and procedures regarding referrals by Main Dental Home Providers, especially regarding in-Network and Out-of-Network referrals;
5. Member cost-sharing obligations (for CHIP Members only), benefit limitations, Value-added Services, and prohibitions on balance-billing Members for Medically Necessary Covered Dental Services;
6. Cultural Competency Training based on National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS);
7. Texas Health Steps dental benefits, periodicity, required components of a dental checkup, the importance of documenting all required components of the dental checkup in the medical record, and the necessity of documentation to support a complete dental checkup qualifying for reimbursement is provided;
8. Non-Capitated Services, including processes for obtaining emergency services and Medical transportation services available to Medicaid Members through the Medicaid Transportation Program (including rides to services by bus, taxi, van, airfare, etc., gas money, mileage reimbursement, and meals and lodging when away from home);
9. 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 Texas Health Steps dental services for Children of Migrant Farmworkers enrolled in Medicaid;
11. Missed appointment referrals and assistance provided by the Texas Health Steps Outreach and Informing Unit for Medicaid Members;
12. Administrative issues such as claims filing (including the processes regarding claims appeals and recoupments) and services available to Members; and
13. Claims submission requirements, including the information necessary to submit a clean claim.

When developing Provider training materials, the Dental Contractor must outreach to major stakeholders, such as trade associations and provider groups.

Provider materials produced by the Dental Contractor must comply with state and federal laws, rules and regulations, and the requirements of the Attachment A, “HHSC Dental Contract Terms and Conditions” and the UMCM.

As described above, HHSC must approve the Dental Contractor’s Provider Manual and all substantive revisions. Additionally, the Dental Contractor must submit, for HHSC’s review, all other Provider Materials relating to Medicaid or CHIP prior to publication or distribution. If HHSC has not responded to 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 reserves the right to require discontinuation or correction of any Provider Materials, including those that are previously approved by HHSC.

#### **8.1.5.8 Provider Hotline**

The Dental Contractor must operate a toll-free telephone line for Provider inquiries from 8 a.m. to 5 p.m., local time throughout the State, Monday through Friday, except for State-approved holidays. The State-approved holiday schedule is updated annually and can be found at <http://sao.hr.state.tx.us/compensation/holidays.html>. The Provider Hotline must be staffed with personnel who are knowledgeable about Medically Necessary Covered Dental Services and the Dental Program. The Dental Contractor must ensure that after regular business hours, on weekends, and on state approved holidays the line 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 Member with an urgent condition.

Section  
8.1.5.8  
modified by  
Version 1.1

The Dental Contractor must ensure the Provider Hotline has an automated response option in which the Dental Providers may enter a child's unique 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, if the child is in CHIP (any amounts drawn against HHSC 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 the following minimum performance requirements for the Dental Program:

1. 99% of calls are answered by the fourth ring or an automated call pick-up system is used;
2. no more than one percent (1%) of incoming calls receive a busy signal;
3. the average hold time is two (2) minutes or less; and
4. the call abandonment rate is seven percent (7%) or less.

The Dental Contractor must conduct ongoing call quality assurance to ensure these standards are met. The Provider Hotline may serve multiple lines of business if Hotline staff is knowledgeable about the Dental Program.

The Dental Contractor must conduct ongoing call quality assurance to ensure these standards are met. The Dental Contractor must monitor its performance regarding Provider Hotline standards and submit performance reporting summarizing call center performance for the Hotline as indicated in **Section 8.1.14**, "General Reporting Requirements."

If HHSC determines that it is necessary to conduct onsite monitoring of the Dental Contractor's Provider Hotline functions, the Dental Contractor is responsible for all reasonable costs incurred by HHSC or its authorized agents relating to such monitoring.

#### **8.1.5.9 Provider Reimbursement**

Section 8.1.5.9 modified by Versions 1.2, 1.4, 1.7, 1.8, and 1.12

The Dental Contractor must make payment for all Medically Necessary Covered Dental Services provided to Members. The Dental Contractor's Network Provider Agreement must include a complete description of the payment methodology or amount, as described in UMCM Chapter 8.1.

The Dental Contractor must ensure claims payment is timely and accurate as described in **Section 8.1.12.5**, "Claims Processing Requirements" and UMCM Chapter 2.0. 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 (PPACA) and, upon implementation, corresponding federal regulations:

- Section 6505 of PPACA, entitled "Prohibition on Payments to Institutions or Entities Located Outside of the United States."

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 Texas Government Code § 533.005(a)(25), the Dental Contractor cannot 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 HHSC's Director of Program Operations and provide a copy

to the Health Plan Manager, if the reduction is not based on a change in the Medicaid fee schedule or cost containment initiative implemented by HHSC. The Dental Contractor must submit the request at least 90 days prior to the planned effective date of the reduction. If HHSC does not issue a written statement of disapproval within 45 days of receipt, then the Dental Contractor may move forward with the reduction on the planned effective date.

Further, the Dental Contractor must give Providers at least 30 days' notice of changes to the Dental Contractor's fee schedule, excluding changes derived from changes to the Medicaid fee schedule, before implementing the change. If the Dental Contractor fee schedule is derived from the Medicaid fee schedule, the Dental Contractor must implement fee schedule changes no later than 30 days after the Medicaid fee schedule change, and any retroactive claim adjustments must be completed within 60 days after HHSC retroactively adjusts the Medicaid fee schedule.

The Dental Contractor will, at a minimum, process and pay claims for Medically Necessary Covered Dental Services as specified in **Attachment B-2.1**, "CHIP Medically Necessary Covered Dental Services" and **Attachment B-2**, "Medicaid Medically Necessary Covered Dental Services."

The Dental Contractor will not pay any claim submitted by a Dental Provider excluded or suspended from the Medicare, Medicaid, or CHIP programs for Waste, Abuse, and Fraud. The Dental Contractor must not pay any claim submitted by a Dental Provider that is on payment hold under the authority of HHSC or its authorized agents, or who has pending accounts receivable with HHSC or its authorized agents. For purposes of this section, payment holds and accounts receivables include payment holds and accounts receivables imposed by any dental program under HHSC's authority.

The Dental Contractor must inform all dental Providers about the information required to submit a claim in the Network Provider agreement and during provider training (see **Section 8.1.5.7**, "Provider Manual, Materials and Training"). The Dental Contractor must make available to dental providers claims coding and processing guidelines. Dental Providers must receive 90 calendar days' notice before the Dental Contractor's implementation of changes to claims guidelines. With HHSC approval, the Dental Contractor may implement a change in less than 90 days if the proposed changes are considered favorable to the provider.

#### **8.1.5.10 Termination of Provider Contracts**

The Dental Contractor must notify HHSC within five days after termination of (1) a Main Dentist contract that impacts more than ten percent of its Members or (2) any Provider contract that impacts more than ten percent of its Network for a provider type by Service Area and Program. The Dental Contractor must also notify HHSC of all Provider terminations in accordance with the Provider Termination Report under UMCM Chapter 5.4.1, Provider Network Reports.

Additionally, the Dental Contractor must make a good faith effort to give written notice of termination of a Network Provider to each Member who receives his or her primary care, or who is seen on a regular basis by, the Network Provider as follows:

1. For involuntary terminations (terminations initiated by the Dental Contractor), the Dental Contractor must provide notice within 15 days after the effective date of termination unless state or federal law permits or requires notice to be provided under a different timeframe.
2. For voluntary terminations (terminations initiated by the Provider), the Dental Contractor must provide notice at least 30 days before the effective date of the termination. In the event that the Provider sends untimely notice of termination to the MCO making it impossible for the Dental Contractor to send Member notice within the required timeframe, the Dental Contractor must provide notice as soon as practical but no more than 30 days after the Dental Contractor was notified.

The Dental Contractor must send notice to: (1) all its members of a Main Dental Home Provider's panel, and (2) all its Members who have had one (1) visit within the past three (3) months or two (2) or more visits in the past 12 months with the Network Provider.

#### **8.1.5.11 Provider Advisory Groups**

The Dental Contractor must establish and conduct quarterly meetings with Network Providers. The Dental Contractor must maintain a record of Provider Advisory Group meetings, including agendas and minutes, for at least three years.

#### **8.1.5.12 This Section Intentionally Left Blank**

#### **8.1.5.13 Provider Protection Plan**

The Dental Contractor must comply with HHSC's provider protection plan requirements for reducing the administrative burdens placed on Network Providers, and ensuring efficiency in

Section 8.1.5.10 modified by Versions 1.10, 1.11 and 1.12

Section 8.1.5.12 added by Version 1.4; modified by Version 1.7; and deleted in its entirety by Version 1.8

Section 8.1.5.13 added by Version 1.5 and modified by Version 1.7

Network enrollment and reimbursement. At a minimum, the plan must comply with the requirements of Texas Government Code § 533.0055, and:

- Provide for timely and accurate claims adjudication and proper claims payment in accordance with UMCM Chapter 2.0.
- Include Network Provider training and education on the requirements for claims submission and appeals, including the Dental Contractor’s policies and procedures (see also Section 8.1.5.7, “Provider Manual, Materials and Training.”)
- Ensure Member access to care, in accordance with Section 8.1.4, “Access to Care,” and the UMCM’s Geo-Mapping requirements (see UMCM Chapters 5.14.5 and 5.14.6.)
- Ensure prompt credentialing, as required by Section 8.1.5.5, “Provider Credentialing and Re-credentialing.”
- Ensure compliance with state and federal standards regarding prior authorizations, as described in Sections 8.1.9, “Utilization Management.”
- Provide 30 days’ notice to Providers before implementing changes to policies and procedures affecting the prior authorization process. However, in the case of suspected fraud, waste, or abuse by a single Provider, the Dental Contractor may implement changes to policies and procedures affecting the prior authorization process without the required notice period.
- Include other measures developed by HHSC, or other measures that are developed by the provider protection plan work group or the Dental Contractor that are approved by HHSC.

Additionally, the Dental Contractor must participate in HHSC’s work group, which will develop recommendations and proposed timelines for other components of the provider protection plan.

### **8.1.6 Member Services**

The Dental Contractor must maintain a Member Services Department to assist Members, their family members, or guardians in obtaining Medically Necessary Covered Dental Services for Members. The Dental Contractor must maintain employment standards and requirements (e.g., education, training, and experience) for Member Services Department staff and provide a sufficient number of staff for the Member Services Department to meet the requirements of this

Section, including Member Hotline response times, and Linguistic Access capabilities (see **Section 8.1.6.6**, “Member Hotline,” for requirements).

#### **8.1.6.1 Member Materials**

Section  
8.1.6.1  
modified by  
Versions  
1.2, 1.8,  
and 1.12

The Dental Contractor must design, print and distribute Member identification (ID) cards and Member Handbooks to Members. Within five (5) Business Days following the receipt of an Enrollment File from the HHSC Administrative Services Contractor, the Dental Contractor must mail a Member ID card and Member Handbook to the Account Name or Case Head for each new Member. When the Account Name or Case Head represents two (2) or more new Members, the Dental Contractor is only required to send one (1) Member Handbook. The Dental Contractor is responsible for mailing materials only to those Members for whom valid address data is contained in the Enrollment File.

The Dental Contractor must design, print and deliver hard copies of the Provider Directories to the HHSC Administrative Services Contractor as described in **Section 8.1.6.4**.

Member Materials must be at or below a 6th grade reading level, as measured by the appropriate score on the Flesch reading ease test. Member Materials must be written and distributed in English, Spanish, and the languages of other Major Population Groups making up 10% or more of the Dental Program population in the State. HHSC will provide the Dental Contractor with reasonable notice when the population reaches the 10% threshold for a “Major Population Group.”

All Member Materials must be available in a format accessible to the visually impaired, which may include large print, Braille, and CD or other electronic formats. All Materials must comply with UMCM Chapter 3.19, “Dental Member Handbook Critical Elements”.

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 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’s initial review of the Member Materials is part of the Operational Readiness Review described in **Section 7**, “Transition Phase Requirements.”

HHSC reserves the right to require discontinuation, revision, or correction of any Member Materials, including those previously approved by HHSC.

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. For CHIP Dental Contractors, this restriction also applies to the Dental Contractor's Evidence of Coverage or Certificate of Coverage documents.

#### **8.1.6.2 Member Identification (ID) Card**

All Member ID cards must, at a minimum, include the critical elements identified in the UMCM, Chapter 3.20 "Dental Member ID Card Critical Elements."

The Dental Contractor must reissue the Member ID card if a Member reports a lost card, there is a Member name change, or for any other reason that results in a change to the information on the ID card.

#### **8.1.6.3 Member Handbook**

The Dental Contractor must develop separate Member Handbooks for the Medicaid and CHIP Programs, and issue Member Handbooks to all Dental Program Members. HHSC must approve the Member Handbooks, and any substantive revisions, prior to publication and distribution. The Member Handbooks must, at a minimum, meet the Member Materials requirements specified in **Section 8.1.6.1** above and must include critical elements UMCM Chapter 3.19, "Dental Member Handbook Critical Elements," including an explanation of the prohibition on balance billing Dental Members for Medically Necessary Covered Dental Services.

The Dental Contractor must produce a revised Member Handbook, or an insert informing Members of changes to Medically Necessary Covered Dental Services, upon HHSC notification and at least 30 days prior to the effective date of a change in Medically Necessary Covered Dental Services. In addition to modifying the Member Materials for new Members, the Dental Contractor must notify all existing Members of the Medically Necessary Covered Dental Services change during the timeframe specified in this subsection.

#### **8.1.6.4 Provider Directory**

Section  
8.1.6.4  
modified by  
Versions  
1.8 and  
1.12

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 (1) 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, “Marketing Policies and Procedures.”

The Provider Directories for each Program must, at a minimum, meet the Member Materials requirements specified by **Section 8.1.6.1** 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 8.1.5.5**, “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.

Section  
8.1.6.4.1  
added by  
Versions  
1.12

#### **8.1.6.4.1 Hard Copy Provider Directory**

The hard copy Provider Directory must contain the requirements of UMCM Chapter 3.17 Dental Provider Directory Critical Elements.

At a minimum, the Dental Contractor must update hardbound copies of the Provider Directory on a quarterly basis. The Dental Contractor must make such updates available to existing Members upon request, and must provide the updates to the HHSC Administrative Services Contractor in hard copy and via File Transfer Protocol (FTP) at the beginning of each State Fiscal Quarter.

The Dental Contractor must send the most recent Provider Directory, including any updates, to Members upon request. The Dental Contractor must, at least annually, offer the Provider Directory to members in writing or orally through its Member outreach efforts and education materials.

Section  
8.1.6.4.2  
added by  
Versions  
1.12

#### **8.1.6.4.2 Online Provider Directory**

The Dental Contractor must develop, implement, and maintain an online Provider Directory to provide an electronic provider look-up search of its Provider Network. The Dental Contractor must develop and maintain procedures for systematically updating the Provider Network database which must include predictable scheduled algorithms. The Dental Contractor Online Provider Directory must be updated on a weekly basis to reflect the most current Dental Contractor Provider Network.

The online Provider Directory must contain the requirements of UMCM Chapter 3.34 MMC/CHIP Online Provider Directory Critical Elements.

The Dental Contractor must maintain a mobile optimized site for the online Provider Directory, minimize download and wait time, and must not use tools or techniques that require significant memory, disk resources, or special intervention such as plug-ins or additional software. HHSC strongly encourages 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.

The online Provider Directory must include the functionality as required by the UMCM 3.34 MMC/CHIP Online Provider Directory Critical Elements.

#### **8.1.6.5 Internet Website**

The Dental Contractor must develop and maintain, consistent with HHSC standards and Texas Insurance Code [§ 843.2015](#) and other applicable state laws, a website to provide general information about the Dental Program, its Provider Network (including an online Provider Directory as outlined in UMCM Chapter 3.34, "Online Provider Directory Search Tool Required Critical Elements"), its Customer Services, and its Complaints and Appeals process. The website must contain a link to financial literacy information on the Office of Consumer Credit Commissioner's webpage. The Dental Contractor may develop a page within its existing website to meet the requirements of this section. The Dental Contractor must also maintain a mobile optimized site for mobile device use.

Section  
8.1.6.5  
modified by  
Versions  
1.1, 1.4, 1.8,  
1.10, and  
1.12

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.

The Dental Contractor's internet website must contain the requirements of UMCM Chapter 3.32, "MMC/CHIP Website Critical Elements."

HHSC reserves the right to require discontinuation, revision, or correction of any Member Materials posted on the Dental Contractor's website, including those previously approved by HHSC.

#### **8.1.6.6 Member Hotline**

The Dental Contractor must operate a toll-free hotline that Members can call 24 hours a day, seven (7) days a week. The Member Hotline must be staffed with personnel who are knowledgeable about the Dental Program and Medically Necessary Covered Dental Services, between the hours of 8:00 a.m. to 5:00 p.m. local time throughout the State, Monday-Friday, excluding state-approved holidays. The State-approved holiday schedule is updated annually and can be found at <http://sao.hr.state.tx.us/compensation/holidays.html>.

The Dental Contractor must ensure that after hours, on weekends, and on holidays 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 cases of emergency. All recordings must be in English, Spanish, and the languages of other Major Population Groups identified by HHSC. A voice mailbox must be available after hours for callers to leave messages. The Dental Contractor Member Services representatives must return Member calls received by the automated system from Members or their representatives on the next Business Day.

If the Member Hotline does not have a voice-activated menu system, the Dental Contractor must have a menu system that will accommodate Members who cannot access the system through other physical means, such as pushing a button.

The Dental Contractor must ensure that its Member Service representatives treat all callers with dignity and respect the callers' need for privacy. At a minimum, Member Service representatives must be:

1. Knowledgeable about the scope and limitations of the Medicaid and CHIP dental benefits, including the limitations on procedures and annual CHIP benefit cap;
2. For CHIP Members, 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 the specific Member(s);
3. Able to give accurate information about Network Providers in a particular area;
4. Knowledgeable about Fraud, Abuse, and Waste and the requirements to report any conduct that, if substantiated, may constitute Fraud, Abuse, or Waste in the Dental Program;
5. Trained regarding Cultural Competency;

6. Able to answer non-clinical questions about referrals or the process for receiving authorization for procedures or services;
7. Able to answer non-clinical questions about accessing Non-Capitated Services, including medical services available through CHIP health plans, Medicaid health plans, or other Medicaid service delivery models; and
8. For CHIP Members, able to give correct cost-sharing information relating to premiums, co-pays or deductibles, as applicable. See UMCM Chapter 6.3 for additional information regarding CHIP cost-sharing.

Hotline services must meet Cultural Competency requirements and must appropriately handle calls from non-English speaking (and particularly, Spanish-speaking) callers, as well as calls from individuals who are deaf or hard-of-hearing. To meet these requirements, the Dental Contractor must either employ bilingual Spanish-speaking Member Services representatives or must subcontract as necessary to meet these requirements. The Dental Contractor must provide such oral interpretation services to all Hotline callers free of charge.

The Dental Contractor must process all incoming correspondence and telephone inquiries from Members in a timely and responsive manner. The Dental Contractor cannot impose maximum call duration limits and must allow calls to be of sufficient length to ensure adequate and accurate information is provided to the Member. The Dental Contractor must ensure that the toll-free Member Hotline meets the following minimum performance requirements:

1. At least 99 percent of calls are answered by the fourth ring or an automated call pick-up system;
2. No more than one percent (1%) of incoming calls receive a busy signal;
3. At least 80% of calls must be answered by toll-free line staff within 30 seconds measured from the time the call is placed in queue after selecting an option;
4. The call abandonment rate is seven percent (7%) or less; and
5. Average hold time is two (2) minutes or less.

The Dental Contractor must conduct ongoing quality assurance to ensure these standards are met.

The Member Services Hotline may serve multiple managed care programs if Hotline staff is knowledgeable about Dental Program services. The Dental Contractor must monitor its performance regarding HHSC Member Hotline standards and submit Performance Reports summarizing call center performance for the Member Hotline as indicated in **Section 8.1.14**, “General Reporting Requirements,” and UMCM Chapter 5.4.3.8, “Dental Member Hotline.”

If HHSC determines that it is necessary to conduct onsite monitoring of the Dental Contractor’s Member Hotline functions, the Dental Contractor is responsible for all reasonable costs incurred by HHSC or its authorized agents relating to such monitoring.

#### **8.1.6.7 Member Education**

The Dental Contractor must, at a minimum, develop and implement health education initiatives that effectively and accurately educate Members about:

1. How the Dental Program operates;
2. Medically Necessary Covered Dental Services, CHIP Member cost-sharing obligations, benefit limitations, and any Value-Added Services offered by the Dental Contractor;
3. Dental exams and preventive care;
4. The importance of oral health, including the relationship between oral health and systemic/overall health;
5. How to obtain Medically Necessary Covered Dental Services; and
6. Medical Transportation Program for Medicaid Members.

The Dental Contractor must provide a range of oral health promotion and wellness information and activities for Members in formats that meet the needs of all Members. The Dental Contractor must propose, implement, and assess innovative Member education strategies for oral health and prevention. The Dental Contractor must work with its Providers to integrate dental preventive education and oral health training into the care of each Member.

The Dental Contractor must notify Members that balance billing is not allowed. HHSC rules prohibit providers from balance billing Members (See [1 Tex. Admin. Code §§ 354.1005, 370.451](#) and [370.453](#)). Specifically, HHSC rules require providers to accept payment from the Dental Contractor for Medically Necessary Covered Dental Services provided to Members as payment in full, and prohibit providers from billing Members or their guardians for any remaining balances for Medically Necessary Covered Dental Services. Balance billing does not include collection of

authorized copayment amounts from CHIP Members, and collection of fees for services in excess of benefit limits. HHSC balance billing rules apply to Network Providers and Out-of-Network providers.

#### **8.1.6.8 Cultural Competency Plan**

The Dental Contractor must have a comprehensive written Cultural Competency Plan describing how the Dental Contractor will ensure culturally competent services, and provide Linguistic Access and Disability-related Access. The Cultural Competency Plan must adhere to the following: Title VI of the Civil Rights Act guidelines and the provision of auxiliary aids and services, in compliance with the Americans with Disabilities Act, Title III, Department of Justice Regulation 36.303, 42 C.F.R. § 438.10(f)(6)(i), and 1 Tex. Admin. § 353.411.

The Cultural Competency Plan must describe how the individuals and systems within the Dental Contractor's organization will effectively provide services to Members, caregivers, and Providers of all cultures, races, ethnic backgrounds, 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. The Dental Contractor also agrees to take reasonable steps to provide services and information, both orally and in writing, in appropriate languages other than English, in order to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities. The Dental Contractor must submit the Cultural Competency Plan to HHSC for Readiness Review During the Operations Phase, modifications and amendments to the plan must be submitted to HHSC no later than 30 days prior to the effective date of a change. The Cultural Competency Plan must also be made available to the Dental Contractor's Network Providers. HHSC may require the MCO to update the plan to incorporate new or amended requirements based on HHSC guidance. In that event, the MCO has 60 days to submit the updated plan to HHSC.

As required by 1 Tex. Admin. Code § 353.411, the Dental Contractor must arrange and pay for Competent Interpreter services for Members to ensure effective communication regarding treatment, medical history, or health condition. The Dental Contractor must maintain policies and procedures outlining the manner in which Members can access Competent Interpreter services (including when the Member is in a Provider's office or accessing emergency services).

Section 8.1.6.8 modified by Versions 1.1, 1.4, 1.7, 1.8, and 1.10

**8.1.6.9 Member Complaint and Appeal Process**

The Dental Contractor must develop, implement and maintain a system for tracking, resolving, and reporting Member Complaints regarding its services, processes, procedures, and staff. The Dental Contractor must ensure that Member Complaints are resolved within 30 calendar days after receipt. The Dental Contractor is subject to remedies, including liquidated damages, if at least 98 percent of Member Complaints are not resolved within 30 days of receipt (see **Attachment A**, "Dental Contract Terms and Conditions," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix").

The Dental Contractor must develop, implement and maintain a system for tracking, resolving, and reporting Member 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. Within this process, the Dental Contractor must respond fully and completely to each Appeal and establish a tracking mechanism to document the status and final disposition of each Appeal. The Dental Contractor must ensure that Member Appeals are resolved within 30 calendar days of receipt, 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 is subject to liquidated damages if at least 98 percent of Member Appeals are not resolved within 30 days of receipt (see **Attachment A**, "Dental Contract Terms and Conditions," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix").

The Dental Contractor must follow the Medicaid Member Complaint and Appeal System described in **Section 8.2.5** of this RFP, and the CHIP Member Complaint and Appeal Process described in **Sections 8.3.2** of this RFP.

**8.1.6.10 This Section Intentionally Left Blank**

**8.1.7 Marketing and Prohibited Practices**

The Dental Contractor and its Subcontractors must adhere to the Marketing Policies and Procedures as set forth in the Contract, including UMCM Chapter 4. HHSC must approve all marketing materials before use and/or distribution. All materials must comply with all state and federal marketing requirements, including State insurance laws and TDI regulations regarding marketing.

Section 8.1.6.10 deleted in its entirety by Version 1.4

Section 8.1.7 modified by Version 1.11

### **8.1.8 Quality Assessment and Performance Improvement**

The Dental Contractor must provide for the delivery of quality care with the primary goal of improving the dental health status of Members and, where the Member's condition is not amenable to improvement, maintain the Member's current dental health status by implementing measures to prevent any further decline in condition or deterioration of dental health status. The Dental Contractor must work in collaboration with Network Providers to actively improve the quality of care provided to Members, consistent with the Quality Improvement Goals and all other requirements of the Contract. The Dental Contractor must provide mechanisms for Members and Network Providers to offer input into the Dental Contractor's quality improvement activities.

#### **8.1.8.1 QAPI Program Overview**

The Dental Contractor must develop, maintain, and operate a Quality Assessment and Performance Improvement (QAPI) Program consistent with the Contract and TDI requirements for health maintenance organizations, including [28 Tex. Admin. Code §11.1901\(a\)\(5\)](#) and [§ 11.1902](#), even if the Dental Contractor is licensed as an indemnity insurer. For the Medicaid Program, the Dental Contractor must also meet the requirements of [42 C.F.R. §438.240](#).

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 submit a QAPI Program Annual Summary in a format and timeframe specified by HHSC or its designee. The Dental Contractor must keep participating providers and other Network Providers informed about the QAPI Program and related activities. The Dental Contractor must include in Provider contracts a requirement securing cooperation with the QAPI.

The Dental Contractor must approach all clinical and non-clinical aspects of QAPI based on principles of Continuous Quality Improvement (CQI)/Total Quality Management (TQM) and must:

1. Evaluate performance using objective quality indicators;
2. Foster data-driven decision-making;
3. Recognize that opportunities for improvement are unlimited;
4. Solicit Member and Network Provider input on performance and QAPI activities;
5. Support continuous ongoing measurement of clinical and non-clinical effectiveness and Member satisfaction;

6. Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and
7. Support re-measurement of effectiveness and Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

#### **8.1.8.2 QAPI 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. At a minimum, 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;
3. Includes annual objectives and/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.

#### **8.1.8.3 Clinical Indicators**

The Dental Contractor must engage in the collection of clinical indicator data. The Dental Contractor must use such clinical indicator data in the development, assessment, and modification of its QAPI Program.

#### **8.1.8.4 QAPI 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 work performed by the Subcontractor. The file must be available for review by HHSC or its designee upon request.

#### **8.1.8.5 Provider Credentialing and Profiling**

In accordance with UMCC Section 8.1.4.4, the Dental Contractor must review and approve the credentials of all participating licensed and unlicensed Providers who participate 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 UMCM Chapter 5.7.1.

Section  
8.1.8.5  
modified by  
Version 1.10

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 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, including Dental Program-specific Benchmarks, where appropriate; and
3. Providing feedback to individual Providers regarding the results of their performance and the overall performance of the Provider Network.

#### **8.1.8.6 Network Management**

The Dental Contractor must:

1. Use the results of its Network Provider profiling activities to identify areas of improvement for individual Providers, and/or groups of Providers.
2. Establish Individual Provider and group specific quality improvement goals for priority areas in which a Network 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.
4. At least annually, measure and report to HHSC on the Provider Network and individual Providers' progress, or lack of progress, towards such improvement goals.

##### **8.1.8.6.1 Dental Contractor Value-Based Contracting**

The Dental Contractor must develop and submit to HHSC a written plan for expansion of value-based contracting with its physician and non-physician Providers that encourages innovation and collaboration, as well as increases quality and efficiency. Contracting and payment structures should be focused on incentivizing quality outcomes, shared savings, or both resulting from the reduction of inappropriate utilization of services rather than be based on volume. The plan will include mechanisms by which the Dental Contractor will provide incentive payments to Network Providers for quality care resulting in reductions of inappropriate services.

The plan will include quality metrics required for incentives, recruitment strategies of providers, and a proposed structure for incentive payments, shared savings, or both. Beginning with SFY15, the Dental Contractor must submit its state fiscal year plan to HHSC no later than November 1 of each year using UMCM Chapter 8.4, "Plan for Value-Based Contracting." HHSC will evaluate the plan and provide feedback to Dental Contractor. Upon HHSC's approval of the plan, HHSC will retrospectively evaluate the Dental Contractor on its execution of the written plan. Modifications can be made to the plan after submission but are subject to HHSC review and approval. Plan approval is based on the following criteria: the number of providers, diversity of selected providers, geographic representation, and the methodology of the shared savings, data sharing strategy with providers, and other factors. Each year, the annual plan must show a measurable increase in the percent of business (providers, dollars, or other) being incentivized from the previous year.

HHSC's retrospective review of the execution of the plan may include a review of encounter data, the Dental Contractor's financial statistical reports, and surveys or interviews with the Dental Contractor's representatives or providers. HHSC may ask the Dental Contractor to submit additional information upon request. HHSC may delay or reduce payments to the Dental Contractor if it does not submit a plan that meets the HHSC requirements by the required deadline or if it does not effectively execute a plan that has been approved by HHSC.

#### **8.1.8.6.2 Provider and Stakeholder Meetings**

Section  
8.1.8.6.2  
added by  
Version 1.8

The Dental Contractor is required to coordinate and facilitate meetings with Network Providers on a quarterly basis. The Dental Contractor will meet with providers to discuss and identify issues related to claims, enrollment and other relevant dental issues. The Dental Contractor will submit the proposed agenda to the State for approval no later than 10 Business Days prior to the scheduled meeting. These meetings can be a combination of telephone calls and face-to-face meetings.

The Dental Contractor must also participate in stakeholder meetings as directed by HHSC. When requested by HHSC, the Dental Contractor must include participation of management and/or senior level staff at stakeholder meetings. The Dental Contractor must also solicit participation from trade associations, including but not limited to the Texas Dental Association (TDA), the Texas Academy of General Dentistry (TAGD), and the Texas Academy of Pediatric Dentistry (TAPD).

### **8.1.8.7 Collaboration with the External Quality Review Organization (EQRO)**

The Dental Contractor will collaborate with HHSC’s EQRO to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. The purpose of the studies, surveys, or other analytical approaches is to assess the quality of care and service provided to Members and to identify opportunities for Dental Contractor improvement. To facilitate this process, the Dental Contractor will supply claims data to the EQRO, or another Contractor identified by HHSC, in a format identified by HHSC in consultation with the Dental Contractor. The Dental Contractor will also supply the EQRO, or another Contractor identified by HHSC, dental records for focused clinical reviews conducted by the EQRO. The Dental Contractor must also work collaboratively with HHSC and the EQRO to annually measure selected HEDIS measures that require chart reviews.

### **8.1.9 Utilization Management (UM)**

The Dental Contractor’s UM Program must be consistent with the Texas Dental Practice Act’s requirements, Texas State Board of Dental Examiners (TSBDE) rules, and national guidelines from the American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD).

Section  
8.1.9  
modified by  
Versions  
1.6 and  
1.11

The Dental Contractor must have a written UM program description, which includes, at a minimum:

1. Procedures to evaluate the need for Medically Necessary Covered Dental Services ;
2. For CHIP Members who have exhausted their annual benefit limits, procedures to evaluate prior authorization requests for additional services necessary to return the Member to normal, pain and infection-free oral functioning (see Attachment B-2.1, CHIP Covered Services);
3. The clinical review criteria used, the information sources, 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; and
5. The staff position functionally responsible for the day-to-day management of the UM function.

The Dental Contractor must make best efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating dental provider as appropriate in making UM determinations.

The Dental Contractor must issue coverage determinations, including Adverse Determinations, within three (3) Business Days after receipt of the request for authorization of services.

The Dental Contractor UM Program must include written policies and procedures to ensure:

1. Consistent application of review criteria that are compatible with Members' needs and situations;
2. Determinations to deny or limit services are made by Texas licensed dentists through a peer-to-peer review process conducted under the direction of the Dental Director. Peer-to-peer consultation regarding UM determinations must be available upon request from the Provider;
3. Appropriate personnel are available to respond to Utilization Review inquiries 8:00 a.m. to 5:00 p.m., local time throughout the State, Monday-Friday, with a telephone system capable of accepting Utilization Review inquiries after normal business hours. The Dental Contractor must respond to calls within one (1) Business Day;
4. Confidentiality of clinical information; and
5. 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 services as required by 42 C.F.R. § 438.210(e), and quality is not adversely impacted by financial and reimbursement-related processes and decisions.

For preauthorization or concurrent review programs, a qualified Texas licensed Dentist must supervise and finalize 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. Evaluate the appropriate use of dental technologies, including dental procedures, drugs and devices;
3. Target areas of suspected inappropriate service utilization;

4. Detect over- and under-utilization; including procedures to address under-utilization of essential services such as dental checkups, First Dental Home visits, and sealants;
5. Routinely generate Provider profiles regarding utilization patterns and compliance with Utilization Review criteria and policies;
6. Compare Member and Network Provider utilization with norms for comparable individuals;
7. Refer suspected cases of provider or Member Fraud, Abuse, or Waste to the Office of Inspector General (OIG) as required by **Section 8.1.13**, "Fraud, Waste, and Abuse."

#### **8.1.9.1 Compliance with State and Federal Prior Authorization Requirements**

The Dental Contractor must adopt prior authorization (PA) requirements that comply with state and federal laws governing authorization of dental services, including Texas Insurance Code § 1217.004, which require Dental Contractors to use national standards for electronic prior authorization of health care benefits no later than two years after adoption, and accept PA requests submitted using the Texas Department of Insurance's (TDI's) standard form, once adopted.

Section  
8.1.9.1  
added by  
Version 1.4

#### **8.1.9.2 Toll-free Fax Line for Service Authorizations**

The Dental Contractor must provide access to a toll-free fax line where Providers may send requests for authorization of services and any supplemental information related to service authorization. The fax line must be available 24 hours per day, 7 days a week.

Section  
8.1.9.2  
added by  
Version 1.8

#### **8.1.10 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 Member, up to the 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 Member's Effective Date of Coverage.

Coverage under Medicaid and CHIP is secondary to all other insurance coverage. A Member may receive collateral dental benefits under a different type of insurance such as workers compensation or personal injury protection under an automobile 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 may obtain reimbursement from the responsible insurance entity not to exceed 100% of the amount paid for

the Medically Necessary Covered Dental Services. See **Section 8.2.6** for additional information regarding coordination of benefits and recoveries from third parties.

### **8.1.11 Accounting and Financial 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); **Attachment A**, "Dental Contract Terms and Conditions," and UMCM Chapter 6.1, “Cost Principles for Expenses.” HHSC will not recognize nor pay services that cannot be properly substantiated by the Dental Contractor and verified by HHSC.

Section  
8.1.11  
modified by  
Version 1.1

The Dental Contractor must:

1. Maintain accounting records for the Dental Program separate and apart from other corporate accounting records.
2. Maintain records for all claims payments, refunds, and adjustment payments; capitation payments; and interest income and payments for administrative services or functions. The Dental Contractor must maintain separate records for dental and administrative fees, charges, and payments.
3. Ensure and provide access to HHSC and/or its auditors or agents to the detailed records and supporting documentation for all costs incurred by the Dental Contractor. The Dental Contractor must ensure such access to its Affiliates for any costs billed to or passed to the Dental Contractor with respect to the Dental Program.
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 agrees to pay for all reasonable costs incurred by HHSC to perform an examination, review or audit of the Dental Contractor’s records pertaining to the Dental Program.

#### **8.1.11.1 Financial Reporting Requirements**

HHSC will require the Dental Contractor to provide separate financial reports for Medicaid and CHIP to support Contract monitoring as well as state and federal reporting requirements. All financial information and reports submitted by the Dental Contractor become the property of HHSC. HHSC may, at its discretion, release such information and reports to the public at any

Section  
8.1.11.1  
modified by  
Versions  
1.1 and 1.8

time and without notice to the Dental Contractor. In accordance with state and federal laws regarding Member confidentiality, HHSC will not release any Member-identifying information contained in such reports.

At its option, HHSC may require financial reporting in addition to the reports specified herein. Any data submitted with respect to the required financial reports or filings that is in PDF (or similar file format such as TIF) must be generated in a text-searchable format.

Due dates, content, and formats for the following deliverables and reports may be referenced herein or in HHSC's UMCM, including the Deliverables Matrix:

**(a) Financial-Statistical Reports (FSR)** – The Dental Contractor must file four (4) quarterly and two (2) annual FSRs for each complete State Fiscal Year, in the format and timeframe specified by HHSC in UMCM Chapter 5.3.1. The FSR is one of the primary financial reports used by HHSC to monitor Contract financial results. It is a modified (HHSC-defined) form of an income statement, with some other elements added. Not all expenses incurred may be included on the FSR.

All amounts reported in the FSRs must be reported in accordance with UMCM Chapter 6.1, “Cost Principles for Expenses.” Each FSR must provide amounts by month, with a year-to-date total (based on the SFY, or other Contract period as designated by HHSC). Each successive FSR will show the most current amounts for each month in the SFY; thus, a given month's amount may change in future FSRs as more claims run-out is experienced for the month. Quarterly FSRs are generally due 30 days after the end of each State Fiscal Quarter. The Dental Contractor must transmit these reports electronically, in a locked MS Excel file. There is no paper copy submission.

After the 4<sup>th</sup> Quarter FSR, the first annual FSR for a SFY (the “90-day FSR”) must reflect claims run-out and accruals through the 90<sup>th</sup> calendar day after the end of the Contract Year. This report must be filed on or before the 120<sup>th</sup> calendar day after the end of the Dental Contract Period. If the Dental Contractor has made a pre-tax profit in excess of the thresholds as established in the Contract with respect to the Experience Rebate, then a payment for any amounts to be refunded to HHSC is due in conjunction with filing the 90-day FSR. The

second annual report for a given SFY (the “334-day FSR”) must reflect data completed through the 334<sup>th</sup> calendar day after the end of each Contract Period and must be filed on or before the 365<sup>th</sup> calendar day following the end of each Contract Period. The 334-day FSR is routinely audited by HHSC and/or its independent auditors. HHSC will post all or part of an FSR on the HHSC website.

- (b) Claims Lag Report** - The Dental Contractor must submit a Claims Lag Report on a quarterly basis, by the last day of the month following the reporting period. The report must disclose the amount of incurred claims each month and the amount paid each month, on a contract-to-date basis. The report must be submitted in accordance with UMCM Chapter 5.6.2.
- (c) Third Party Liability and Recovery (TPL/TPR) Reports** – The Dental Contractor must file TPL/TPR Reports in accordance with the format developed by HHSC in UMCM Chapter 5.3.4. HHSC will require the Dental Contractor to submit TPL/TPR Reports no more often than quarterly. TPL/TPR Reports must include total dollars of costs avoided, and total dollars recovered from third party payers through the Dental Contractor’s coordination of benefits and subrogation efforts during the Quarter.
- (d) Report of Legal and Other Proceedings and Related Events** - The Dental Contractor must comply with the HHSC UMCM’s requirements regarding the disclosure of certain matters involving the Dental Contractor, its Affiliates, and/or its Material Subcontractors, as specified in Chapter 5.8, “Report of Legal and Other Proceedings.” Reports are due both on an as-occurs basis and annually each August 31<sup>st</sup>. The as-occurs report is due no later than 30 days after the event triggering the notification requirement.
- (e) Audit Reports** - The Dental Contractor must comply with the UMCM’s requirements regarding notification and/or submission of certain internal and external audit reports (see Chapter 5.3.11).
- (f) Affiliate Report** – The Dental Contractor must submit an Affiliate Report on an as-occurs basis and annually by August 31<sup>st</sup> of each year in accordance with the UMCM. The “as-occurs” update is due within 30 days of the event triggering the change. Note that “Affiliate” is a defined term (see **Attachment A**, "Dental Contract Terms and Conditions").

**(g) MCO Disclosure Statement** - The Dental Contractor must file:

1. An updated MCO Disclosure Statement by September 1<sup>st</sup> of each Contract Year; and
2. A “change notification” abbreviated version of the report, no later than 30 days after any of the following events:
  - a. Entering into, renewing, modifying, or terminating a relationship with an affiliated party;
  - b. After any change in control, ownership, or affiliations; or
  - c. After any material change in, or need for addition to, the information previously disclosed.

The MCO Disclosure Statement will include, at a minimum, a listing of the Dental Contractor’s control, ownership, and any affiliations, and information regarding Affiliate transactions. This report will replace, and be in lieu of, the former “Section 1318 Financial Disclosure Report” and the “Form CMS 1513,” and will disclose the same information, plus other information as may be required by HHSC and/or CMS Program Integrity requirements. Minor quarterly adjustments in stock holdings for publicly-traded corporations are excluded from the reporting requirements. The reporting format is included in the UMCM.

**(h) TDI Filings** – The Dental Contractor must provide HHSC with a copy of the following information, no later than 10 calendar days after submission to TDI:

- a. The “Annual Statement” and the “Annual Audited Financial Report” including all schedules, attachments, exhibits, supplements, management discussion, supplemental filings, etc., and any other annual financial filings (including any filings that may take the place of the above-named annual financial filings and any financial filings that occur less frequently than on a quarterly basis);
- b. The annual figures for controlled risk-based capital; and
- c. The quarterly financial statements.

Additionally, if the Dental Contractor is a foreign carrier (i.e., domiciled in another state), copies of any filings with the National Association of Insurance Commissioners (NAIC), as well as the financial statements filed with the state insurance department in its state of

domicile, must be submitted to HHSC no later than 10 calendar days after submission to NAIC or the state of domicile.

Notwithstanding the 10 calendar day deadlines described above, the Dental Contractor must notify HHSC if it cannot provide the most recent Annual Statements by March 31<sup>st</sup> each year, and the Annual Audited Financial Report by June 30<sup>th</sup> each year. The notice should include an expected submission date.

**(i) Registration Statement (also known as the “Form B”)** - With the following exceptions, Dental Contractors must submit a complete state insurance department registration statement, also known as Form B, and all annual and other amendments to this form, and any other related or similar information filed by the Dental Contractor with the insurance regulatory authority of its domiciliary jurisdiction. The exceptions to this requirement are those Dental Contractors that are either: (i) part of a County Hospital District or other governmental entity, or (ii) a stand-alone entity with no parent or other Affiliates. If the Dental Contractor is excepted from the TDI Form B filing requirement, the Dental Contractor must demonstrate this and explain the nature of the exemption.

The Form B is filed in three forms: (i) the initial registration; (ii) the annual amendment; and (iii) the every-five-years complete restatement of registration. For purposes herein, the Dental Contractor must submit:

1. the complete registration restatement that was due to TDI by approximately May 2010;
2. each annual registration amendment form (which is due to TDI within 120 days of the end of the Dental Contractor’s parent’s fiscal year), commencing with the most recent one that the Dental Contractor has filed after May 2010;
3. future complete five-year registration re-statements (the first of which will be due to TDI by approximately May 2015); and
4. any other registration statement amendments or restatements that may be submitted to TDI, per TDI regulations.

If the Dental Contractor was not yet subject to TDI requirements with respect to the May 2010 registration re-statement, it must submit its initial registration

If the Dental Contractor anticipates that the registration statement annual amendment form will be filed at some other date than approximately 120 days after the end of the parent's fiscal year, then the Dental Contractor must notify HHSC of the anticipated filing date.

All registration statement submission items herein are due to HHSC by either (i) 10 calendar days after the Dental Contractor's submission of the item to TDI, or (ii) the date identified in this section, whichever comes later.

- (j) TDI Examination Report** - The Dental Contractor must furnish HHSC with a full and complete copy of any examination report issued by TDI, including the financial, market conduct, target exam, quality of care components, and corrective action plans and responses. The Dental Contractor must submit this information to HHSC no later than 10 calendar days after the Dental Contractor receives the final version of the examination report from TDI.

The Dental Contractor must furnish HHSC with a copy of any similar examination report issued by a state insurance department in any other states where the Dental Contractor operates a Medicaid, CHIP, or other managed care product. These reports are also due no later than 10 calendar days after the Dental Contractor receives the final version of the examination report.

Each September 1<sup>st</sup>, the Dental Contractor must notify HHSC of the anticipated date of the next issuance of a state department of insurance financial examination report, unless the last submitted financial examination report is less than two (2) years old. 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 there are no other states.

- (k) 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. 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 UMCM Chapter 6.1, "Cost Principles for Expenses."

**(l) Filings with other entities, and other annual financial reports** - The Dental Contractor must submit an electronic copy of the following reports or filings pertaining to the Dental Contractor, or its parent, or its parent's parent:

1. *SEC Form 10-K*. For publicly-traded (stock-exchange-listed) for-profit corporations, submit the most-recent annual SEC Form 10K filing.
2. *IRS Form 990*. For non-profit entities, submit the most recent annual IRS Form 990 filing, complete with all attachments or schedules. If a non-profit entity is exempt from the IRS 990 filing requirement, demonstrate this and explain the nature of the exemption.
3. If the Dental Contractor is a non-profit entity that is a component or subsidiary of a County Hospital District, or otherwise an entity of a government, then submit the annual financial statements as prepared under the relevant rules or statutes governing annual financial reporting and disclosure for the Dental Contractor and/or its parent, including all attachments, schedules, and supplements.
4. *Annual Report*. The Dental Contractor must submit this report if it is different than or supplementary to the audited financial statements or Form 10-K required herein, and if it is distributed to either shareholders, customers, employees, owners, parent, bank or creditors, donors, the community, or to any regulatory body or constituents, or is otherwise externally distributed or posted.
5. *Bond or debt rating analysis*. If the Dental Contractor or its ultimate parent has been the subject of any bond rating analysis, ratings affirmation, write-up, or related report, such as by AM Best, Fitch Ratings, Moody's, Standard & Poor, etc., submit the most recent complete detailed report from each rating entity that has produced such a report.

All of the above reports or filings are due to HHSC no later than 30 calendar days after the report is filed or otherwise initially distributed. Each report should include all exhibits, attachments, notes, supplemental data, management letters, auditor letters, etc., and any

updates, revisions, clarifications, or supplemental filings. If the reporting entity has a regular required due date for any of the above reports, and receives an extension on the filing deadline, then the Dental Contractor should notify HHSC of any such extension and the estimated revised filing date.

Section  
8.1.12  
modified by  
Version 1.7

### **8.1.12 Management Information System (MIS) Requirements**

The Dental Contractor must maintain a MIS that supports all functions of the Dental Contractor's processes and procedures for the flow and use of Dental Program data. 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 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. TPL/TPR Subsystem.

The MIS must enable the Dental Contractor to meet the Contract 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 Program administration.

The Dental Contractor must have a system that can be adapted to changes in business practices/policies within the timeframes negotiated by the Parties. The Dental Contractor is expected to cover the cost of such systems modifications over the life of the Contract.

The Dental Contractor is required to participate in the monthly systems conference calls with HHSC.

The Dental Contractor must provide HHSC prior written notice of Major Systems Changes and implementations no later than 180 days prior to the planned change or implementation, including any changes relating to a Material Subcontractors, in accordance with the requirements of this Contract and **Attachment A**, “Dental Contract Terms and Conditions.” HHSC retains the right to modify or waive the notification requirement contingent upon the nature of the request from the Dental Contractor.

The Dental Contractor must notify HHSC of Major Systems Changes in writing, as well as by e-mail to HPM staff. The notification must detail the following.

- The aspects of the system that will be changed and date of implementation
- How these changes will affect the Provider and Member community, if applicable
- The communication channels that will be used to notify these communities, if applicable
- A contingency plan in the event of downtime of system(s)

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. Failure to comply will result in contractual remedies, including damages. HHSC retains the right to modify or waive the notification requirement contingent upon the nature of the request from the Dental Contractor.

The Dental Contractor must provide HHSC any 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 with official points of contact within its organization for MIS issues, and timely notify HHSC when these contacts change.

HHSC, or its agent, may conduct a Systems Readiness Review to validate the Dental Contractor’s ability to meet the MIS requirements as described in this Section and in **Section 7**, “Transition Phase Requirements.” During the Operations Phase, System Readiness Reviews may include a desk review and/or an onsite review and must be conducted for the following events:

1. Dental Contractor changes location; or
2. Dental Contractor changes its processing system, including changes in Material Subcontractors performing MIS or claims processing functions.

If HHSC determines that it is necessary to conduct an onsite review, the Dental Contractor is responsible for all reasonable travel costs associated with such onsite reviews. For purposes of this section, “reasonable travel costs” 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. This provision does not limit HHSC’s ability to collect other costs as damages in accordance with **Attachment A**, Section 12.02(e), “Damages.”

If for any reason, the Dental Contractor does not fully meet the MIS requirements, then the Dental Contractor must, upon request by HHSC, either correct such deficiency or submit to HHSC a Corrective Action Plan and Risk Mitigation Plan to address such deficiency. Immediately upon identifying a deficiency, HHSC may impose remedies, including without limitation actual or liquidated damages, according to the severity of the deficiency. Refer to **Attachment A**, “Dental Contract Terms and Conditions,” Article 12, “Remedies and Disputes” and **Attachment B-3**, “Deliverables/Liquidated Damages Matrix” for additional information regarding remedies and damages. Refer to **Section 7**, “Transition Phase Requirements” and **Section 8.1.2**, “Additional Readiness Reviews and Monitoring Efforts” for additional information regarding Readiness Reviews. Refer to **Attachment A**, Section 4.08(c) for information regarding Readiness Reviews of the Dental Contractor’s Material Subcontractors.

#### **8.1.12.1 Encounter Data**

The Dental Contractor must provide complete and accurate Encounter Data for all Medically Necessary Covered Dental Services, including Value-Added Services. Encounter Data must follow the format and include the data elements described in the most current version of HIPAA-compliant 837D Companion Guides and Encounters Submission Guidelines. HHSC will specify the method of transmission, the submission schedule, and any other requirements in UCM Chapter 5.0, “Consolidated Deliverables Matrix.” The Dental Contractor must submit Encounter Data transmissions at least monthly, and include all Encounter Data and Encounter Data adjustments processed by the Dental Contractor. Encounter Data quality validation must incorporate assessment standards developed jointly by the Dental Contractor and HHSC. The Dental Contractor must make original records available for inspection by HHSC for validation purposes. Encounter Data that does not meet quality standards must be corrected and returned within a time period specified by HHSC.

Section  
8.1.12.1  
modified by  
Versions 1.4  
and 1.10

For reporting claims processed by the Dental Contractor and submitted on Encounter 837D format, the Dental Contractor must use the procedure codes, diagnosis codes, provider identifiers, 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.

HHSC will use the Encounter Data to run the Quarterly Encounter Reconciliation Report, which reconciles the year-to-date paid claims reported in the Financial Statistical Report (FSR) to the appropriate paid dollars reported in the Vision 21 Data Warehouse. This report is based on querying the Vision 21 Data Warehouse 60 calendar days after the last day of the quarter. The Dental Contractor may be subject to liquidated damages as specified in Attachment B-3.

Refer to the Encounter Data Submission Guide and 837D Companion Guide in the Procurement Library.

The Dental Contractor's Provider Agreements must require Network Providers to comply with the requirements of Texas Government Code § 531.024161, regarding reimbursement of claims based on orders or referrals by supervising providers.

#### **8.1.12.2 Dental Contractor Deliverables related to MIS Requirements**

At the beginning of each State Fiscal Year, the Dental Contractor must submit the following documents and corresponding checklists for HHSC's review and approval:

1. Disaster Recovery Plan;\*
2. Business Continuity Plan;\* and
3. Security Plan.

\* The Business Continuity Plan and the Disaster Recovery Plan may be combined into one document.

Additionally, at the beginning of each State Fiscal Year, if the Dental Contractor modifies the following documents, it must submit the revised documents and corresponding checklists for HHSC's review and approval:

1. Joint Interface Plan;

2. Risk Management Plan; and
3. Systems Quality Assurance Plan.

The Dental Contractor must submit plans and checklists to HHSC in accordance with UMCM Chapter 5.2, "Information Concerning MIS Deliverables," Chapter 7, "Management Information Systems," and Chapter 5.0, "Consolidated Deliverables Matrix." Additionally, if a Systems Readiness Review is triggered by one of the events described in **Section 8.1.12**, the Dental Contractor must submit all of the plans identified in this **Section 8.1.12.2** in accordance with an HHSC-approved timeline.

The Dental Contractor must follow all applicable Joint Interface Plans (JIPs) and all required file submissions for HHSC's Administrative Services Contractor, External Quality Review Organization (EQRO), and HHSC Medicaid Claims Administrator. The JIPs can be accessed through UMCM Chapter 7.1, "Joint Interface Plans (JIP)."

### **8.1.12.3 System-wide Functions**

The Dental Contractor's MIS system must include key business processing functions and/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 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, produce standard Explanation of Benefits (EOBs) for Members;

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 Financial Statistical Reports (FSRs) conform to the Federal Acquisition Regulations (FAR) and the Cost Principles for Expenses chapter of the UMCM, with respect to segregating costs that are allowable for inclusion in HHSC-designed financial reports;
12. Relate and extract data elements to produce report formats (provided within the UMCM) or otherwise 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 Member-related information with their current Main Dental Home Provider number;
15. Maintain and cross-reference all Member- related information with current and historical Medicaid or CHIP Program Provider numbers;
16. Track utilization of benefits within the Program's benefit limit(s); and
17. Report benefit utilization information to other Dental Contractors and HHSC.

#### **8.1.12.4 Health Insurance Portability and Accountability Act (HIPAA) Compliance**

Section  
8.1.12.4  
modified by  
Version 1.7

The Dental Contractor's MIS system must comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, P.L. 104-191 (August 21, 1996), as amended or modified. The Dental Contractor must comply with Accredited Standards Committee (ASC) X12 Electronic Data Interchange (EDI) requirements, including the HIPAA-compliant version. Dental Contractor's enrollment files must be in the 834 HIPAA-compliant format. Eligibility inquiries must be in the 270/271 format and all claims and remittance transactions in the 835 format.

The Dental Contractor must also be 5010 compliant by January 2012. The following website includes the final rules for 5010 Compliancy and ICD-10 Compliancy:

[www.cms.hhs.gov/TransactionCodeSetsStands/02\\_TransactionsandCodeSetsRegulations.asp](http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp) .

The Dental Contractor must provide its Members with a privacy notice as required by HIPAA, including 45 C.F.R. § 164.520, and provide HHSC with a copy of its standard privacy notices

during Readiness Review and any changes to the notice prior to distribution. The Dental Contractor must comply with all privacy and security requirements under state and federal law, including the requirements adopted under the HIPAA and title XIII, subtitle D of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5).

#### **8.1.12.5 Claims Processing Requirements**

The Dental Contractor must process and adjudicate all provider claims for Medically Necessary Covered Dental Services that are filed within the timeframes specified in UMCM Chapter 2.0, “Claims Manual.” The Dental Contractor is subject to contractual remedies, including liquidated damages and interest, if the Dental Contractor does not process and adjudicate claims within the timeframes listed in the UMCM.

Section  
8.1.12.5  
modified by  
Versions  
1.1, 1.3,  
1.6, 1.7,  
and 1.8

The Dental Contractor must administer an effective, accurate, and efficient claims payment process in compliance with federal laws and regulations, applicable state laws and rules, and the Contract, including UMCM Chapter 2.0, “Claims Manual.” In addition, the Dental Contractor process and pay Medicaid provider claims in accordance with the benefit limits and exclusions as listed in the **Texas Medicaid Provider Procedures Manual**. The Dental Contractor and its Subcontractors cannot directly or indirectly charge or hold a Member or Provider responsible for claims adjudication or transaction fees.

The Dental Contractor must maintain an automated claims processing system that registers the date a claim is received by the Dental Contractor, the detail of each claim transaction (or action) 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, and 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 **Attachment A**, “Dental Contract Terms and Conditions,” Section 9.01, “Record Retention and Audit.” All claims data must be easily sorted and produced in formats as requested by HHSC.

The Dental Contractor must offer its Providers or their agents the option of submitting and receiving claims information through an Electronic Data Interchange (EDI) that allows for automated processing and adjudication of claims. EDI processing must be offered as an alternative to the filing of paper claims. Electronic claims must use HIPAA-compliant electronic formats.

HHSC reserves the right to require the Dental Contractor to receive initial electronic claims through an HHSC-contracted vendor at a future date. This function will allow Providers to send claims to one location, which will then identify where the claim should be submitted. The Dental Contractor will be expected to have an interface that allows receipt of these electronic submissions. If HHSC implements this requirement, then the Dental Contractor must maintain a mechanism to receive claims in addition to the HHSC claims portal. Providers must be able to send claims directly to the Dental Contractor or its Subcontractor.

The Dental Contractor must provide a provider portal that supports functionality to reduce administrative burden on Network Providers at no cost to the Providers. A provider portal brings information together from diverse sources in a uniform way. The provider portal functionality must include the following.

- Client eligibility verification
- Submission of electronic claims
- Prior Authorization requests
- Claims appeals and reconsiderations
- Exchange of clinical data and other documentation necessary for prior authorization and claim processing

To the extent possible, the provider portal should support both online and batch processing as applicable to the information being exchanged. Batch Processing is a billing technique that uses a single program loading to process many individual jobs, tasks, or requests for service. Specifically in managed care, batch billing is a technique that allows Providers to send billing information all at once in a “batch” rather than in separate individual transactions. 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.

The Dental Contractor must make an electronic funds transfer (EFT) payment process (for direct deposit) available to Network Providers.

The Dental Contractor may deny a claim submitted by a provider for failure to file in a timely manner as provided for in UCMCM Chapter 2.0. The Dental Contractor must withhold all or part of payment for any claim submitted by a provider:

- (1) excluded or suspended from the Medicare, Medicaid, or CHIP programs for Fraud, Abuse, or Waste;
- (2) on payment hold under the authority of HHSC or its authorized agent(s); or
- (3) with debts, settlements, or pending payments due to HHSC, or the state or federal government.

With the following exceptions, the Dental Contractor must complete all audits of a provider claim no later than two years 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 Fraud, Waste, or Abuse 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 Attachment A, Section 9.02(c), conclude an examination, audit, or inspection of a provider more than two years after the MCO received the claim. Finally, the two-year limitation does not apply when HHSC has recovered a capitation from the MCO based on a Member's ineligibility. If an exception to the two-year limitation applies, then the MCO may recoup related payments from providers.

If an additional payment is due to a provider as a result of an audit, the Dental Contractor must make the payment no later than 30 days after it completes the audit. If the audit indicates that the Dental Contractor is due a refund from the provider, the Dental Contractor must send the provider written notice of the basis and specific reasons for the recovery no later than 30 days after it completes the audit. If the provider disagrees with the Dental Contractor's request, the Dental Contractor must give the provider an opportunity to appeal, and may not attempt to recover the payment until the provider has exhausted all appeal rights.

The Dental Contractor is subject to the requirements related to coordination of benefits for secondary payors in the Texas Insurance Code [Section 843.349\(e-f\)](#), even if it is licensed as an indemnity insurer.

The Dental Contractor must notify HHSC of major claim system changes in writing no later than 180 days prior to implementation of such change. The Dental Contractor must provide an implementation plan and schedule of proposed changes. HHSC reserves the right to require a desk or on-site readiness review of the changes, as described in **Sections 8.1.2** and **8.1.12**.

The Dental Contractor must inform all Network Providers about the information required to submit a claim as part of the provider training, and no later than 30 days after the effective date of the Network Provider agreement. This information must also be included in the Dental Contractor's Network Provider agreement or Provider Manual. The Dental Contractor must make any policies affecting claims adjudication and claims coding and processing guidelines available to Providers for the applicable provider type. Network Providers must receive at least 90 days prior written notice of the Dental Contractor's implementation of changes to these claims policies and guidelines.

#### **8.1.12.6 National Correct Coding Initiative**

Dental Contractor's must comply with the requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies implemented as a result of this initiative.

#### **8.1.13 Fraud, Waste, and Abuse**

The Dental Contractor is subject to all state and federal laws, rules and regulations relating to Fraud, Waste, and Abuse in health care and the Dental Program. 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 Fraud, Waste, or Abuse.

1. The Dental Contractor is subject to and must meet all requirements in [Texas Government Code § 531.113](#), [Texas Government Code § 533.012](#), [1 Tex. Admin. Code §§ 353.501-](#)

Section 8.1.13 modified by Versions 1.1, 1.2, 1.6, 1.8, 1.10, and 1.12

[353.505](#), and [1 Tex. Admin. Code §§ 370.501-370.505](#) as well as all laws specified in the Contract.

2. The Dental Contractor must require all employees who process Medicaid claims, including Subcontractors, to attend annual training as provided by HHSC per Texas Government Code § 531.105.
3. The Dental Contractor must perform pre-payment review for identified providers as directed by OIG.
4. 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 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 the State and the OIG.
5. Failure to comply with any requirement of Sections 8.1.13 and 8.1.14.2(c) and (d) may subject the Dental Contractor to liquidated damages and/or administrative enforcement pursuant to 1 Tex. Admin. Code Chapter 371 Subchapter G, in addition to any other legal remedy.

#### **8.1.13.1 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 fraud, waste, or abuse for all services provided under the Contract, including those that the Dental Contractor subcontracts to outside entities.

1. The Dental Contractor's SIU does not have to be physically located in Texas but must be adequately staffed to handle Texas volume. The SIU must have adequate staff and resources apportioned at the levels and experience sufficient to effectively work Texas cases based on objective criteria considering, but not necessarily limited to, the Dental Contractor's total 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](#).
2. The Dental Contractor must submit a written Fraud, Waste, and Abuse compliance plan to OIG for approval each year. The plan must be submitted 90 days prior to the start of the State Fiscal Year. (See **Section 7**, "Transition Phase Requirements." for requirements regarding timeframes for submitting the original plan.) If a Dental Contractor has not made

any changes to its plan from the previous year, it may notify OIG that: (1) no changes have been made to the previously-approved plan and (2) the plan will remain in place for the upcoming State Fiscal Year. The notification must be signed and certified by an officer or director of the Dental Contractor that is responsible for carrying out the Fraud, Waste, and Abuse compliance plan. Upon receipt of a written request from OIG, the Dental Contractor must submit the complete Fraud, Waste, and Abuse compliance plan.

### **8.1.13.2 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 the Inspector General for the HHSC OIG, HHSC or its authorized agents, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services (DHHS), Federal Bureau of Investigation (FBI), the Office of the Attorney General (OAG), the Texas Department of Insurance (TDI), or other units of state or federal government.

1. The Dental Contractor must designate one primary and one secondary contact person for all HHSC OIG records requests. HHSC OIG records requests will be sent to the designated contact person(s) in writing by email, fax or mail, and will provide the specifics of the information being requested (see below).
2. The Dental Contractor must respond to the appropriate HHSC OIG staff member within the timeframe designated in the request. If the Dental Contractor is unable to provide all of the requested information within the designated timeframe, the Dental Contractor may request an extension in writing (email) to the OIG requestor no less than two Business Days prior to the due date.
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 HHSC OIG's record request.

The most common requests include, but are not limited to:

- 1099 data and other financial information – 3 Business Days.

Section  
8.1.13.2  
modified by  
Version 1.12

- Claims data for sampling and recipient investigations – 5 Business Days.
- Urgent claims data requests – 3 Business Days (with OIG manager’s approval).
- Provider education information – 10 Business Days.
- Files associated with an investigation conducted by a Dental Contractor – 15 Business Days.
- Provider profile, UR summary reports, and associated provider education activities and outcomes – as indicated in the request.
- Member and/or pharmacy data as required by OIG.
- Other time-sensitive requests – as needed.

#### **8.1.13.3 Monthly Claims Data Submission Requirements**

1. The Dental Contractor and its subcontractors shall submit processed claims data on a monthly basis that meets established OIG data quality standards and requirements. These standards are defined by OIG to ensure receipt of complete and accurate data for investigative purposes. OIG will revise and amend these standards and requirements as necessary to ensure continuous quality improvement. The Dental Contractor and its subcontractors shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with OIG data quality standards and requirements as originally defined or subsequently amended.
2. The Dental Contractor and its subcontractors shall comply with industry-accepted clean claim standards for all data submissions to OIG, including 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 OIG without alteration or omission.
3. The Dental Contractor and its subcontractors shall submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by OIG, in order to support comprehensive financial reporting, utilization analysis and investigative efforts.
4. The Dental Contractor and its subcontractors shall submit processed claims data according to standards and formats as defined by OIG, complying with standard code sets and maintaining integrity with all reference data sources including provider and

member data. All data submissions by the Dental Contractor and its subcontractors will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing.

5. Any batch submission from an Dental Contractor or its subcontractors which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the Dental Contractor and its subcontractors for immediate correction. Re-submittals of rejected files, or notification of when the file will be resubmitted shall be completed within five Business Days. Due to the need for timely data and to maintain integrity of processing sequence, should the Dental Contractor or its subcontractors fail to respond in accordance with this Section, the Dental Contractor and its subcontractors shall address any issues that prevent processing of a claims batch in accordance with procedures specified and defined by OIG.
6. The Dental Contractor and its subcontractors shall supply Electronic Funds Transfer (EFT) account numbers on a monthly basis in a format defined by OIG for all Medicaid providers who have elected to receive payments via EFT and who are participating in their plans.
7. Failure by the Dental Contractor or its subcontractor to submit data as described in this section may result in administrative enforcement by HHSC OIG as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G or liquidated damages as specified in Attachment B-3.

#### **8.1.13.4 Payment Holds and Settlements**

1. 42 C.F.R. § 455.23 requires the State Medicaid agency to suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or suspend payment only in part. In Texas, HHSC OIG is responsible for evaluating allegations of fraud and imposing payment suspensions when appropriate. The rules governing payment suspensions based upon pending investigations of credible allegations of fraud apply to Medicaid managed care entities. Managed care capitation payments may be included in a suspension when an individual network provider is under investigation based upon credible allegations of fraud, depending on the allegations at issue.

2. The Dental Contractor must cooperate with HHSC OIG when HHSC OIG imposes payment suspensions or lifts a payment hold. When HHSC OIG sends notice that payments to a provider have been suspended, the Dental Contractor must also suspend payments to the provider within one business day. When notice of a payment hold or a payment hold lift is received, the Dental Contractor must respond to the notice within three business days and inform HHSC OIG of action taken.
3. The Dental Contractor must also report all of the following information to HHSC OIG after it suspends payments to the provider: date the suspension was imposed, date the suspension was discontinued, reason for discontinuing the suspension, outcome of any appeals, amount of adjudicated Medicaid payments held, and, if applicable, the good cause rationale for not suspending payment (for example, the provider is not enrolled in the Dental Contractor's network) or imposing a partial payment suspension. If the Dental Contractor does not suspend payments to the provider, or if the Dental Contractor does not correctly report the amount of adjudicated payments on hold, HHSC may impose contractual or other remedies. The Dental Contractor must report the fully adjudicated hold amount on the monthly open case list report required by UCM Chapter 5.5 and provide this information to OIG upon request.
4. 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: Sanctions Division, along with an itemized spreadsheet detailing the Provider's claims paid so that the claims data can be reconciled with the monthly Remittance & Status statements.
5. For payment suspensions initiated by the MCO, the MCO must report the following information to HHSC OIG: the nature of the suspected fraud, basis for the suspension, date the suspension was imposed, date the suspension was discontinued, reason for discontinuing the suspension, outcome of any appeals, the amount of payments held, the percentage of the hold, and, if applicable, the good cause rationale for imposing a partial payment suspension.
6. Dental Contractors must maintain all documents and claim data on Providers who are under OIG investigation or any internal investigations that are referred to OIG for recoupment. The Dental Contractor's failure to comply with this Section 8.1.13 and all

state and federal laws and regulations relating to Fraud, Waste, and Abuse in healthcare and the Medicaid and CHIP programs are subject to administrative enforcement by OIG as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G.

#### **8.1.13.5 Additional Requirements for Medicaid Dental Contractors**

In accordance with Section 1902(a)(68) of the Social Security Act, a Dental Contractor and their Subcontractors that receives or makes 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. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
2. Include as part of such written policies detailed provisions regarding the Dental Contractor's or Subcontractor's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.
3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the Dental Contractor's or Subcontractor's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

#### **8.1.14 General Reporting Requirements**

The Dental Contractor must provide and must require its Subcontractors to provide at no cost to the Texas Health and Human Services Commission (HHSC):

1. all information required under the 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; and
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 the Dental Contractor to establish timeframes and formats reasonably acceptable to both parties.

Section  
8.1.14  
modified by  
Version 1.4

Any deliverable or report in **Section 8.1.14**, “General Reporting Requirements,” without a specified due date is due quarterly on the last day of the month following the end of the reporting period. Where the due date states 30 days, the Dental Contractor is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 days, the Dental Contractor is to provide the deliverable by the 15th day of the 2nd month following the end of the Reporting period. (See UMCM Chapter 5.0, “Consolidated Deliverables Matrix”.)

#### **8.1.14.1 Performance Measurement**

The Dental Contractor must provide HHSC or its designee all information necessary to analyze the Dental Contractor’s provision of quality care to Members using measures to be determined by HHSC in consultation with the Dental Contractor.

Section 8.1.14.1 modified by Versions 1.4 and 1.10

#### **8.1.14.2 Reports**

The Dental Contractor must provide the following reports, in addition to the Financial Reports described in **Section 8.1.11**, “Accounting and Financial Reporting Requirements,” and those reporting requirements listed elsewhere in the Contract. UMCM Chapter 5, “Deliverables, Report Formats, Due Dates,” includes a list of required reports, and a description of the format, content, file layout, and submission deadlines for each report.

Section 8.1.14.2 modified by Versions 1.2, 1.3, 1.8, 1.11, and 1.12

- (a) **Claims Summary Report** - The Dental Contractor must submit quarterly Claims Summary Reports, separated by Program, to HHSC or its designee by the 30<sup>th</sup> day following the end of the reporting period unless otherwise specified. The format for the Claims Summary Report is contained in UMCM Chapter 5.6.1.4, “Dental Claims Summary Report.” Claim Types include facility and/or professional services.
- (b) **QAPI Program Annual Summary Report** - The Dental Contractor must submit a QAPI Program Annual Summary in a format and timeframe as specified in UMCM Chapter 5.7, “Quality Reports.”
- (c) **Fraudulent Practices Report** - Utilizing the HHSC-Office of Inspector General (OIG) Fraud referral form, the Dental Contractor’s assigned officer or director must report and refer all possible acts of Waste, Abuse or Fraud to the HHSC-OIG within 30 Business Days of receiving the reports of possible acts of Fraud, Abuse or Waste from the Dental Contractor’s Special Investigative Unit (SIU). The report and referral must include: an investigative report

identifying the allegation, statutes/regulations violated or considered, and the results of the investigation; copies of program rules and regulations violated for the time period in question; copies of any Dental Contractor contractual provisions, policies, published Dental Contractor program bulletins, policy notification letters, or provider policy or procedure manuals that apply to the alleged conduct for the time period in question; the estimated overpayment identified; a summary of the interviews conducted; the Encounter Data submitted by the provider for the time period in question; and all supporting documentation obtained as the result of the investigation. This requirement applies to all reports of possible acts of Waste, Abuse and Fraud.

Additional reports required by the OIG relating to Waste, Abuse or Fraud are listed in UCMC Chapter 5.5, "Fraud Deliverable/Report Formats."

- (d) Provider Termination Report** – The Dental Contractor must submit a quarterly report that identifies all Network Providers (both primary care and specialty) who cease to participate in the Dental Contractor's Provider Network, either voluntarily or involuntarily. The Report must be submitted to HHSC using the Provider Termination Report under UCMC 5.4.1 Provider Network Reports, no later than 30 days after the end of the reporting period.
- (e) Network & Capacity Report** – The CHIP Dental Contractor must submit a quarterly report that includes all Providers in the Dental Contractor's Provider Network. The report must be submitted to HHSC using the Network and Capacity Report in the UCMC Chapter 5.4.1 Provider Network Reports, no later than 30 days after the end of the reporting quarter.
- (f) Provider Complaints, Member Complaints, and Member Appeals** - The Dental Contractor must submit quarterly Complaints and Appeals reports. The Dental Contractor must include in its reports complaints and appeals submitted to the Dental Contractor and/or any Subcontractor delegated to provide a service for the Dental Contractor. All Member or Provider complaints submitted orally or in writing (e.g. via email, call, letter, etc.) to the Dental Contractor and/or its Subcontractor must be included within the Dental Contractor's complaint reports. The Dental Contractor Member Appeal report must include counts of expedited and standard appeals received and resolved during the reporting quarter in addition to pending appeals. The Dental Contractor must submit its Complaints and Appeals Reports 45 days

following the end of the State Fiscal Quarter, using the Provider Complaints, Member Complaints, and Member Appeals reports in UMCM Chapter 5.4.2 Complaints and Appeals Report. The Dental Contractor must not submit its complaint and/or appeals reports prior to the due date if it has pending complaints or appeals.

- (g) Hotline Reports** - The Dental Contractor must submit, quarterly status reports for the Member Services Hotline and the Provider Hotline to measure the Dental Contractor's compliance in accordance with the performance standards set out in **Sections 8.1.6.6** Member Hotline and **Section 8.1.5.8** Provider Hotline in UMCM Chapter 5.4.3 Hotline Reports.

If the Dental Contractor is not meeting a hotline performance standard, HHSC may require the Dental Contractor to submit monthly hotline Performance Reports and implement corrective actions until the hotline performance standards are met. If a Dental Contractor has a single hotline serving multiple hotline functions (i.e. Member, Provider), HHSC may request that the Dental Contractor submit certain hotline response information by hotline function and/or Program on an annual basis. HHSC may also request additional hotline information if the Dental Contractor is not meeting a hotline performance standard.

- (h) Historically Underutilized Business (HUB) Reports** – Upon contract award, the Dental Contractor must attend a post award meeting, which will be scheduled by the HHSC HUB Program Office, to discuss the development and submission of a HUB Subcontracting Plan (HSP) Progress Assessment Report (PAR) for the inclusion of HUBs. The Dental Contractor must maintain its original HSP and submit monthly PAR reports documenting the Dental Contractor's good faith effort to comply with the originally submitted HSP. The report must be in the format specified in UMCM Chapter 5.4.4.4, for the HUB monthly reports. The Dental Contractor must comply with the HUB Program's HSP and PAR requirements for all Subcontractors.

- (i) Frew Quarterly Monitoring Report (Medicaid Only)** – Each calendar year quarter, HHSC prepares a report for the court that addresses the status of the Consent Decree paragraphs for the *Frew v. Smith* lawsuit. The Dental Contractor must prepare responses to questions posed by HHSC on the Frew QMR Dental Plan Response template. The timeframe, format, and details of the report is contained and described in UMCM Chapter 12.34.

- (j) **Children of Migrant Farmworkers Annual Plan (FWC Plan—Medicaid Only)** – the Dental Contractor must submit an annual plan, in the timeframe and format described in UMCM Chapters 12.27 and 12.28, that describes how the Dental Contractor will identify and provide accelerated services to Children of Migrant Farmworkers.
- (k) **Children of Migrant Farmworkers Annual Report (FWC Annual Report – Medicaid Only)** – The Dental Contractor must submit an annual report, in the timeframe and format described in UMCM Chapters 12.27, 12.29, 12.30, 12.31, and 12.32, about the identification of and delivery of services to Children of Migrant Farmworkers (FWC).
- (l) **Out-of-Network Utilization Reports** – The Dental Contractor must file quarterly Out-of Network Utilization Reports in accordance with UMCM Chapter 5.3.8, “Out Of Network (OON) Utilization Report.” Quarterly reports are due 30 days after the end of each quarter.
- (m) **CHIP Federal Report (CHIP only)** – The Dental Contractor must submit an annual report in the timeframe and format described in the UMCM that addresses the dental services provided to CHIP Members.
- (n) **Enrollment/Credentialing Denial Report** - The Dental Contractor must submit a quarterly report in accordance with UMCM Chapter 5.4.1.9 identifying Providers who were denied enrollment in the Dental Contractor’s network. The report must be submitted in the format specified by HHSC in the UMCM, no later than 30 days after the end of the reporting period.

### **8.1.15 Federally Qualified Health Centers (FQHCs)**

The Dental Contractor must make reasonable efforts to include FQHCs in its Provider Network. If a Member visits an FQHC (or a Municipal Health Department’s public clinic) for Medically Necessary Covered Dental Services at a time that is outside of regular business hours (as defined by HHSC in rules, including weekends or holidays), the Dental Contractor is obligated to reimburse the FQHC or public clinic for Medically Necessary Covered Services. The Dental Contractor must do so at a rate that is equal to the allowable rate for those services as determined under Section 32.028 of the Human Resources Code. In such case, the Member does not need a referral from a Main Dental Home Provider.

Section  
8.1.15  
modified by  
Versions  
1.1 and 1.2

Under both CHIP and Medicaid, Dental Contractors are required to pay full encounter rates (as determined by HHSC) directly to FQHCs for Medically Necessary Covered Services, via one or more payments, at the time the claim is paid. HHSC cost settlements (or “wrap payments”) do not apply.

Under CHIP, Dental Contractors may not count the full encounter rate against a Member’s benefit limit. Thus, the Dental Contractor may not use the PPS rates to reduce the benefit amount allowed. Instead, the Dental Contractor must apply the lower “usual and customary” rate (as defined by TDI in 28 T.A.C. Section 11.506) towards the benefit limit. The Dental Contractor must utilize a correspondingly appropriate methodology to track and decrement available benefit dollars remaining for each Member.

#### **8.1.16 Payment by Members**

Except as provided in **Section 8.1.16.1**, Dental Contractors, Network Providers, and Out-of-Network Providers are prohibited from billing or collecting any amount from a Member for Medically Necessary Covered Dental Services that are within the Member’s benefit limits.

Dental Contractors must inform Members of their responsibility to pay the costs for non-Covered Dental Services, and must require its Network Providers to:

- (1) inform Members of costs for non-Covered Dental Services prior to rendering such services;
- and
- (2) obtain a signed Private Pay form from such Members.

##### **8.1.16.1 CHIP Dental Contractors**

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

Section  
8.1.16.1  
modified by  
Version 1.1  
and 1.7

Families that meet the enrollment period cost share limit requirement must report it to the HHSC Administrative Services Contractor. The HHSC Administrative Service Contractor notifies the Dental Contractor that a family’s cost share limit has been reached. Upon notification from the HHSC Administrative Services Contractor that a family has reached its cost-sharing limit for the term of coverage, the Dental Contractor will generate and mail to the CHIP Member a new Member ID card within five (5) days, showing that the CHIP Member’s cost-sharing obligation for

that term of coverage has been met. No cost-sharing may be collected from these CHIP Members for the balance of their term of coverage.

Providers are responsible for collecting all CHIP Member copayments at the time of service. Copayments that families must pay vary according to their income level.

Copayments do not apply, at any income level, to Medically Necessary Covered Dental Services that qualify as routine preventive and diagnostic dental services, as defined by 42 C.F.R. § 457.520 and §2103(e)(2) of the Social Security Act.

Except for costs associated with unauthorized non-emergency services provided to a Member by Out-of-Network providers and for non-Covered Dental Services, the copayments outlined in the CHIP Cost Sharing Table in UCMCM Chapter 6.3, "CHIP Cost Sharing" are the only amounts that a provider may collect from a CHIP-eligible family. Although the emergency services described in **Section 8.1.3.3** are Non-Capitated Services, the Dental Contractor must educate members and Providers that cost sharing for such emergency services is limited to the copayment amounts set forth in the CHIP Cost Sharing Table. If the cost of a Covered Service is less than the Member's CHIP copayment for that Covered Service, the copayment amount the Member pays will be capped at the cost of the Covered Service.

The Dental Contractor's Network Provider agreements must limit the amount CHIP Providers may charge Members for services in excess of the Member's benefit limits. A Network Provider must agree to limit charges to the Network Providers' contracted rates for services that would have been Covered Dental Services if they were within the benefit limit.

Federal law prohibits charging premiums, deductibles, coinsurance, copayments, or any other cost-sharing to CHIP Members of Native Americans or Alaskan Natives. The HHSC Administrative Services Contractor will notify the Dental Contractor of CHIP Members who are not subject to cost-sharing requirements. The Dental Contractor is responsible for educating Providers regarding the cost-sharing waiver for this population.

A Dental Contractor's monthly Premium Payment will not be adjusted for a 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 obligation for that month.

## **8.2 Additional Medicaid Scope of Work**

The following provisions apply only to the Medicaid Program.

### **8.2.1 Continuity of Care and Out-of-Network Providers**

The Dental Contractor must ensure that the care of newly enrolled Members is not disrupted or interrupted. The Dental Contractor must take special care to provide continuity in the care of newly enrolled Members whose health condition has been treated by specialty care providers or whose health could be placed in jeopardy if Medically Necessary Covered Dental Services are disrupted or interrupted. The Dental Contractor must ensure Members receiving services through a prior authorization receive continued authorization of those services for the shortest period of one of the following: (1) 90 calendar days after the transition to a new Dental Contractor, (2) until the expiration date of the prior authorization, or (3) until the Dental Contractor has evaluated and assessed the Member and issued or denied a new authorization. If a Member is new to a Dental Contractor's plan and has an open authorization for Covered Dental Services from HHSC's Claims Administrator or another Dental Contractor in the Medicaid or CHIP Dental Program, the Dental Contractor must accept that authorization and not require additional authorization or review. The only exception is in the case of orthodontic treatments authorized by HHSC's Claims Administrator prior to March 1, 2012. With these authorizations, the Dental Contractor may request additional information from the Provider and/or Claims Administrator to review the case for medical necessity. If the Dental Contractor determines the services previously authorized do not meet the criteria for medical necessity, the Dental Contractor may develop a treatment plan to end the services previously authorized.

Section 8.2.1  
modified by  
Versions 1.1  
and 1.6

Additionally, if a Member is new to a Dental Contractor's plan, and is completing one or more dental procedures initiated prior to joining that plan, 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 Member's previous plan.

The Dental Contractor must pay a Member's existing Out-of-Network providers for Medically Necessary Covered Dental Services until the 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 the Dental Contractor, whichever is shorter. Payment to Out-of-Network providers must be made within the time period required for Network Providers. The Dental Contractor must comply with Out-of-Network provider reimbursement rules as adopted by HHSC in [1 Tex. Admin. Code § 353.4](#).

This section does not extend the obligation of the Dental Contractor to reimburse the Member's existing Out-of-Network providers for ongoing care for:

1. More than 90 days after a Member enrolls in the Dental Contractor's plan, or
2. For more than nine (9) months in the case of a Member who, at the time of enrollment in the Dental Contractor, has been diagnosed with and receiving treatment for a terminal illness and remains enrolled in the Dental Contractor.

If Medically Necessary Covered Dental Services are not available within the Dental Contractor's Network, the Dental Contractor must provide Members with timely and adequate access to Out-of-Network services for as long as those services are necessary and not available in the Network, in accordance with 42 C.F.R. §438.206(b)(4). The Dental Contractor will not be obligated to provide a Member with access to Out-of-Network services if such services become available from a Network Provider.

The Dental Contractor must ensure that each Member has access to a second opinion regarding the use of any Medically Necessary Covered Dental Service. A 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 Member, in accordance with 42 C.F.R. §438.206(b)(3).

If a Medicaid Member enrolled in the Dental Contractor's plan for at least one month is receiving orthodontic treatment and either ages out of the program or loses eligibility, the Dental Contractor is responsible for completion of the course of treatment. The only exception is if the Member is disenrolled with cause, but is still Medicaid eligible. For example, if a Member goes into a State Supported Living Center, the Dental Contractor will no longer be responsible for services rendered.

## **8.2.2 Provisions Related to Medically Necessary Covered Dental Services for Medicaid Members**

### **8.2.2.1 Texas Health Steps (EPSDT)**

#### **8.2.2.1.1 Dental Checkups**

The Dental Contractor must develop effective methods to ensure that children birth through age 20 receive Texas Health Steps dental services and must arrange for these services for all eligible Medicaid 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 Medicaid members every 6 months, starting at six (6) months of age. Children from six (6) to 35 months of age who are participating in the First Dental Home Initiative may be eligible for visits every three (3) months, if Medically Necessary. Newly enrolled Members must receive a dental checkup no later than 90 days after enrollment. The Dental Contractor must ensure dental checkups are provided in a timely manner to all Medicaid Members.

#### **8.2.2.1.2 Education/ Outreach**

The Dental Contractor must ensure that Members are provided information and educational materials about the services available through the Texas Health Steps Program, and how and when they may obtain the services. The information should tell the Member how they can obtain dental benefits, services through the Medical Transportation Program, and advocacy assistance from the MCO. Standard language describing Texas Health Steps services, including medical, dental and case management services is provided in the UMCM. The Dental Contractor should use this language for Member Materials. Any additions to or deviations from the standard language must be reviewed and approved by HHSC prior to publication and distribution to Members.

The Dental Contractor must cooperate and coordinate with the Texas Health Steps outreach unit to ensure prompt delivery of services to Members who miss dental checkups.

The Dental Contractor must cooperate and coordinate with the State, outreach programs and Texas Health Steps regional program staff and agents to ensure prompt delivery of services to

Section  
8.2.2.1.2  
modified by  
Versions  
1.1, 1.5,  
and 1.11

Children of Migrant Farmworkers and other migrant populations who may transition into and out of the MCO's Program more rapidly or unpredictably than the general population.

The Dental Contractor must make an effort to 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 both familiar and convenient to the Members. The Dental Contractor must make a good faith effort to comply with Head Start's requirement that Members participating in Head Start receive their Texas Health Steps checkup no later than 45 days after enrolling into either program.

### **8.2.2.1.3 Training**

The Dental Contractor must provide appropriate training to all Network Providers and Provider staff in the Providers' area of practice regarding the scope of benefits available and the Texas Health Steps Program. The Dental Contractor must also collect Provider evaluations on the subject matter and methodology for each training session conducted. Training topics must include information regarding:

1. Texas Health Steps dental benefits, periodicity, and required components of a dental checkup, the importance of documenting all required components of the checkup in the medical record, and the necessity of documentation to support a complete checkup qualifying for reimbursement is provided;
2. Non-Capitated Medical transportation services available to Medicaid Members such as rides to services by bus, taxi, van, airfare, etc., gas money, mileage reimbursement, and meals and lodging when away from home;
3. The importance of updating contact information to ensure accurate Provider Directories and the Medicaid Online Provider Lookup;
4. The Dental Contractor's process for acceleration of THSteps dental services for FWC Members;
5. Missed appointment referrals and assistance provided by the THSteps Outreach and Informing Unit; and
6. Administrative issues such as claims filing and services available to Members.

The Dental Contractor must solicit input from major stakeholders, such as trade associations and provider groups, regarding provider training.

Section  
8.2.2.3  
modified by  
Versions  
1.1, 1.3,  
and 1.12

### **8.2.2.2 Children of Migrant Farmworkers (FWC)**

The Dental Contractor must cooperate and coordinate with the State, outreach programs, and Texas Health Steps regional program staff and agents to ensure prompt delivery of services, in accordance with the timeframes in this Contract, to FWC Members and other migrant populations who may transition into and out of the Dental Program more rapidly and/or unpredictably than the general population.

The Dental Contractor must provide accelerated services to FWC Members. For purposes of this section, “accelerated services” are services that are provided to FWC Members 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 Member is out of Texas. The need for accelerated services must be determined on a case-by-case basis and according to the FWC Member’s age, periodicity schedule and health care needs.

### **8.2.2.3 Medicaid Non-capitated Services**

The following Texas Medicaid programs, services, or benefits have been excluded from Dental Covered Dental Services. Medicaid Members are eligible to receive these Non-capitated Services on a Fee-for-Service basis. Dental Contractors should refer to relevant chapters in the **Texas Medicaid Provider Procedures Manual** for more information.

1. Texas Health Steps environmental lead investigation (ELI);
2. Early Childhood Intervention (ECI) case management/service coordination;
3. DSHS case management for Children and Pregnant Women;
4. Texas School Health and Related Services (SHARS);
5. Health and Human Services Commission’s Medical Transportation; and
6. Emergency services as described in **Section 8.1.3.3**.

## **8.2.3 Provider Complaints and Appeals**

### **8.2.3.1 Provider Complaints**

Dental Contractors must develop, implement, and maintain a system for tracking and resolving all Medicaid Provider complaints. Within this process, 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. The Dental Contractor must resolve Provider complaints within 30 days from the date the complaint is received. The Dental Contractor is

Section  
8.2.2.3  
modified by  
Versions  
1.1 and 1.6

subject to remedies, including liquidated damages, if at least 98 percent of Provider complaints are not resolved within 30 days of receipt of the complaint by the Dental Contractor. (Please see **Attachment A**, "Dental Contract Terms and Conditions," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix".) HHSC may, in its reasonable discretion, grant a written extension if the Dental Contractor demonstrates good cause.

Dental Contractors must also resolve Provider complaints received by HHSC no later than the due date indicated on HHSC's notification form. HHSC will generally provide Dental Contractors ten (10) Business Days to resolve such complaints. If a Dental Contractor cannot resolve a complaint by the due date indicated on the notification form, it may submit a request to extend the deadline. HHSC may, in its reasonable discretion, grant a written extension if the Dental Contractor demonstrates good cause.

Unless HHSC has granted a written extension as described above, the Dental Contractor is subject to contractual remedies, including liquidated damages if Provider complaints are not resolved by the timeframes indicated herein.

In the event a Dental Contractor subcontracts for any services required to be provided by the Dental Contractor, the Dental Contractor must directly manage Provider complaints regarding that Subcontractor and within the timelines established above.

### **8.2.3.2 Appeal of Provider Claims**

Dental Contractors must develop, implement, and maintain a system for tracking and resolving all Medicaid Provider appeals related to claims payment, as required by Texas Government Code § 533.005(a)(15). Within this process, the Dental Contractor must respond fully and completely to each Medicaid Provider's claims payment appeal and establish a tracking mechanism to document the status and final disposition of each Medicaid Provider's claims payment appeal.

The Dental Contractor is subject to liquidated damages if at least 98 percent of Provider Appeals are not resolved within 30 calendar days of the Dental Contractor's receipt.

Section  
8.2.3.2  
modified by  
Versions  
1.1, 1.4,  
and 1.7

In addition, the Dental Contractor's process must comply with Texas Government Code §533.005(a)(19).

Dental Contractors must contract with Non-network providers to resolve claims disputes related to denial on the basis of Medical Necessity that remain unresolved subsequent to a provider appeal. The provider 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 Medicare or commercial lines of business. The determination of the provider resolving the dispute must be binding on the Dental Contractor and a Network Provider. The provider 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 reserves the right to amend this process to include an independent review process established by HHSC for final determination on these disputes.

#### **8.2.4 Member Rights and Responsibilities**

In accordance with 42 C.F.R. §438.100, Dental Contractors must maintain written policies and procedures for informing Members of their rights and responsibilities, and must notify Members of their right to request a copy of these rights and responsibilities. The Member Handbook must include a notice that complies with UMCM Chapter 3.19.

#### **8.2.5 Medicaid Member Complaints and Appeals System**

The Dental Contractor must develop, implement, and maintain a Member Complaint and Appeal system 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, "Grievance System," and the provisions of [1 Tex. Admin. Code Chapter 357](#), relating to Medicaid managed care organizations.

The Complaint and Appeal system must include a Complaint process, an Appeal process, and access to HHSC's Fair Hearing System. The procedures must be the same for all Members and must be reviewed and approved in writing by HHSC or its designee. Modifications and amendments to the Member Complaint and Appeal system must be submitted for HHSC's approval at least 30 days prior to the implementation.

##### **8.2.5.1 Member Complaint Process**

The Dental Contractor must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting and resolving Complaints by Members or their authorized

representatives. 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 serve as an authorized representative.

The Dental Contractor must resolve all Member Complaints no later than 30 days from the date the Complaint is received. As described below, HHSC may shorten the timeframe for resolution if it refers the Member Complaint to the Dental Contractor. The Dental Contractor is subject to remedies, including liquidated damages, if at least 98 percent of Member Complaints are not resolved within 30 days of receipt of the Complaint by the Dental Contractor. (Please see the **Attachment A**, "Uniform Managed Care Contract Terms and Conditions" and **Attachment B-3**, “Deliverables/Liquidated Damages Matrix.”) The Complaint procedure must be the same for all Members. 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 Complaint process.

Member Complaints received by HHSC and referred to the Dental Contractor must be resolved no later than the due date indicated on HHSC’s notification form. HHSC will provide Dental Contractors up to ten (10) Business Days to resolve such Complaints, depending on the severity and/or urgency of the Complaint. HHSC may, in its reasonable discretion, grant a written extension if the Dental Contractor demonstrates good cause. Unless the HHSC has granted a written extension as described above, the Dental Contractor is subject to contractual remedies, including liquidated damages, if Member Complaints are not resolved by the timeframes indicated herein.

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. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Complaints.

The Dental Contractor's Complaint procedures must be provided to Members in writing and through free oral interpretive services. A written description of the Dental Contractor's Complaint procedures must be available in prevalent non-English languages for Major Population Groups identified by HHSC, at no more than a 6th grade reading level. The Dental Contractor must include a written description of the Complaint 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 must provide such oral interpretive services to callers free of charge.

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. Date;
2. Identification of the individual filing the Complaint;
3. Identification of the individual recording the Complaint;
4. Nature of the Complaint;
5. Disposition of the Complaint (i.e., how the Dental Contractor resolved the Complaint);
6. Corrective action required; and
7. Date resolved.

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 Business 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 the Member makes a request for disenrollment from the Dental Contractor and wants to select a different Dental Contractor, the Dental Contractor must give the Member information on the disenrollment process and direct the Member to the HHSC ASC. If the Member requests disenrollment from managed care, the Dental Contractor must direct the Member to HHSC. 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 or its designee to resolve all Member Complaints. Such cooperation may include, but is not limited to, providing information or assistance to HHSC Complaint team members.

The Dental Contractor must provide designated Member Advocates, as described in **Section 8.2.5.9**, to assist Members in understanding and using the Dental Contractor's Complaint system. The Dental Contractor's Member Advocates must assist Members in writing or filing a Complaint and monitoring the Complaint through the Dental Contractor's Complaint process until the issue is resolved.

#### **8.2.5.2 Medicaid Standard Member Appeal Process**

The Dental Contractor must develop, implement and maintain an Appeal procedure that complies with state and federal laws, rules, and regulations, including 42 C.F.R.§ 431.200 and 42 C.F.R. Part 438, Subpart F, "Grievance System." An Appeal is a disagreement with an Dental Contractor Action as defined in **Attachment A**, "Dental Contract Terms and Conditions." The Appeal procedure must be the same for all Members. When a Member or his or her authorized representative expresses orally or in writing any dissatisfaction or disagreement with an Action, the Dental Contractor must regard the expression of dissatisfaction as a request to Appeal an Action.

A Member must file a request for an Appeal with the Dental Contractor within 30 days from receipt of the notice of the Action. The Dental Contractor is subject to remedies, including liquidated damages, if at least 98 percent of Member Appeals are not resolved within 30 days of receipt of the Appeal by the Dental Contractor. (Please see the **Attachment A**, "Dental Contract Terms and Conditions," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix.") To ensure continuation of currently authorized services, however, the Member must file the Appeal on or

Section  
8.2.5.2  
modified by  
Version  
1.11

before the later of: (1) 10 days following the Dental Contractor's mailing of the notice of the Action, or (2) the intended effective date of the proposed Action. The Dental Contractor must designate an officer who has primary responsibility for ensuring that Appeals are resolved in compliance with written policy and within the 30-day time limit.

The provisions of Chapter 4201, Texas Insurance Code, relating to a Member's right to Appeal an Adverse Determination made by the Dental Contractor or a utilization review agent to an independent review organization, do not apply to a Medicaid recipient. Chapter 4201 is preempted by federal Fair Hearings requirements.

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 Texas licensed Dentists who have the appropriate clinical expertise in treating the Member's condition or disease.

The Dental Contractor must provide designated Member Advocates, as described in **Section 8.2.5.9**, to assist Members in understanding and using the Appeal process. The Dental Contractor's Member Advocates must assist Members in writing or filing an Appeal and monitoring the Appeal through the Dental Contractor's Appeal process until the issue is resolved.

The Dental Contractor must have a routine process to detect patterns of Appeals. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Appeals.

The Dental Contractor's Appeal procedures must be provided to Members in writing and through free oral interpretive services. A written description of the Appeal procedures must be available in prevalent non-English 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 (1) toll-free telephone number with TTY/TDD and interpreter capabilities for

requesting an Appeal of an Action. The Dental Contractor must provide such oral interpretive services to callers free of charge.

The Dental Contractor's process must require that every oral Appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless the Member or his or her representative requests an expedited resolution. All Appeals must be recorded in a written record and logged with the following details:

- 1) Date notice is sent;
- 2) Effective date of the Action;
- 3) Date the Member or his or her representative requested the Appeal;
- 4) Date the Appeal was followed up in writing;
- 5) Identification of the individual filing;
- 6) Nature of the Appeal; and
- 7) Disposition of the Appeal, including a copy of the notice of disposition and the date it was sent to Member.

The Dental Contractor must send a letter to the Member within five (5) Business Days acknowledging receipt of the Appeal request. Except for the resolution of an Expedited Appeal as provided in **Section 8.2.5.3** of this RFP, the Dental Contractor must complete the entire standard Appeal process within 30 calendar days after receipt of the initial written or oral request for Appeal. The timeframe for a standard 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 Appeals are resolved within these timeframes and in accordance with the Dental Contractor's written policies.

During the Appeal 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 that, in the case of an expedited resolution, limited time will be available.

The Dental Contractor must provide the Member and his or her representative opportunity, before and during the Appeal process, to examine the Member's case file, including medical 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, including the legal representative of a deceased Member's estate.

In accordance with 42 C.F.R. § 438.420, the Dental Contractor must continue the Member's 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 this 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 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;
2. Ten (10) days pass after the Dental Contractor mails the notice resolving the Appeal against the Member, unless the Member, within the 10-day timeframe, has requested a Fair Hearing with continuation of benefits. In such a case, the benefits will continue until a 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 has been met.

In accordance with 42 C.F.R. § 438.420(d), if the final resolution of the 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 may recover such costs from the Member.

If the Dental Contractor or State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Dental Contractor must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires.

If the Dental Contractor or State Fair Hearing Officer reverses a decision to deny authorization of services and the Member received the disputed services while the 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 Appeal.

### **8.2.5.3 Expedited Medicaid Appeals**

In accordance with 42 C.F.R. §438.410, the Dental Contractor must establish and maintain an expedited review process for Appeals. Such expedited process will apply 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 or health. The Dental Contractor must follow all Appeal requirements for standard Member Appeals as set forth in **Section 8.2.5.2** of this RFP, except where differences are specifically noted. The Dental Contractor must accept oral or written requests for Expedited Appeals.

Members must exhaust the Dental Contractor's Expedited Appeal process before making a request for an expedited Fair Hearing. After the Dental Contractor receives the request for an Expedited Appeal, it must hear an approved request for a Member to have an Expedited Appeal and notify the Member of the outcome of the Expedited Appeal within three (3) Business Days.

The timeframe for notifying the Member of the outcome of the Expedited Appeal 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 8.2.5.5** of this RFP. The Dental Contractor is responsible for notifying the Member of his or her right to access an expedited 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 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 Appeal. The Dental Contractor must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a Member's request.

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 (2) calendar days with a written notice.

#### **8.2.5.4 Access to Fair Hearing for Medicaid Members**

The Dental Contractor must inform Members that they have the right to access the Fair Hearing process at any time during the Appeal system provided by the Dental Contractor, with the following exception. In the case of an expedited Fair Hearing process, the Dental Contractor must inform the Member that he or she must first exhaust the Dental Contractor's internal Expedited Appeal process prior to filing a request for an Expedited Fair Hearing. The Dental Contractor must notify Members that they may be represented by an authorized representative in the Fair Hearing process.

If a Member requests a Fair Hearing, the Dental Contractor will complete the request for Fair Hearing and submit the form via facsimile to the appropriate Fair Hearings office, within five (5) calendar days of the Member's request for a Fair Hearing.

Within five (5) calendar days of notification that the 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

Section  
8.2.5.4  
modified by  
Version  
1.11

the packet to the Member. The evidence packet must comply with HHSC's 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 Fair Hearings as scheduled.

#### **8.2.5.5 Notices of Action and Disposition of Appeals for Medicaid Members**

The Dental Contractor must notify the Member, in accordance with [1 T.A.C. Chapter 357](#), whenever the Dental Contractor takes an Action. The notice must, at a minimum, include any information required by UCMC Chapters 3.21 and 3.22, regarding notices of actions and incomplete prior authorization requests.

#### **8.2.5.6 Timeframe for Notice of Action**

In accordance with 42 C.F.R. § 438.404(c), the Dental Contractor must mail a notice of Action within the following timeframes:

1. For termination, suspension, or reduction of previously authorized Medicaid-Covered Dental Services, 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 any Action 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 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 Action), 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).

#### **8.2.5.7 Notice of Disposition of Appeal**

In accordance with 42 C.F.R. §438.408(e), the Dental Contractor must provide written notice of disposition of all Appeals including Expedited Appeals. The written resolution notice must include the results and date of the Appeal resolution. For decisions not wholly in the Member's favor, the notice must contain:

1. The right to request a Fair Hearing;
2. How to request a Fair Hearing;
3. The circumstances under which the Member may continue to receive benefits pending a Fair Hearing;
4. How to request the continuation of benefits;
5. If the Dental Contractor's Action is upheld in a Fair Hearing, the Member may be liable for the cost of any services furnished to the Member while the Appeal is pending; and
6. Any other information required by [1 Tex. Admin. Code Chapter 357](#) that relates to a managed care organization's notice of disposition of an Appeal.

#### **8.2.5.8 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 Appeals, as expeditiously as the Member's health condition requires, but the notice must not exceed the timelines provided in this Section for Standard or Expedited 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 standard 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 (2) calendar days with a written notice.

### **8.2.5.9 Medicaid Member Advocates**

The Dental Contractor must provide Member Advocates to assist Members. Member Advocates must be physically located within the HHSC-defined regions (refer to the HHSC Regions Map in the **Procurement Library**) unless an exception is approved by HHSC. Member Advocates must inform Members of the following:

1. Their rights and responsibilities,
2. The Complaint process,
3. The Appeal process,
4. Medically Necessary Covered Dental Services available to them, including preventive services, and
5. Information on how to access Non-capitated Services available to Members.

Member Advocates must assist Members in writing Complaints and are responsible for monitoring Complaints through the Dental Contractor's Complaint process.

Member Advocates are responsible for making recommendations to the Dental Contractor's management on any changes needed to improve either the care provided or the way care is delivered. Member Advocates are also responsible for helping or referring Members to community resources that are available to meet Members' needs if services are not available from the Dental Contractor as Medically Necessary Covered Dental Services.

### **8.2.6 Third Party Liability and Recovery and Coordination of Benefits**

Medicaid coverage is secondary when coordinating benefits with all other insurance coverage, unless an exception applies under federal 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 Out-of-Network 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 provider rates. For Out-of-Network 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 Out-of-Network payment ([1 Tex. Admin. Code §353.4](#)).

Section  
8.2.6  
modified by  
Versions  
1.1, 1.2, and  
1.10

The Dental Contractor is responsible for establishing a plan and process for avoiding and recovering costs for services that should have been paid through a third party. The plan and process must be in accordance with state and federal laws, rules, and regulations, including Section 1902(a)(25)(E) and (F) of the Social Security Act, which require MCOs to pay and later seek recovery from liable third parties: (1) for prenatal and preventive pediatric care, and (2) in the context of a state child support enforcement action. The projected amount of TPR that the Dental Contractor is expected to recover may be factored into the rate setting process.

HHSC will provide the Dental Contractor, by Plan code, a monthly Member file (also known as a TPR client file). The file is an extract of those Medicaid Members who are known or believed to have other insurance. The file contains any Third Party Recovery (TPR) data that HHSC's claims administration agent has on file for individual Medicaid clients, organized by name and client number, and adding additional relevant information where available, such as the insured's name/contact information, type of coverage, the insurance carrier, and the effective dates.

The Dental Contractor must provide related reports to HHSC, as stated in **Section 8.1.11.1**, “Financial Reporting Requirements.”

After 120 days from the date of adjudication of a claim that is subject to TPR, HHSC has the right to attempt recovery, independent of any Dental Contractor action. HHSC will retain, in full, all funds received as a result of any state-initiated TPR or subrogation action.

### **8.2.7 SSI Members**

A Member's SSI status is effective the date the State's eligibility system identifies the Member as Type Program 13 (TP13). The State is responsible for updating the State's eligibility system within 45 days of official notice of the Member's Federal SSI eligibility by the Social Security Administration (SSA). Once HHSC has updated the State's eligibility system to identify a CHIP Dental Program Member as TP13, following standard eligibility cut-off rules, HHSC will allow the Member to prospectively move to the Medicaid Dental Program. HHSC will not retroactively disenroll a Member from the CHIP Dental Program.

### **8.3 Additional CHIP Scope of Work**

The following provisions only apply to the CHIP Program.

### **8.3.1 CHIP Provider Complaint and 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. The Dental Contractor is subject to remedies, including liquidated damages, if at least 98 percent of Provider Complaints are not resolved within 30 days of receipt of the Complaint by the HMO. Please see **Attachment A**, "Dental Contract Terms and Conditions," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix".

#### **8.3.1.1 Complaints from Providers**

The Dental Contractor must develop, implement, and maintain a system for tracking and resolving all provider complaints. Within this process, 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. The Dental Contractor must resolve provider complaints within 30 calendar days from the date the complaint is received. The Dental Contractor is subject to remedies, including liquidated damages, if at least 98 percent of Provider Complaints are not resolved within 30 days of receipt of the Complaint by the Dental Contractor. Please see **Attachment A**, "Dental Contract Terms and Conditions," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix".

Dental Contractors must also resolve provider complaints received by HHSC no later than the due date indicated on HHSC's notification form. HHSC will generally provide Dental Contractors ten (10) Business Days to resolve such complaints. If a Dental Contractor cannot resolve a complaint by the due date indicated on the notification form, it may submit a request to extend the deadline. HHSC may, in its reasonable discretion, grant a written extension if the Dental Contractor demonstrates good cause.

Unless HHSC has granted a written extension as described above, the Dental Contractor is subject to contractual remedies, including liquidated damages if provider complaints are not resolved by the timeframes indicated herein.

#### **8.3.1.2 Appeal of Provider Claims**

The Dental Contractor must develop, implement, and maintain a system for tracking and resolving all appeals from Network and Out-of-Network 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 process, and finalize, all appealed claims to a paid or denied status within 30 calendar days of receipt of the appealed claim. The Dental Contractor is subject to remedies, including liquidated damages, if 98 percent of appealed claims are not processed and finalized to a paid or denied status within 30 days of receipt of the appealed claim. The Dental Contractor must finalize all claims, including appealed claims, within 24 months of the date of service.

Provider complaints and appeals are subject to disposition consistent with applicable insurance laws and TDI regulations.

### **8.3.2 CHIP Member Complaint and Appeal Process**

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 CHIP Member Complaints and Appeals (that are not elevated to TDI) within 30 days from the date the Complaint or Appeal is received unless the Dental Contractor can document that the 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 is subject to remedies, including liquidated damages, if at least 98 percent of Member Complaints or Member Appeals are not resolved within 30 days of receipt of the Complaint or Appeal by the Dental Contractor (see **Attachment A**, "Dental Contract Terms and Conditions" and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix"). Any person, including those dissatisfied with the Dental Contractor's resolution of a Complaint or Appeal, may report an alleged violation to TDI.

### **8.3.3 Third Party Liability and Recovery and Coordination of Benefits**

CHIP coverage is secondary when coordinating benefits with all other insurance coverage. Coverage provided under CHIP will pay benefits for Medically Necessary Covered Dental Services that remain unpaid after all other insurance coverage has been paid.

Dental Contractors are authorized to engage in Third Party Recovery (TPR) actions for claims resulting from the care and/or treatment of Members. The Dental Contractor is responsible for

establishing a plan and process 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 state insurance laws and regulations. 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 required reports as stated in **Section 8.1.11**, “Accounting and Financial Reporting Requirements.”

After 120-days from the date of adjudication on any claim, encounter, or other related payment by the Dental Contractor that is subject to TPR, HHSC may attempt recovery independent of any action by the Dental Contractor. HHSC will retain, in full, all funds received as a result of the state-initiated recovery or subrogation action.

The Dental Contractor will provide a Member quarterly file, which contains the following information if available to the Dental Contractor: the Member name, address, claim submission address, group number, employer's mailing address, social security number, and date of birth for each subscriber or policyholder and each dependent of the subscriber or policyholder covered by the insurer. The file shall be used for the purpose of matching the Texas eligibility file against the Dental Contractor Member file to identify Members enrolled in the Dental Contractor's plan who may have TPR information not known to the Program.

## DOCUMENT HISTORY LOG

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Baseline	n/a	September 1, 2011	Initial version of Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.1	March 1, 2012	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.2	September 1, 2012	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.3	March 1, 2013	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.4	September 1, 2013	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.5	January 1, 2014	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.6	February 1, 2014	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.7	September 1, 2014	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.8	March 1, 2015	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.9	May 1, 2015	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.10	September 1, 2015	Section 9.2 is modified to align with the LD Matrix and to add language that the MCOs need to include third-party software information in the MCOs' transition plan.  Section 9.3 is modified to add clarification regarding HHSC's potential need for MCO's

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			third party software for contract turnover. Section 9.4 is modified to require an update of the Turnover Plan 12 months prior to the end of the Contract Period.
Revision	1.11	March 1, 2016	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."
Revision	1.12	September 1, 2016	Contract amendment did not revise Attachment B-1, RFP Section 9, "Turnover Requirements."

<sup>1</sup> Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.

<sup>2</sup> Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.

<sup>3</sup> Brief description of the changes to the document made in the revision.

## Table of Contents

<b>9. Turnover Requirements</b> .....	<b>4</b>
9.1 Introduction.....	4
9.2 Turnover Plan .....	4
9.3 Transfer of Data and Information .....	5
9.4 Turnover Services.....	6
9.5 Post-Turnover Services .....	6

## **9. Turnover Requirements**

### **9.1 Introduction**

This section presents the Turnover requirements. “Turnover” is defined as those activities that the Dental Contractor must perform prior to or upon termination of the Contract in situations where the Dental Contractor will transition data and documentation acquired under the Contract to HHSC or a subsequent contractor.

### **9.2 Turnover Plan**

Twelve (12) months after the Effective Date of the Contract, the Dental Contractor must provide a Turnover Plan covering the turnover of the records and information maintained to either HHSC or a subsequent contractor. The Turnover Plan will be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan should also include information about third-party software used by the MCO in the performance of duties under the 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 under Section 9.3 of the Contract.

The Turnover Plan must describe the Dental Contractor’s policies and procedures that will ensure:

1. The least disruption in the delivery of Medically Necessary Covered Dental Services to Members during the transition to a subsequent contractor.
2. Cooperation with HHSC and a subsequent contractor in notifying Members of the transition, as requested and in the form required or approved by HHSC.
3. Cooperation with HHSC and a subsequent contractor in transferring information to HHSC or a subsequent contractor, as requested and in the form required or approved by HHSC.

The Turnover Plan must be approved by HHSC, and include at a minimum:

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 will use to monitor Turnover activities.
3. The Dental Contractors' approach to training HHSC or a subsequent contractor's staff in the operation of its business processes.

HHSC is not limited or restricted in the ability to require additional information from the Dental Contractor or modify the Turnover Plan as necessary.

### **9.3 Transfer of Data and Information**

Section 9.3  
modified by  
Version 1.10

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 provision, "documentation" means all operations, technical and user manuals used in conjunction with the software, 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 **Attachment A, Section 15.03**, "HHSC Dental Contract Terms and Conditions" for additional information concerning intellectual property rights.

In addition, the Dental Contractor will provide to HHSC the following:

1. Data, information, and services necessary and sufficient to enable HHSC to map all Texas CHIP Dental Services 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.
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 a subsequent contractor. If HHSC determines that data or information are not accurate, complete, nor HIPAA compliant, HHSC reserves the right to 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 the responsibility of the Dental Contractor.

#### **9.4 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.

#### **9.5 Post-Turnover Services**

Thirty (30) days following Turnover of operations, 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 document is approved by HHSC. HHSC may withhold up to 20% of the last month's Premium Payment until the Turnover activities are complete and the Turnover Plan is approved by HHSC.

Section 9.4  
modified by  
Version 1.10

If the Dental Contractor does not provide the required data or information necessary for HHSC or a subsequent contractor to assume the operational activities successfully, the Dental Contractor agrees to reimburse HHSC for all reasonable costs and expenses, including, but not limited to: transportation, lodging, and subsistence to carry out inspection, audit, review, analysis, reproduction and transfer functions at the location(s) of such records; and attorneys' fees and costs. This section does not limit HHSC's ability to impose remedies or damages as set forth in the Contract.

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-2 – Medicaid/CHIP Dental Services RFP, Medicaid Medically Necessary Covered Dental Services**

Version 1.12

**DOCUMENT HISTORY LOG**

<b>STATUS<sup>1</sup></b>	<b>DOCUMENT REVISION<sup>2</sup></b>	<b>EFFECTIVE DATE</b>	<b>DESCRIPTION<sup>3</sup></b>
Baseline	n/a	September 1, 2011	Initial version of Attachment B-2, "Medicaid Medically Necessary Covered Dental Services."
Revision	1.1	March 1, 2012	Contract amendment did not revise Attachment B-2, "Medicaid Medically Necessary Covered Dental Services."
Revision	1.2	September 1, 2012	Contract amendment did not revise Attachment B-2, "Medicaid Medically Necessary Covered Dental Services."
Revision	1.3	March 1, 2013	Contract amendment did not revise Attachment B-2, "Medicaid Medically Necessary Covered Dental Services."
Revision	1.4	September 1, 2013	Covered Services is modified for consistency with other MCO contracts.
Revision	1.5	January 1, 2014	Contract amendment did not revise Attachment B-2, "Medicaid Medically Necessary Covered Dental Services."
Revision	1.6	February 1, 2014	Contract amendment did not revise Attachment B-2, "Medicaid Medically Necessary Covered Dental Services."
Revision	1.7	September 1, 2014	Contract amendment did not revise Attachment B-2, "Medicaid Medically Necessary Covered Dental Services."
Revision	1.8	March 1, 2015	Contract amendment did not revise Attachment B-2, "Medicaid Medically Necessary Covered Dental Services."
Revision	1.9	May 1, 2015	Contract amendment did not revise Attachment B-2, "Medicaid Medically Necessary Covered Dental Services."
Revision	1.10	September 1, 2015	Contract amendment did not revise Attachment B-2, "Medicaid Medically Necessary Covered Dental Services."
Revision	1.11	March 1, 2016	Contract amendment did not revise Attachment B-2, "Medicaid Medically Necessary Covered Dental Services."
Revision	1.12	September 1, 2016	Contract amendment did not revise Attachment B-2, "Medicaid Medically Necessary Covered Dental Services."

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Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-2 – Medicaid/CHIP Dental Services RFP, Medicaid Medically Necessary Covered Dental Services**

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<p><sup>1</sup> Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.</p> <p><sup>2</sup> Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.</p> <p><sup>3</sup> Brief description of the changes to the document made in the revision.</p>			

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-2 – Medicaid/CHIP Dental Services RFP, Medicaid Medically Necessary Covered Dental Services**

Version 1.12

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## **Texas Medicaid Dental Program Covered Services**

With the exception of Non-capitated Services, the Dental Contractor is responsible for providing Members a benefit package that includes all Medically Necessary services covered under the traditional, fee-for-service Medicaid dental program (“Traditional Medicaid”).

Non-capitated Services are listed in Attachment B-1, **RFP Sections 8.1.3.3 and 8.2.2.3**. Non-capitated services are not included in the Dental Contractor’s Capitation Rates; however, the Dental Contractor must coordinate these Non-capitated Services so that Members have access to a full range of Medically Necessary Medicaid services, both capitated and non-capitated.

The Dental Contractor’s benefit package may also include Value-added Services approved by HHSC (see Uniform Managed Care Manual Chapter 4.4, “Dental Value-added Services Template.”)

Texas Medicaid Dental Program benefits are subject to the same benefit limits and exclusions that apply to Traditional Medicaid, but are not subject to the maximum fees imposed under Traditional Medicaid. For a complete list of the limitations and exclusions that apply to each Medicaid benefit category, refer to the current ***Texas Medicaid Provider Procedures Manual (TMPPM)***, which can be accessed online at: <http://www.tmhp.com>. For informational purposes only, the maximum fees for Traditional Medicaid are located in the Texas Medicaid Fee Schedule in the *TMPPM* and online at <http://public.tmhp.com/FeeSchedules/Default.aspx>.

The following is a non-exhaustive, high-level list of Covered Services in the Texas Medicaid Dental Program. Covered Services are subject to modification based on changes in federal and state laws, rules, regulations, and policies.

**Texas Medicaid Dental Program Covered Services include the following Medically Necessary services.**

- Diagnostic and preventive
- Therapeutic
- Restorative
- Endodontic
- Periodontal
- Prosthodontic (removable and fixed)
- Implant and oral and maxillofacial surgery
- Orthodontic
- Adjunctive general

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-2.1 – Medicaid/CHIP Dental Services RFP,CHIP Medically Necessary Covered Dental Services**

Version 1.12

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Baseline	n/a	September 1, 2011	Initial version of Attachment B-2.1, "CHIP Medically Necessary Covered Dental Services."
Revision	1.1	March 1, 2012	Contract amendment did not revise Attachment B-2.1, "CHIP Medically Necessary Covered Dental Services."
Revision	1.2	September 1, 2012	Schedule of CHIP Benefits is modified to add diagnostic services and to correct the AAPD reference.
Revision	1.3	March 1, 2013	Contract amendment did not revise Attachment B-2.1, "CHIP Medically Necessary Covered Dental Services."
Revision	1.4	September 1, 2013	Schedule of CHIP Benefits has been modified to reference the most recent version for CDT codes and the TMPPM for Maximum Allowable Charge. In addition, the CDT 2009-2010 column and Maximum Allowable Charge column are removed from the Services table.
Revision	1.5	January 1, 2014	Contract amendment did not revise Attachment B-2.1, "CHIP Medically Necessary Covered Dental Services."
Revision	1.6	February 1, 2014	Contract amendment did not revise Attachment B-2.1, "CHIP Medically Necessary Covered Dental Services."
Revision	1.7	September 1, 2014	Contract amendment did not revise Attachment B-2.1, "CHIP Medically Necessary Covered Dental Services."
Revision	1.8	March 1, 2015	Contract amendment did not revise Attachment B-2.1, "CHIP Medically Necessary Covered Dental Services."
Revision	1.9	May 1, 2015	Contract amendment did not revise Attachment B-2.1, "CHIP Medically Necessary Covered Dental Services."

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Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

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Revision	1.10	September 1, 2015	Contract amendment did not revise Attachment B-2.1, "CHIP Medically Necessary Covered Dental Services."
Revision	1.11	March 1, 2016	Contract amendment did not revise Attachment B-2.1, "CHIP Medically Necessary Covered Dental Services."
Revision	1.12	September 1, 2016	Contract amendment did not revise Attachment B-2.1, "CHIP Medically Necessary Covered Dental Services."

<sup>1</sup> Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.

<sup>2</sup> Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.

<sup>3</sup> Brief description of the changes to the document made in the revision.

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-2.1 – Medicaid/CHIP Dental Services RFP,CHIP Medically Necessary Covered Dental Services**

Version 1.12

## Schedule of CHIP Dental Benefits

Covered Dental Services are subject to a \$564 annual benefit limit unless an exception applies. In addition, some of the benefits identified in the schedule below are subject to annual limits. Limitations are based on a 12-month coverage period.

CHIP Members who have exhausted the \$564 annual benefit limit continue to receive the following Covered Dental Services in excess of the \$564 annual benefit maximum:

- (1) the diagnostic and preventive services due under the 2009 American Academy of Pediatric Dentistry periodicity schedule; and
- (2) other Medically Necessary Covered Dental Services approved by the Dental Contractor through a prior authorization process. These services must be necessary to allow a CHIP Member to return to normal, pain and infection-free oral functioning. Typically this includes:
  - Services related to the relief of significant pain or to eliminate acute infection;
  - Services related to treat traumatic clinical conditions;
  - Services that allow the CHIP Member to attain the basic human functions (e.g., eating, speech); and
  - Services that prevent a condition from seriously jeopardizing the CHIP Member's health/functioning or deteriorating in an imminent timeframe to a more serious and costly dental problem.

Refer to the most recent version of the *Code on Dental Procedures and Nomenclature* for coding that applies to Covered Dental Services.

The Maximum Allowable Charge for a CHIP Covered Dental Service is the Medicaid fee-for-service rate. Refer to the Texas Medicaid Fee Schedule in the *Texas Medicaid Provider Procedures Manual* or online at <http://public.tmhp.com/FeeSchedules/Default.aspx> for the Maximum Allowable Charge for each service.

## DIAGNOSTIC SERVICES

### EVALUATION

Periodic Oral Evaluation – established patient

Limited Oral Evaluation – problem focused

Schedule of  
CHIP  
Dental  
Benefits is  
modified by  
Versions  
1.2 and 1.4

Comprehensive Oral Evaluation - Limited to one per Child's lifetime per dentist.

## **X-RAYS**

Intraoral Complete Series (including bitewings) –Limited to one per 36 months

Intraoral-periapical, first film

Intraoral-periapical, each additional film

Bitewings-single film

Bitewings-two films

Bitewings-four films

Panoramic film—Limited to one panoramic film for age 5 through 9 and one panoramic film for age 10 through 18. Limited to one per 5 years.

## **PREVENTIVE SERVICES**

### **CLEANINGS**

Prophylaxis (Cleaning)-adult

Prophylaxis (Cleaning)-child

Topical application of fluoride - child

Topical application of fluoride - adult

Sealant per tooth—limited to one per tooth per lifetime (permanent molars and Maxillary per-molars only)

Space maintainer – fixed unilateral

Space maintainer – fixed bilateral

Space maintainer – removable unilateral

Space maintainer – removable bilateral

### **RESTORATIVE SERVICES (Includes Any Required Local and Topical Anesthetics)**

**AMALGAM (SILVER FILLINGS)** (All amalgam fillings are limited to one per tooth per 12 months.)

Amalgam – one surface, primary

Amalgam – one surface, permanent

Amalgam – two surface, primary

Amalgam – two surface, permanent

Amalgam – three surface, primary

Amalgam – three surface permanent

Amalgam – four or more surface, primary or permanent

**RESIN FILLINGS (WHITE FILLINGS)** (All resin fillings are limited to one per tooth per 12 months)

Resin-based composite – one surface, anterior

Resin-based composite – two surface, anterior

Resin-based composite – three surfaces, anterior

Resin-based composite – four or more surfaces or involving incisal angle, anterior

Resin-based composite – one surface, posterior, primary

Resin-based composite – one surface, posterior, permanent

Resin-based composite – two surfaces, posterior, primary

Resin-based composite – two surfaces, posterior, permanent

Resin-based composite - three surfaces, posterior, primary

Resin-based composite - three surfaces, posterior, permanent

Resin-based composite - four or more surfaces, posterior

**CROWNS (CAPS)** (All crowns are limited to one per tooth per 5 years)

Crown –resin-based composite (indirect)

Crown – resin with high noble metal

Crown – resin with predominantly base metal

Crown – resin with noble metal

Crown – porcelain/ceramic substrate

Crown – porcelain fused to high noble metal

Crown – porcelain fused to predominantly base metal

Crown – porcelain fused to noble metal

Crown – full cast high noble metal

Crown – full cast predominantly base metal

## **OTHER RESTORATIVE SERVICES**

Prefabricated stainless steel crown –primary tooth. Limited to one per tooth per lifetime.

Prefabricated stainless steel crown – permanent tooth. Limited to one per tooth per lifetime.

## **ENDODONTIC SERVICES**

### **PULPOTOMY / PULPECTOMY**

Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament

Pulpal therapy (resorbable filling) - anterior primary incisors and cuspids (excluding final restoration)

Pulpal therapy (resorbable filling) – posterior primary first and second molars (excluding final restoration)

**ROOT CANALS** (All root canals are limited to one per tooth per lifetime.)

Endodontic therapy, anterior tooth (excluding final restoration)

Endodontic therapy, bicuspid tooth (excluding final restoration)

Endodontic therapy, molar (excluding final restoration)

## **PERIODONTIC SERVICES**

Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant

Periodontal scaling and root planning – four or more teeth per quadrant

Full mouth debridement to enable comprehensive evaluation and diagnosis

## **PROSTHODONTIC SERVICES**

Complete denture – maxillary (upper)

Complete denture – mandibular (lower)

Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)

Mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)

Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-2.1 – Medicaid/CHIP Dental Services RFP,CHIP Medically Necessary Covered Dental Services**

Version 1.12

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Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)

## **ORAL and MAXILLOFACIAL SERVICES**

### **EXTRACTIONS (TOOTH REMOVAL)**

Extraction, erupted tooth or exposed root (Elevation and/or forceps removal)

### **SURGICAL EXTRACTIONS (TOOTH REMOVAL)**

Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth

Removal of impacted tooth – soft tissue

Removal of impacted tooth – partially bony

Removal of impacted tooth – completely bony

**Note:** If a Member is undergoing a course of treatment, the Covered Services terminate on the Date of Disenrollment.

**DOCUMENT HISTORY LOG**

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Baseline	n/a	September 1, 2011	Initial version of Attachment B-3, "Dental Services Deliverables/Liquidated Damages Matrix."
Revision	1.1	March 1, 2012	Contract amendment did not revise Attachment B-3, "Dental Services Deliverables/Liquidated Damages Matrix."
Revision	1.2	September 1, 2012	Item #28 is modified to correct the names of the Frew Dental Reports.
Revision	1.3	March 1, 2013	Contract amendment did not revise Attachment B-3, "Dental Services Deliverables/Liquidated Damages Matrix."
Revision	1.4	September 1, 2013	Items 3, 6, 7, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 27, 28, 29, 34, 35, and 36 are modified to add "not submitted" to the LD. Item 10 is modified to add requirements regarding interest payments. Item 25 is added. All subsequent items are renumbered.
Revision	1.5	January 1, 2014	Item 28 is modified to change "SIU Reports" to "MCO Open Case List Reports.'
Revision	1.6	February 1, 2014	Item 9 "Geo-Mapping" is added. All subsequent items are renumbered.
Revision	1.7	September 1, 2014	Item 8 is modified to change "\$500" to "\$250". Item 9.1 is added. Item 29 is modified to change "\$500" to "\$250"; "quarterly" to "monthly"; and, move "Fraud" to the front of Waste.

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			Item 35 replaces “turnover” with, “Measured at Time of Transfer of Data and ongoing after the Transfer of Data until satisfactorily completed”.
Revision	1.8	March 1, 2015	<p>In each contract section, after the first appearance of the term, “Uniform Managed Care Manual” is changed to “UMCM.”</p> <p>Item 4.1 is added.</p> <p>Item 11 is modified to clarify the standard.</p> <p>Items 20, 21, and 24 are modified to remove the cross reference in the performance Standard.</p> <p>Item 26 is modified to remove “per Financial Arrangement Code” from the liquidated damages (a)(1) and (a)(2).</p> <p>Item 32 is modified to increase the amount commensurate with the amount assessed for Clean Claims processing.</p>
Revision	1.9	May 1, 2015	Contract amendment did not revise Attachment B-3, “Dental Services Deliverables/Liquidated Damages Matrix.”
Revision	1.10	September 1, 2015	<p>Item 8 is modified to increase the LD from \$250 to \$1,000 per calendar day of noncompliance.</p> <p>Item 9.1 is modified to add CHIP.</p> <p>Item 19 is modified to change 30 days to 10 days to match language in 8.1.17.1</p> <p>Item 26 is modified to change “TED” to “Vision 21”.</p> <p>Item 28 is modified to increase the LD from \$500 to \$1,000 per calendar day of noncompliance.</p>

**DOCUMENT HISTORY LOG**

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			Item 28.1 is added. Item 28.2 is added. Item 28.3 is added. Item 29 is modified to increase the LD from \$250 to \$1,000 per calendar day of noncompliance. Item 30 is modified to remain consistent with other LDs being assessed. Item 36 is modified to change from six months to twelve months.
Revision	1.11	March 1, 2016	Item 4.2 is added. Item 4.3 is added. Item 4.4 is added. Item 13.1 is added. Item 13.2 is added. Item 34.1 is added.
Revision	1.12	September 1, 2016	Item 28.4 is added. Item 30 subsections (b) and (c) are deleted.

<sup>1</sup> Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.  
<sup>2</sup> Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.  
<sup>3</sup> Brief description of the changes to the document made in the revision.

## Dental Services Deliverables/Liquidated Damages Matrix

#	Service/Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
1.	General Requirement: Failure to Perform a Dental Administrative Service	The Dental Contractor fails to timely perform a Dental Administrative Service that is not otherwise associated with a performance standard in this matrix.	Transition, Operations, Turnover	Each incident of non-compliance.	Up to \$5,000.00 per calendar day/per Program for each incident of non-compliance.
2.	General Requirement: Failure to Provide a Dental Covered Service	The Dental Contractor fails to timely provide a Dental Covered Service that is not otherwise associated with a performance standard in this matrix.	Transition, Operations, Turnover	Each calendar day of non-compliance.	Up to \$ 7,500.00 per day for each incident of non-compliance.
3.	General Requirement	All reports and deliverables as specified in the Contract (including the UMCM) must be submitted according to the timeframes and requirements stated in the Contract (including all attachments). (Specific reports or deliverables listed separately in this matrix are subject to the specified liquidated damages.)	Transition, Operations, Turnover	Each calendar day of non-compliance.	HHSC may assess up to \$250 per calendar day/per Program if the report/deliverable is not submitted, late, inaccurate, or incomplete.
	Item 3 modified by Version 1.4				

<sup>1</sup> Derived from the Contract or HHSC's Uniform Managed Care Manual.

<sup>2</sup> Standard specified in Contract or through negotiations with the Dental Contractor.

<sup>3</sup> Period during which HHSC will evaluate service for purposes of tailored remedies.

<sup>4</sup> Measure against which HHSC will apply remedies.

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – Medicaid/CHIP Dental Services RFP, Dental Services Deliverables/Liquidated Damages Matrix**

Version 1.12

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
4.	Contract Attachment A, Dental Contract Terms and Conditions, Section 4.08, Subcontractors	The Dental Contractor must notify HHSC in writing within three (3) Business Days after making a decision to terminate a Subcontract with a Material Subcontractor or upon receiving notification from the Material Subcontractor of its intent to terminate such Subcontract.	Transition, Operations, Turnover	Each calendar day of non-compliance.	HHSC may assess up to \$5,000 per calendar day of non-compliance.
4.1	Contract Attachment B-1, RFP §§ 6, 7, 8 and 9 UCMC	All reports as specified in Sections 6, 7, 8 and 9 of Attachment B-1 must be submitted according to the requirements stated in the Contract (including all attachments) and the UCMC.	Transition Period, Quarterly during Operations Period	Per incident of noncompliance, per Medicaid Dental Contractor, per Service Area.	HHSC may assess up to \$1,000 if the report is not submitted in the format/template required by HHSC.
Item 4.1 added by Version 1.8					
4.2	Contract Attachment A, "Uniform Managed Care Contract Terms and Conditions", Section 7.07 HIPAA and Article 11	The Dental Contractor must meet all privacy and security standards under applicable state or federal law, rule, regulation and HHSC contract requirement.	Transition Period, Quarterly during Operations Period	Per violation	Privacy: HHSC may assess up to \$5,000 per reporting period for each privacy violation of applicable federal or state law or the HHSC privacy standards in the contract.  Security: HHSC may assess up to \$1,000 per reporting period for each security violation of security requirements under federal or state law or the HHSC security standard in the contract.
Item 4.2 added by Version 1.11					
4.3	Contract Attachment A,	The Dental Contractor must meet all confidentiality standards, under	Transition Period, Quarterly during	Per privacy/security incident	HHSC may assess up to \$5,000 per reporting for each breach by

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – Medicaid/CHIP Dental Services RFP, Dental Services Deliverables/Liquidated Damages Matrix**

Version 1.12

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
	"Uniform Managed Care Contract Terms and Conditions", Section 7.07 HIPAA and Article 11	applicable state or federal law, rule, regulation and HHSC contract requirement.	Operations Period		Dental Contractor scenario as required by HHSC.
	Item 4.3 added by Version 1.11				
4.4	Contract Attachment A, "Uniform Managed Care Contract Terms and Conditions", Section 7.07 HIPAA and Article 11	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 Period, Quarterly during Operations Period	Per, violation of breach notification and/or response standards of an actual or suspected privacy breach which may or actually requires notification to HHSC, an individual, the press and/or a federal regulatory body; or may require appropriate mitigation and/or remediation activity.	HHSC may assess up to \$1,000 per day for each Dental Contractor violation of breach notice, breach response standard for each violation and/or for each privacy violation impacting an individual according to applicable federal or state breach notification law or the HHSC breach notification and response standards in the contract.
	Item 4.4 added by Version 1.11				
5.	RFP §1.2, Procurement Schedule	The Dental Contractor must be operational no later than the Operational Start Date. HHSC will determine when the Dental Contractor is operational based on the requirements in Section 7.	Transition	Each calendar day of non-compliance.	HHSC may assess up to \$10,000 per calendar day/per Program for each day beyond the Operational Start Date that the Dental Contractor is not operational until the day that the Dental Contractor is operational, including all

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – Medicaid/CHIP Dental Services RFP, Dental Services Deliverables/Liquidated Damages Matrix**

Version 1.12

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
					systems.
6.	RFP §7.2.4, Financial Readiness Review	The Dental Contractor must submit a Financial Update Report no later than 60 days prior to the Operational Start Date.	Transition	Per calendar day of non-compliance	HHSC may assess up to \$1,000 per calendar day the report is not submitted, late, inaccurate, or incomplete.
Item 6 modified by Version 1.4					
7.	RFP §7.2.6, Systems Readiness Review; RFP §8.1.12.2, Deliverables Related to MIS Requirements;  Uniform Managed Care Manual (UMCM) Chapters 5.0, 5.2, and 7.1	The Dental Contractor must submit the MIS plans and checklists to HHSC no later than 120 days prior to the Operational Start Date, and thereafter according to the format and schedule identified in §8.1.12.2.	Transition, Operations	Each calendar day of non-compliance, per report.	HHSC may assess up to \$1,000 per calendar day for each day a deliverable is not submitted, late, inaccurate, or incomplete.
Item 7 modified by Version 1.4					
8.	Attachment B-1, RFP Sections 7.2.8. 1 and 8.1.13	The Dental Contractor must submit or comply with the requirements of the HHSC-approved Fraud and Abuse Compliance Plan.	Transition, Operations, and Turnover	Each incident of noncompliance, per Dental Contractor Program	HHSC may assess up to \$1,000 per calendar day/per Program for each incident of noncompliance.
Item 8 modified by Versions 1.7 and 1.10					

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – Medicaid/CHIP Dental Services RFP, Dental Services Deliverables/Liquidated Damages Matrix**

Version 1.12

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
9.	Attachment B-1, Section 8.1.3 Access to Care UMCM Chapter 5.14 Geo- Mapping	The Dental Contractor must comply with the contract's mileage standards and benchmarks for member access.	Quarterly	Per incident of noncompliance, Service Area, and Provider type	HHSC may assess up to \$1,000 per quarter, per Service Area, and per Provider type.
Item 9 added by Version 1.6					
9.1	RFP §8.1.4 Provider Network UMCM Chapter 5.38 Out of Network Utilization Report	No more than 20 percent of total dollars billed to a Dental Contractor for "other outpatient services" may be billed by out-of-network providers.	Medicaid OON Utilization Measured Quarterly beginning March 1, 2012.  CHIP OON Utilization Measured Quarterly beginning September 1, 2015.	Per incident of non-compliance, per Medicaid or CHIP Dental Contractor, per Service Area.	HHSC may assess up to \$25,000 per quarter, per Medicaid or CHIP Dental Contractor, per Service Area.
Item 9.1 added by Version 1.7 and modified by Version 1.10					
10.	RFP §8.1.5.8, Provider Hotline	A. The Dental Contractor must operate a separate toll-free Provider telephone hotline for Provider inquiries from 8 a.m. -5 p.m., local time throughout the State, Monday through Friday, excluding State-approved holidays.  B. The Provider Hotline must be	Operations and Turnover	A. Each incident of non-compliance.  B. Each incidence of non-compliance.  C. Per month, each percentage point below the standard	A. Up to \$100 per hour may be assessed for each hour or portion thereof that appropriately staffed toll-free lines are not operational.  B. Up to \$100 per incident may be assessed for each occurrence that HHSC

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – Medicaid/CHIP Dental Services RFP, Dental Services Deliverables/Liquidated Damages Matrix**

Version 1.12

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
		<p>staffed with personnel who are knowledgeable about the Dental Program.</p> <p>C. Performance Standards:</p> <ol style="list-style-type: none"> <li>1. Call pickup rate – At least 99% of calls are answered on or before the fourth ring or an automated call pick up system is used.</li> <li>2. No more than one percent (1%) of incoming calls receive a busy signal.</li> <li>3. Call hold rate – The average hold time is two (2) minutes or less.</li> <li>4. Call abandonment rate – Call abandonment rate is seven percent (7%) or less.</li> </ol>		<p>for 1 and 2, and each percentage point above standard for 3.</p>	<p>identifies through its recurring monitoring processes that toll-free line staff were not knowledgeable of the Dental Program.</p> <p>C. For each Program, up to \$100 may be assessed for each percentage point for each standard that the Dental Contractor fails to meet the requirements for a monthly reporting period for any toll-free lines.</p>
11.	<p>RFP §8.1.5.9, Provider Reimbursement ; RFP §8.1.12.5, Claims Processing; and UMCM Chapter 2</p>	<p>For a Clean Claim not adjudicated within 30 days of receipt by the Dental Contractor, the Dental Contractor must pay the provider interest at 18% per annum, calculated daily for the full period in which the Clean Claim remains unadjudicated beyond the 30-day claims processing deadline. Interest owed to the provider must be paid on the same date as the claim.</p>	<p>Operations, Turnover</p>	<p>Per incident of non-compliance.</p>	<p>HHSC may assess up to \$1,000 per claim if the Dental Contractor fails to pay interest timely.</p>
<p>Item 11 modified by Versions 1.4 and 1.8</p>					

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – Medicaid/CHIP Dental Services RFP, Dental Services Deliverables/Liquidated Damages Matrix**

Version 1.12

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
12.	RFP §8.1.5.9, Provider Reimbursement ;RFP §8.1.12.5, Claims Processing; and UMCM Chapter 2	The Dental Contractor must comply with the claims processing requirements and standards as described in the Scope of Work.	Operations, Turnover	Per quarterly reporting period.	HHSC may assess liquidated damages of up to \$5,000/per Program for the first quarter the Dental Contractor's Aggregated Claims Performance percentages falling below the performance standards. HHSC may assess up to \$25,000/per Program per quarter for each additional quarter that the Aggregated Claims Performance percentages fall below the performance standards.
13.	RFP §8.1.6.1 Member Materials	No later than the fifth (5 <sup>th</sup> ) Business Day following the receipt of the enrollment file from the HHSC Administrative Services Contractor, the Dental Contractor must mail a Member's ID card and Member Handbook to the Account Name or Case Head for each new Member. When the Account Name or Case Head is on behalf of two (2) or more new Members, only one (1) Member Handbook must be sent.	Transition, Operations, Turnover	Each incident that materials are not mailed to the Account Name	HHSC may assess up to \$500 per incident of the Dental Contractor's failure to mail Member Materials to the Account Name or Case Head for each New Member.
13.1	Contract Attachment B-1, RFP §8.1.7 Marketing & Prohibited	The Dental Contractor must meet all Marketing and Member Materials policy requirements and may not engage in prohibited Marketing practices.	Transition, Measured Quarterly during the Operations Period	Per incident of noncompliance.	HHSC may assess up to \$1,000 per incident of noncompliance.

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – Medicaid/CHIP Dental Services RFP, Dental Services Deliverables/Liquidated Damages Matrix**

Version 1.12

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
	Practices UMCM Chapter 4				
	Item 13.1 added by Version 1.11				
13.2	Contract Attachment B-1, RFP §8.1.7 Marketing & Prohibited Practices  UMCM Chapter 4.13	The Dental Contractor must meet all Social Media policy requirements and may not engage in any prohibited Social Media practices.	Ongoing	Per incident of noncompliance	HHSC may assess up to \$500 per business day for each incident of noncompliance.
	Item 13.2 added by Version 1.11				
14.	RFP §8.1.6.6 Member Hotline	<p>A. The Dental Contractor must operate a toll-free hotline that Members can call 24 hours a day, 7 days a week.</p> <p>B. The Member Hotline must be staffed with personnel who are knowledgeable about its Program between the hours of 8:00 a.m. to 5:00 p.m. local time throughout the State, Monday through Friday, excluding State-approved holidays.</p> <p>C. Performance Standards.</p> <p>1. At least 99 percent of calls</p>	Operations, Turnover	<p>A. Each incident of non-compliance.</p> <p>B. Each incident of non-compliance.</p> <p>C. Each percentage point below the standard for 1 and 2 and each percentage point above the standard for 3.</p>	<p>A. Up to \$100 per hour may be assessed for each hour or portion thereof that toll-free lines are not operational.</p> <p>B. Up to \$100 per incident may be assessed for each occurrence that HHSC identifies through its recurring monitoring processes that toll-free line staff were not sufficiently knowledgeable of its Program.</p> <p>C. For each Program, up to \$100 may be assessed for each</p>

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – Medicaid/CHIP Dental Services RFP, Dental Services Deliverables/Liquidated Damages Matrix**

Version 1.12

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
		<p>are answered by the fourth ring or an automated call pick-up system;</p> <p>2. No more than one percent (1%) of incoming calls receive a busy signal;</p> <p>3. At least 80% of calls must be answered by toll-free line staff within 30 seconds measured from the time the call is placed in queue after selecting an option;</p> <p>4. The call abandonment rate is seven percent (7%) or less; and</p> <p>5. Average hold time is two (2) minutes or less.</p>			percentage point for each standard that the Dental Contractor fails to meet the requirements for a monthly reporting period for any toll-free lines.
15.	RFP §8.1.11.1, Financial Reporting Requirements	For each Program, the Dental Contractor must file four (4) quarterly and two (2) annual FSRs for each complete State Fiscal Year, in the format and timeframe specified by HHSC in UMCM Chapter 5.3.1.	Operations, Turnover	Per calendar day of non-compliance.	HHSC may assess up to \$1,000 per calendar day/per Program a quarterly or annual report is not submitted, late, inaccurate, or incomplete.
Item 15 modified by Version 1.4					
16.	RFP §8.1.11.1 Financial Reporting Requirements; 8.1.14.2, Reports; UMCM Chapters	<p>Claims Lag Report must be submitted by the last day of the month following the reporting period.</p> <p>The Dental Contractor must submit quarterly Claims Summary Reports, separated by Program, to HHSC or its</p>	Operations, Turnover	Per calendar day of non-compliance.	HHSC may assess up to \$1,000 per calendar day/per Program the report is not submitted, late, inaccurate, or incomplete.

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – Medicaid/CHIP Dental Services RFP, Dental Services Deliverables/Liquidated Damages Matrix**

Version 1.12

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
	5.6.2 and 5.6.1.4 Item 16 modified by Version 1.4	designee by the 30 <sup>th</sup> day following the end of the reporting period unless otherwise specified.			
17.	RFP §8.1.11.1, Financial Reporting Requirements Item 17 modified by Version 1.4	Financial Disclosure Report: an annual submission no later than 30 days after the end of each calendar year; and update after any change, no later than 30 days after the change.	Operations, Turnover	Per calendar day of non-compliance	HHSC may assess up to \$1,000 per calendar day the report is not submitted, late, inaccurate, or incomplete.
18.	RFP §8.1.11.1, Financial Reporting Requirements Item 18 modified by Version 1.4	Affiliate Report: on an as-occurs basis and annually by August 31 <sup>st</sup> of each year in accordance with the UMCM. The “as-occurs” update is due within 30 days of the event triggering the change.	Operations, Turnover	Per calendar day of non-compliance	HHSC may assess up to \$1,000 per calendar day the report is not submitted, late, inaccurate, or incomplete.
19.	RFP §8.1.11.1, Financial Reporting Requirements Item 19 modified by Versions 1.4 and 1.10	TDI Examination Report: furnish HHSC with a full and complete copy of any TDI Examination Report issued by TDI no later than 10 calendar days after receipt of the final version from TDI	Operations, Turnover	Per calendar day of non-compliance	HHSC may assess up to \$1,000 per calendar day the report is not submitted, late, inaccurate, or incomplete.
20.	RFP §8.1.11.1, Financial Reporting Requirements Item 20 modified by Versions 1.4 and 1.8	TDI Financial Filings: Submit copies to HHSC of reports submitted to TDI.	Operations, Turnover	Per calendar day of non-compliance	HHSC may assess up to \$500 per calendar day the report is not submitted, late, inaccurate, or incomplete.

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – Medicaid/CHIP Dental Services RFP, Dental Services Deliverables/Liquidated Damages Matrix**

Version 1.12

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
21.	RFP §8.1.11.1, Financial Reporting Requirements	Filings with Other Entities, and Other Annual Financial Reports: submit an electronic copy of the reports or filings pertaining to the Dental Contractor, or its parent, or its parent's parent.	Operations, Turnover	Per calendar day of non-compliance	HHSC may assess up to \$500 per calendar day the report is not submitted, late, inaccurate, or incomplete.
	Item 21 modified by Versions 1.4 and 1.8				
22.	RFP §8.1.11.1, Financial Reporting Requirements; UMCM Chapter 5.3.11	Audit Reports - comply with UMCM requirements regarding notification and/or submission of audit reports.	Operations,	Per calendar day of non-compliance	HHSC may assess up to \$500 per calendar day the report is not submitted, late, inaccurate, or incomplete.
	Item 22 modified by Version 1.4				
23.	RFP §8.1.11.1, Financial Reporting Requirements; UMCM Chapter 5.8	Report of Legal and Other Proceedings, and Related Events - comply with UMCM requirements regarding the disclosure of certain matters involving the Dental Contractor, its Affiliates, and/or its Material Subcontractors, as specified. This requirement is both on an as-occurs basis, and an annual report due each August 31st.	Transition, Operations,	Per calendar day of non-compliance	HHSC may assess up to \$1,000 per calendar day the report is not submitted, late, inaccurate, or incomplete.
	Item 23 modified by Version 1.4				
24.	RFP §8.1.11.1, Financial Reporting Requirements	Employee Bonus and/or Incentive Payment Plan, Registration Statement (aka "Form B"), and Third Party Recovery (TPR) Reports.	Operations	Per calendar day of non-compliance	HHSC may assess up to \$500 per calendar day the report is not submitted, late, inaccurate, or incomplete.

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – Medicaid/CHIP Dental Services RFP, Dental Services Deliverables/Liquidated Damages Matrix**

Version 1.12

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
Item 24 modified by Versions 1.4 and 1.8					
25.	RFP §8.1.12, Management Information System Requirements (MIS)	The Dental Contractor's MIS system must meet all requirements in Section 8 Scope of Work.	Operations, Turnover	Per calendar day of non-compliance	HHS may assess up to \$5,000 per calendar day of non-compliance.
26.	Contract Attachment B-1, RFP §8.1.12.1 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 calendar day after the last day of the month in which the claim(s) are adjudicated.	Measured Quarterly during Operations Period	Per incident of non-compliance, per Dental Contractor Program	Liquidated Damages: a) Failure to submit Encounter Data: 1. HHSC may assess up to \$2,500 per month, per Program if the Dental Contractor fails to submit encounter data in a quarter. 2. HHSC may assess up to \$5,000 per month, per Program for each month in any subsequent quarter that the Dental Contractor fails to submit Encounter Data. b) Encounter Data Reconciliation: Additionally, HHSC may assess up to \$2,500 per Quarter, per Program if the Dental Contractor is not within the 2% variance. HHSC may assess up to \$5,000 per Quarter, per Program for each
Item 26 added by Version 1.4 and modified by Versions 1.8 and 1.10		Additionally, 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 (FSR) to the appropriate paid dollars reported in the Vision 21 Data Warehouse) includes more than a 2% variance.			

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – Medicaid/CHIP Dental Services RFP, Dental Services Deliverables/Liquidated Damages Matrix**

Version 1.12

#	Service/Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
					additional Quarter that the Dental Contractor is not within the 2% variance.
27.	RFP §8.1.12.2, Deliverables Related to MIS Requirements	The Dental Contractor’s MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan.	Operations, Turnover	Per calendar day of non-compliance.	HHSC may assess up to \$5,000 per calendar day of non-compliance.
28.	Attachment B-1, RFP Section 8.1.13	The Dental Contractor must respond to Office of Inspector General request for information in the manner and format requested.	Transition, Operations, and Turnover	Each calendar day of noncompliance, per Dental Contractor Program.	HHSC may assess up to \$1,000 per calendar day/per Program, that the report is not submitted, late, inaccurate, or incomplete. This amount will increase to \$5,000 per day per MCO program for the fourth and each subsequent occurrence within a 12-month period.
	Item 28 modified by Versions 1.4 and 1.10				
28.1	Attachment B-1, RFP Section 8.1.19	The Dental Contractor must respond to Office of Inspector General request for payment hold amounts accurately and in the manner and format requested.	Transition, Operations, and Turnover	Per instance of noncompliance, per Dental Contractor Program.	HHSC may assess up to the difference between the amount required to be reported by the Dental Contractor under Chapter 5.5 of the UCM and the amount received by HHSC OIG.
	Item 28.1 added by Version 1.10				
28.2	Attachment B-1, RFP Section 8.1.19	The Dental Contractor fails to hold or improperly releases funds subject to a payment hold.	Transition, Operations, and Turnover	Per instance of noncompliance, per Dental Contractor	HHSC may assess up to the amount not held or released improperly.
	Item 28.2 added by Version 1.10				

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – Medicaid/CHIP Dental Services RFP, Dental Services Deliverables/Liquidated Damages Matrix**

Version 1.12

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
28.3	Attachment B-1, RFP Section 8.1.19.2	The Dental Contractor fails to submit claims data as prescribed by OIG.	Transition, Operations, and Turnover	Each instance of noncompliance, per Dental Contractor	HHSC may assess up to \$1,000 per calendar day, per Dental Contractor Program, that the report is not submitted, late, inaccurate, or incomplete. This amount will increase to \$5,000 per day per Dental Contractor program for the fourth and each subsequent occurrence within a 12-month period.
Item 28.3 added by Version 1.10					
28.4	Attachment B-1, RFP Section 8.1.19	The Dental Contractor must perform pre-payment review for identified providers as directed by OIG.	Transition, Operations, and Turnover	Each instance of noncompliance, per Dental Contractor Program	Failure to impose pre-payment review on a provider(s) as directed by OIG within 10 business days of receiving the request. \$1,000 per day, per program
Item 28.4 added by Version 1.12					
29.	Attachment B-1, RFP Section 8.1.14.2, UCMC Chapter 5.5	The Dental Contractor must submit a Fraudulent Practices Report to the HHSC-OIG within 30 Business Days of receiving a report of possible Fraud, Waste, or Abuse from the Dental Contractor's Special Investigative Unit (SIU).	Transition, Operations, and Turnover	Each calendar day of noncompliance, per Dental Contractor Program.	HHSC may assess up to \$1,000 per calendar day/per Program, that the report is not submitted, late, inaccurate, or incomplete. This amount will increase to \$5,000 per day per MCO program for the fourth and each subsequent occurrence within a 12-month period.
Item 29 modified by Versions 1.4, 1.5, 1.7, and 1.10					
		The Dental Contractor must submit monthly MCO Open Case List Reports.			
30.	RFP §8.1.14.2 Reports	(a) Frew Quarterly Monitoring Report – The Dental Contractor must submit	(a) Quarterly  (b) Annually	Each calendar day of non-compliance.	HHSC may assess up to \$1,000 per calendar day the reports are

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – Medicaid/CHIP Dental Services RFP, Dental Services Deliverables/Liquidated Damages Matrix**

Version 1.12

#	Service/Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
	UMCM Chapter 12 Frew  Item 30 modified by Versions 1.2, 1.4, 1.10, and 1.12	<p>each quarter responses to questions on this report's template addressing the status of Frew Consent Decree paragraphs for Medicaid.</p> <p>(b) Children of Migrant Farmworkers Annual Plan – The Dental Contractor must submit an annual plan that describes how the Dental Contractor will identify and provide accelerated services to Children of Migrant Farmworkers who are enrolled in Medicaid.</p> <p>(c) Children of Migrant Farmworkers Annual Report – The Dental Contractor must submit an annual report that summarizes the Dental Contractor's migrant efforts as stated in its Children of Migrant Farmworkers Annual Plan for Medicaid.</p>	(c) Annually		not submitted, late, inaccurate, or incomplete.
31.	RFP §8.2.3.1, Provider Complaints Process; §8.3.1.1, Complaints from Providers	<p>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.</p> <p>The Dental Contractor also must resolve Provider Complaints received by HHSC no later than the due date indicated on HHSC's notification form.</p>	Operations, Turnover	Per reporting period.	<p>HHSC may assess up to \$250 per reporting period if the Dental Contractor fails to meet the performance standard.</p> <p>HHSC may assess up to \$250 per HHSC-referred complaint that is not resolved by the due date indicated on HHSC's notification form.</p>

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
32.	RFP §8.2.3.2, Appeal of Provider Claims Process; §8.3.1.2, Appeal of Provider Claims	The Dental Contractor must resolve at least 98% of the Provider Appeals within 30 calendar days from the date the Appeal is filed with the Dental Contractor.	Operations, Turnover	Per reporting period.	HHSC may assess up to \$5,000 per reporting period if the Dental Contractor fails to meet the performance standard.
Item 32 modified by Version 1.8					
33.	RFP §8.2.5.1, Member Complaints Process; §8.3.2, CHIP Member Complaints and Appeals Process	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.  The Dental Contractor also must resolve Member Complaints received by HHSC no later than the due date indicated on HHSC's notification form.	Operations, Turnover	Per reporting period.	HHSC may assess up to \$250 per reporting period if the Dental Contractor fails to meet the performance standard.  HHSC may assess up to \$250 per HHSC-referred complaint that is not resolved by the due date indicated on HHSC's notification form.
34.	RFP §8.2.5.1, Member Complaints Process; §8.3.2, CHIP Member Complaints and Appeals Process	The Dental Contractor must resolve at least 98% of the Member Appeals within 30 calendar days from the date the Appeal is filed with the Dental Contractor.	Operations, Turnover	Per reporting period.	HHSC may assess up to \$500 per reporting period if the Dental Contractor fails to meet the performance standard.
34.1	Contract Attachment B-1, RFP §§ 6, 7, 8	The Dental Contractor must ensure that the appropriate staff members who have firsthand knowledge of the Member's appeal in order to be able	Transition Period, Quarterly during Operations	Per incident of noncompliance	HHSC may assess up to \$1000 for each State Fair Hearing that the Dental Contractor fails to attend as

Responsible Office: HHSC Office of General Counsel (OGC)

**Subject: Attachment B-3 – Medicaid/CHIP Dental Services RFP, Dental Services Deliverables/Liquidated Damages Matrix**

Version 1.12

#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
	and 9 8.2.6.4 Access to Fair Hearing for Medicaid Members	to speak and provide relevant information on the case attend all State Fair Hearings as scheduled.	Period		required by HHSC.
	Item 34.1 added by Version 1.11				
35.	RFP §9.3, Transfer of Data and Information	The Dental Contractor must provide all Turnover data, information and services in the media and format specified by HHSC, and in accordance with the schedule set forth in the HHSC-approved Turnover Plan.	Measured at Time of Transfer of Data and ongoing after the Transfer of Data until satisfactorily completed	Per incident of non- compliance (failure to provide data and/or failure to provide data in required format).	HHSC may assess up to \$10,000 per calendar day the data is not submitted, late, inaccurate, or incomplete.
	Item 35 modified by Version 1.4 and 1.7				
36.	RFP §9.4, Turnover Services	Twelve months prior to the end of the Contract Period, including any extensions, the Dental Contractor must revise its Turnover Plan. 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 six months prior to the termination date.	Measured at Twelve Months prior to the end of the Contract Period or any extension thereof and ongoing until satisfactorily completed	Each calendar day of non-compliance.	HHSC may assess up to \$1,000 per calendar day the Plan is not submitted, late, inaccurate, or incomplete.
	Item 36 modified by Versions 1.4 and 1.10				
37.	RFP §9.5, Post- Turnover Services	Thirty days following Turnover of operations, the Dental Contractors must provide HHSC with a Turnover Results Report documenting the	Turnover	Each calendar day of non-compliance.	HHSC may assess up to \$250 per calendar day the report is not submitted, late, inaccurate, or incomplete.
	Item 37 modified by Version 1.4				

Responsible Office: HHSC Office of General Counsel (OGC)

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Version 1.12

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#	Service/ Component <sup>1</sup>	Performance Standard <sup>2</sup>	Measurement Period <sup>3</sup>	Measurement Assessment <sup>4</sup>	Liquidated Damages
		completion and results of each step of the Turnover Plan. Turnover will not be considered complete until this document is approved by HHSC.			