RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

October 16, 2017

Prospective Vendor(s):

Subject: Solicitation Number: AHCA ITN 012–17/18

Title: Statewide Medicaid Prepaid Dental Health Program

This solicitation is being issued by the State of Florida, Agency for Health Care Administration, hereinafter referred to as "**AHCA**" or "**Agency**", to select a vendor to provide Statewide Medicaid Prepaid Dental Health Program services. The solicitation package consists of this transmittal letter and the following attachments, exhibits, and appendices:

Attachment	**A**	Instructions and Special Conditions
Exhibit	**A-1**	Questions Template
Exhibit	**A-2-a**	Qualification of Plan Eligibility
Exhibit	**A-2-b**	Additional Required Certifications and Statements
Exhibit	**A-3-a**	Milliman Organizational Conflict of Interest Mitigation Plan
Exhibit	**A-3-b**	Milliman Employee Organizational Conflict of Interest Affidavit
Exhibit	**A-4**	Submission Requirements and Evaluation Criteria Instructions
Exhibit	**A-4-a**	Submission Requirements and Evaluation Criteria
Exhibit	**A-4-a-1**	SRC# 10 – Dental Quality Measurement Tool
Exhibit	**A-4-a-2**	SRC# 15 – Expanded Benefits Tool
Exhibit	**A-4-a-3**	SRC# 36 – Provider Network Agreements
Exhibit	**A-5**	Summary of Respondent Commitments
Exhibit	**A-6**	Certification of Drug-Free Workplace Program
Exhibit	**A-7**	Standard Contract
Attachment	**B**	Scope of Service - Core Provisions
Attachment	**C**	Data Book, Cost Proposal Instructions, and Rate Methodology Narrative
Appendix	**I**	Prepaid Dental Health Program Data Book Database
Appendix	**II**	Prepaid Dental Health Program Data Book Summary Exhibits
Appendix	**III**	Prepaid Dental Health Program Data Book Supplemental Information
Appendix	**IV**	Prepaid Dental Health Program Cost Proposal Template

Your response must comply fully with the instructions that stipulate what is to be included in the response. Respondents submitting a response to this solicitation shall identify the solicitation number, date and time of opening on the envelope transmitting their response. This information is used only to put the Agency mailroom on notice that the package received is a response to an Agency solicitation and therefore should not be opened, but delivered directly to the Procurement Officer.

The designated Agency Procurement Officer for this solicitation is the undersigned. All communications from respondents shall be made in writing and directed to my attention at the address provided in **Attachment A,** Instructions and Special Conditions, **Section A.,** Overview, **Sub-Section 5.,** Procurement Officer unless otherwise instructed in this solicitation.

The term “Proposal”, “Response” or “Reply” may be used interchangeably and mean the respondent’s submission to this solicitation.

Section 120.57(3)(b), Florida Statutes and Section 28-110.003, Florida Administrative Code require that a Notice of Protest of the solicitation documents shall be made within seventy-two hours after the posting of the solicitation. Failure to file a protest within the time prescribed in Section 120.57(3), Florida Statutes, shall constitute a waiver of proceedings under Chapter 120, Florida Statutes.

Sincerely,
Jennifer Barrett
Jennifer Barrett, Chief
Bureau of Support Services

ATTACHMENT A
INSTRUCTIONS AND SPECIAL CONDITIONS

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ATTACHMENT A
INSTRUCTIONS AND SPECIAL CONDITIONS

A. Overview

1. Solicitation Number

AHCA ITN 012-17/18

2. Solicitation Type

Invitation to Negotiate

3. Solicitation Title

Statewide Medicaid Prepaid Dental Health Program

4. Date of Issuance

October 16, 2017

5. Procurement Officer

Jennifer Barrett
Agency for Health Care Administration
Building 2, Suite 203, Mail Stop 15
2727 Mahan Drive
Tallahassee, FL 32308-5403
Email: solicitation.questions@ahca.myflorida.com

6. Solicitation Timeline

The projected solicitation timeline is shown below (all times are Eastern Time). The Agency for Health Care Administration (Agency) reserves the right to amend the timeline in the State's best interest. If the Agency finds it necessary to change any of the activities/dates/times listed, all interested parties will be notified by addenda to the original solicitation document posted on the Vendor Bid System (VBS) (http://myflorida.com/apps/vbs/vbs_www.main_menu).

ACTIVITY	DATE/TIME	LOCATION
Solicitation Issued by Agency	October 16, 2017	Electronically Posted http://myflorida.com/apps/vbs/vbs_www.main_menu
Deadline for Receipt of Written Questions	November 13, 2017 2:00 p.m.	solicitation.questions@ahca.myflorida.com
Anticipated Date for Agency Responses to Written Questions	December 11, 2017 2:00 p.m.	Electronically Posted http://myflorida.com/apps/vbs/vbs_www.main_menu

ATTACHMENT A
INSTRUCTIONS AND SPECIAL CONDITIONS

ACTIVITY	DATE/TIME	LOCATION
Deadline for Receipt of Responses	January 12, 2018 9:00 a.m.	Jennifer Barrett Agency for Health Care Administration 2727 Mahan Drive, Building 2 Mailroom, 1st Floor, Suite 1500 Tallahassee, FL 32308-5403
Public Opening of Responses	January 12, 2018 3:00 p.m.	Agency for Health Care Administration 2727 Mahan Drive, Building 2 Operations Conference Room, 2nd Floor, Suite 200 Tallahassee, FL 32308-5403
Anticipated Dates for Negotiations	May 1, 2018 through May 31, 2018	Agency for Health Care Administration 2727 Mahan Drive, Building 2 Operations Conference Room, 2nd Floor, Suite 200 Tallahassee, FL 32308-5403
Anticipated Posting of Notice of Intent to Award	June 1, 2018	Electronically Posted http://myflorida.com/apps/vbs/vbs_www.main_menu

7. PUR 1000, General Contract Conditions

PUR 1000, General Contract Conditions, is incorporated by reference and is available for prospective respondents to download at:

http://www.dms.myflorida.com/content/download/2933/11777/version/6/file/1000.pdf

8. PUR 1001, General Instructions to Respondents

PUR 1001, General Instructions to Respondents, is incorporated by reference and is available for prospective respondents to download at:

http://www.dms.myflorida.com/content/download/2934/11780/1001.pdf

Unless otherwise noted, instructions in this **Attachment A** shall take precedence over the PUR 1001, General Instructions to Respondents.

9. Restriction on Communications

Respondents to this solicitation or persons acting on their behalf may not contact, between the release of this solicitation and the end of the seventy-two (72) hour period following the Agency posting the notice of intended award, excluding Saturdays, Sundays, and State holidays, any employee or officer of the executive or legislative branch concerning any aspect of this solicitation, except in writing to the Procurement Officer or as provided in this solicitation. Violation of this provision may be grounds for rejecting a response. See Section 287.057(23), Florida Statutes.

10. Respondent Questions

a. The Agency will receive all questions pertaining to this solicitation no later than the date and time specified for written questions in **Section A.,** Overview, **Sub-Section 6.,** Solicitation Timeline.

b. Prospective respondents must submit all questions by email at solicitation.questions@ahca.myflorida.com, utilizing **Exhibit A-1**, Questions Template. **Exhibit A-1**, Questions Template, is a Microsoft Excel document and is available for prospective respondents to download at:

http://ahca.myflorida.com/procurements/index.shtml.

c. The Agency will not accept questions by telephone, surface mail, hand delivery or fax.

d. The Agency's response to questions received will be posted as an addendum to this solicitation as specified in **Section A.,** Overview, **Sub-Section 6.,** Solicitation Timeline and may be grouped as to not repeat the same answer multiple times.

e. The Agency reserves the right to post an addendum to this solicitation in order to address questions received after the written question submission deadline. It is the sole discretion of the Agency to consider questions received after the written questions submission deadline.

11. Solicitation Addenda

If the Agency finds it necessary to supplement, modify, or interpret any portion of this solicitation during this solicitation period, a written addendum will be posted on the VBS as addenda to this solicitation. It is the respondent's responsibility to check the VBS periodically for any information or updates to this solicitation. The Agency bears no responsibility for any resulting impacts associated with a prospective respondent's failure to obtain the information made available through the VBS.

12. Public Opening of Responses

Responses shall be opened on the date, time and at the location indicated in **Section A.,** Overview, **Sub-Section 6.,** Solicitation Timeline. Respondents may, but are not required to, attend. The Agency will only announce the respondent(s) name at the public opening. Pursuant to Section 119.071(1)(b), Florida Statutes, no other materials will be released. Any person requiring a special accommodation because of a disability must contact the Procurement Officer at least five (5) business days prior to this solicitation opening. If you are hearing or speech impaired, contact the Agency by using the Florida Relay Service at (800) 955-8771 (TDD).

13. Program Overview

The State of Florida has offered Medicaid services since 1970. Medicaid is funded by both the State and federal government to provide health care coverage for eligible children, seniors, disabled adults, parents of children and pregnant women. The annual budget for the program is more than $25 billion, and makes up the largest part of the total Florida budget. More than 3.2 million Floridians are enrolled in Florida's Statewide Medicaid Managed Care (SMMC) program. In 2016, the Florida Legislature directed the Agency for Health Care Administration to implement a statewide Medicaid prepaid dental program by no later than March 1, 2019.

14. Program Objectives and Goals

The purpose of this solicitation is to procure up to four (4) Contracts to provide services under the Statewide Medicaid Prepaid Dental Health Program. The Agency's overall objective is for Medicaid enrollees to receive all medically necessary dental services in a timely manner and in accordance with the periodicity schedule, thereby achieving the best possible quality outcomes.

The Agency intends to award Contracts to nationally accredited prepaid dental health plans that offer quality-driven provider networks, streamlined processes that enhance the enrollee and provider experience, expanded benefits targeted to improve dental outcomes for enrollees, top quality scores, and high rates of enrollee satisfaction to deliver an efficient, high-quality, innovative, cost-effective, and integrated health care delivery model.

In addition to the objectives stated above, the Agency intends to award Contracts to dental health plans that offer innovative and evidence-based approaches in meeting the following goals under the Medicaid program:

- Reduce potentially preventable dental-related hospital events; and
- Improve access to preventive dental services.

15. Definitions

The following terms, as used in this **Attachment A**, are defined as:

a. **Balance Sheet** – Statement of total assets, liabilities and net worth at the end of the audit period(s).

b. **Cash Flow Statement(s)** – Statement(s) that reflect the inflow of revenue versus the outflow of expenses resulting from operating, investing, and financing activities during the audit period(s).

c. **Contract Execution** – The date that the resulting Contract is signed by the Agency Secretary, or designee.

d. **Dental Care Services** – As defined in **Attachment B**, Scope of Service – Core Provisions.

e. **Respondent** – Also referred to as Vendor/vendor refers to respondents to this solicitation.

f. **Revenue and Expense Statement(s)** – Statement(s) of profit or loss (for not-for-profits it is the excess of revenues over expenses) during the audit period(s).

16. Type of Contract Contemplated

The Contracts resulting from this solicitation will be a fixed price (unit cost) Contract. The successful respondent (i.e., Prepaid Dental Health Plan) shall be paid by the Agency's fiscal agent pursuant to **Attachment B**, Scope of Service - Core Provisions, **Section XI.**, Method of Payment. The Agency intends that the statewide Contracts resulting from this solicitation will be a Prepaid Dental Health Plan. The selected vendor will be a health maintenance organization under Part 1 of Chapter 641, Florida Statutes, or qualified as a prepaid limited health service organization under Part I of Chapter 636, Florida Statutes, that is paid a prospective per-member-per-month capitation payment for covered services provided to eligible enrollees.

17. Term of Contract

a. Contract Term - The anticipated term of the resulting Contract shall be from the date of Contract execution through September 30, 2023.

b. Each October 1 through September 30 within the Contract term shall be defined as a Contract Year; however, the first Contract Year (Year 1) shall be defined as the date of Contract execution through September 30, 2019.

c. Pursuant to Section 409.973(5)(b), Florida Statutes, the Contract may not be renewed; however, the Agency may extend the resulting Contract(s) term to cover any delays during the transition to a new provider.

B. Response Preparation and Content

1. General Instructions

a. The instructions for this solicitation have been designed to help ensure that all responses are reviewed and evaluated in a consistent manner, as well as to minimize costs and response time.

b. The Agency has established certain requirements with respect to responses submitted to competitive solicitations. The use of "shall", "must", or "will" (except to indicate futurity) in this solicitation, indicates a requirement or condition from which a material deviation may not be waived by the Agency. A deviation is material if, in the Agency's sole discretion,

the deficient response is not in substantial accord with this solicitation's requirements, provides a significant advantage to one respondent over another, or has a potentially significant effect on the quality of the response or on the cost to the Agency. Material deviations cannot be waived. The words "should" or "may" in this solicitation indicate desirable attributes or conditions, but are permissive in nature. Deviation from, or omission of, such desirable features will not in and of itself cause rejection of a response.

c. Respondents shall not retype and/or modify required forms and must submit required forms in the original format. Required forms are available for respondents to download at:

http://ahca.myflorida.com/procurements/index.shtml.

d. A respondent shall not, directly or indirectly, collude, consult, communicate or agree with any other respondent, as to any matter related to the response each is submitting. Additionally, a respondent shall not induce any other respondent to submit or not to submit a response.

e. The costs related to the development and submission of a response to this solicitation is the full responsibility of the respondent and is not chargeable to the Agency.

f. Joint ventures and legal partnerships shall be viewed as one (1) respondent. However, all parties to the joint venture/legal partnership shall submit all mandatory attachments and documentation required by this solicitation from respondents, unless otherwise stated.

g. Pursuant to Section 287.133(2)(a), Florida Statutes, a person or affiliate who has been placed on the convicted Vendor list following a conviction for a public entity crime may not submit a Bid, Proposal, or Reply on a Contract to provide any goods or services to a public entity; may not submit a Bid, Proposal, or Reply on a Contract with a public entity for the construction or repair of a public building or public work; may not submit Bids, Proposals, or Replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a Contract with any public entity; and may not transact business with any public entity in excess of the threshold amount provided in Section 287.017, Florida Statutes for category two for a period of thirty-six (36) months following the date of being placed on the convicted Vendor list.

2. Mandatory Response Content

The respondent shall include the documents listed in this Sub-Section with the submission of the Original Response. Violation of this provision may result in the rejection a response.

a. Transmittal (Cover) Letter

1) This letter serves as the document covering transmittal of the response package and must include the following information:

- Respondent's name;
- Respondent's address;
- Respondent's Federal Employer Identification Number;
- The names of the respondent's official contact person and an alternate who have the authority to bind the respondent to a Contract, along with both individuals' title, address, telephone number, email address, and official signature. These individuals shall be available for contact by telephone and e-mail and be available to attend meetings, as needed; and
- A statement authorizing release of the redacted version of the response in the event the Agency receives a public records request.

b. Required Certifications and Statements

1) The respondent shall complete and submit **Exhibit A-2-a,** Qualification of Plan Eligibility. Each respondent shall certify its eligibility to provide services under the Statewide Medicaid Prepaid Dental Health Program (PDHP) pursuant to Section 409.783(5)(b), Florida Statutes.

2) The respondent shall complete and submit **Exhibit A-2-b,** Additional Required Certifications and Statements.

c. Milliman Organizational Conflict of Interest Mitigation Plan

1) The Agency has determined that in order to evaluate responses and negotiate a Contract that is in the best interests of the state, it is necessary to use the services of Milliman, Inc. ("Milliman") to act as an actuary and advisor throughout all states of the procurement process. The Agency reasonably anticipates that one or more prospective respondents may also use Milliman. The Agency has determined that all reasonably anticipated organizational conflicts of interest relating to its use of Milliman may be avoided by the mitigation plan described in **Exhibit A-3-a**, Milliman Organizational Conflict of Interest Mitigation Plan.

2) All respondents must review and submit **Exhibit A-3-a**, Milliman Organizational Conflict of Interest Mitigation Plan, certifying that they have read the mitigation plan and that they will directly and indirectly fully comply with the mitigation plan through all stages of the procurement. If a respondent is using Milliman for this

procurement, it must also submit **Exhibit A-3-b**, Milliman Employee Organizational Conflict of Interest Affidavit, completed by each identified Milliman personnel that will be assisting the respondent in the procurement.

d. Original Proposal Guarantee

1) The respondent's Original Response must be accompanied by an Original Proposal Guarantee payable to the State of Florida in the amount of **$1,000,000.00**. The proposal guarantee is a firm commitment the respondent shall, upon the Agency's acceptance of its response, execute such contractual documents as may be required within the time specified.

2) The respondent must be the guarantor. If responding as a joint venture/legal partnership, at least one party of the joint venture/legal partnership shall be the guarantor.

3) The proposal guarantee shall be in the form of a bond, cashier's check, treasurer's check, bank draft, or certified check. The Agency will not accept a letter of credit in lieu of the Proposal Guarantee.

4) All proposal guarantees will be returned upon execution of the legal Contract with the successful respondent and receipt of the performance bond required under this solicitation (See **Attachment B.,** Scope of Service – Core Provisions, **Section XV.**, Special Terms and Conditions, **Item W.**, Performance Bond).

5) If the successful respondent fails to execute a Contract within ten (10) consecutive calendar days after a Contract has been presented to the successful respondent for signature, the proposal guarantee shall be forfeited to the State.

6) The proposal guarantee must not contain any provisions that shorten the time from bringing an action to a time less than that provided by the applicable Florida Statute of Limitations (see Section 95.03, Florida Statutes)

e. Financial Information

The respondent shall submit the following financial information.

1) **Financial Statements** – The respondent shall submit its most recent audited financial statements prepared using Statutory Accounting Principles (SAP) for the past **three** (**3**) years as described in **Table 1**, Financial Statement Requirements, below, based upon one of the following entity types:

- An entity with at least three (3) years of financials
- A entity without three (3) years of its own financials

- An entity without three (3) years of its own financials and without a parent entity

Table 1 Financial Statement Requirements		
An entity with at least three (3) years of financials	**An entity without three (3) years of its own financials**	**An entity without three (3) years of its own financials and without a parent entity**
▪ The respondent's most recent audited financial statements for the past three (3) years. ▪ The respondent's National Association of Health Insurance Commissioners' annual Health Statement for the most recent three (3) years. ▪ The most recent audited financial statements for the past three (3) years of its parent entity or of individuals with five percent (5%) or more ownership interest, as applicable.	▪ The most recent audited financial statements of its parent entity for the past three (3) years. ▪ An organizational chart showing the relationship between the respondent and parent entity.	▪ The most recent audited financial statements for the past three (3) years of individuals with five percent (5%) or more ownership interest in the respondent as documented through the respondent's submission of a completed CMS-1513 Disclosure of Ownership and Control Interest Statement Form.

2) **Pro Forma Financial Statements** – The respondent shall provide the following pro forma financial statements for the respondent's Florida operation, broken down by line of business. The pro forma financial statements must be prepared on an accrual basis by month for the first three (3) years (or until profitable), beginning with the first month of recipient enrollment into the plan, assuming initial enrollment in October 2018, and include: (Note: October 2018 is provided as an initial enrollment date solely for the purpose of this item.)

a) A statement of monthly revenue and expenses based upon the anticipated plan enrollment in each region by the last month of the third year of operation;

b) A monthly cash flow analysis; and

c) A balance sheet for each month.

3) **Surplus** – The respondent shall describe and provide calculations used to demonstrate how it will fund the required surplus for the Prepaid Dental Health Plan. The required surplus must be in the form of assets allowable as admitted assets by the Office of Insurance Regulation (OIR), and restricted funds of deposits (Agency insolvency account, OIR restricted deposits), the greater of $1.5 million, ten percent (10%) total liabilities, or two percent (2%) annualized premiums. (Section 641.225, Florida Statutes)

4) **Insolvency Protection Account** – The respondent shall describe and provide calculations used to demonstrate how it will fund the Agency Insolvency Protection Account, as specified below. The Agency will evaluate the audited financial reports of the respondent and/or parent entity to determine the respondent's ability to fund the Agency Insolvency Protection Account. If funding for the Agency Insolvency Protection Account will come from a source other than the respondent or parent entity, the respondent shall indicate the source and provide an audit, bank statement, and/or bank letter demonstrating the ability to fund this requirement.

5) **Prepaid Dental Health Plan -** five percent (5%) of the estimated monthly capitation amount that would be paid to the successful respondent by the Agency each month until a maximum total of two percent (2%) of the annualized total Contract amount is funded. The respondent shall provide a calculation of the five percent (5%) estimate and indicate the anticipated source and method of funding this requirement.

f. Submission Requirements and Evaluation Criteria

1) Respondents shall comply with the instructions contained in **Exhibit A-4,** Submission Requirements and Evaluation Criteria Instructions.

2) Respondents shall complete and submit **Exhibit A-4-a,** Submission Requirements and Evaluation Criteria.

g. Cost Proposal and Cost Proposal Rate Sheets

1) The respondent shall complete and submit **Attachment C,** Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, including applicable appendices/exhibits. Instructions for completing the Cost Proposal are provided in **Attachment C**, Data Book, Cost Proposal Instructions, and Rate Methodology Narrative.

2) The respondent's cost proposal shall include all required rates and supporting information for all required eligibility groups. Reimbursement requirements that apply to the Prepaid Dental Health Plan are described in **Attachment B**, Scope of Service - Core Provisions, **Section XI.**, Method of Payment.

Certain reimbursement-related components will be established by the Agency, rather than subject to respondent bid and negotiation. Those components include items in **Attachment C,** Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, including applicable appendices/exhibits.

h. Summary of Respondent Commitments

The respondent shall complete and submit **Exhibit A-5,** Summary of Respondent Commitments, as part of its response in accordance with the instructions contained therein.

3. Additional Response Content

a. Certification of Drug-Free Workplace

The State supports and encourages initiatives to keep the workplace of Florida's suppliers and contractors drug free. Section 287.087, Florida Statutes provides that, where identical responses are received, preference shall be given to a response received from a respondent that certifies it has implemented a drug-free workplace program. If applicable, the respondent shall sign and submit **Exhibit A-6,** Certification of Drug-Free Workplace, to certify that the respondent has a drug-free workplace program.

C. Response Submission Requirements

1. Hardcopy and Electronic Submission Requirements

a. General Provision

Electronic submissions via MyFloridaMarketPlace will not be accepted for this solicitation.

b. Hardcopies of the Response

1) Original Response

The respondent shall submit **one (1)** Original Response. The Original Response shall be marked as the "Original" and contain the transmittal letter that bears the original signature of the binding authority and the original Proposal Guarantee. The box that contains the Original Response shall be marked **"Contains Original".** All forms requiring signature shall bear an original signature with the original response.

2) **Duplicate Copies of the Original Response**

The respondent shall submit **four (4)** duplicate copies of the Original Response.

3) **Packaging and Delivery**

a) Hard copy responses shall be bound individually and submitted in up to three (3), three-inch, three-ring binders or secured in a similar fashion to contain pages that turn easily for review.

b) Each component of the hard copy response shall be clearly labeled and tabbed in the order specified below:

- Transmittal Letter;
- **Exhibit A-2-a**, Qualification of Plan Eligibility;
- **Exhibit A-2-b**, Additional Required Certifications and Statements;
- **Exhibit A-3-a**, Milliman Organizational Conflict of Interest Mitigation Plan;
- **Exhibit A-3-b**, Milliman Employee Organizational Conflict of Interest Affidavit (if applicable);
- Original Proposal Guarantee;
- Financial Information – tabbed separately as follows:
  - Financial Statements
  - Pro Forma Financial Statements
  - Surplus
  - Insolvency Protection
- **Exhibit A-4-a,** Submission Requirements and Evaluation Criteria and applicable attachments/exhibits;
- **Exhibit A-5**, Summary of Respondent Commitments;
- **Exhibit A-6**, Certification of Drug-Free Workplace (if applicable); and
- **Attachment C,** Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, **Appendix IV,** Prepaid Dental Health Program Cost Proposal Template – Respondent Name. **Note: Respondents shall use this naming convention for Appendix IV.**

c) Hard copy responses shall be double sided.

d) Hard copy responses must be submitted in a sealed package (i.e., outer boxes must be sealed, individual binders within the box do not require individual sealing), to

the Procurement Officer identified in **Section A.,** Overview, **Sub-Section 5.,** Procurement Officer, no later than the time indicated in **Section A.,** Overview, **Sub-Section 6.,** Solicitation Timeline.

e) Hard copy responses shall be submitted via United States (U.S.) mail, courier, or hand delivery. Responses sent by fax or email will not be accepted. The Agency will not consider responses received after the date and time specified in **Section A.,** Overview, **Sub-Section 6.,** Solicitation Timeline, and any such responses will be returned to the respondent unopened.

c. Electronic Copy of the Response

1) The respondent shall submit one (1) electronic copy of the entire response on a USB flash drive.

2) The electronic copy of the response, including all attachments, shall be submitted as Portable Document Format (PDF) documents. The PDF documents must be searchable, allow printing and must not be password protected (unlocked).

3) The electronic copy of the PDF documents shall be saved on the USB flash drive, with each component listed below saved separately in individual file folders:

- Transmittal Letter;
- **Exhibit A-2-a**, Qualification of Plan Eligibility;
- **Exhibit A-2-b**, Additional Required Certifications and Statements;
- **Exhibit A-3-a**, Milliman Organizational Conflict of Interest Mitigation Plan;
- **Exhibit A-3-b**, Milliman Employee Organizational Conflict of Interest Affidavit (if applicable);
- Financial Information – tabbed separately as follows:
  - Financial Statements
  - Pro Forma Financial Statements
  - Surplus
  - Insolvency Protection
- **Exhibit A-4-a**, Submission Requirements and Evaluation Criteria and applicable attachments/exhibits;
- **Exhibit A-5**, Summary of Respondent Commitments;
- **Exhibit A-6**, Certification of Drug-Free Workplace (if applicable); and
- **Attachment C,** Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, **Appendix IV,** Prepaid Dental Health Program Cost Proposal Template – Respondent

Name. **Note: Respondents shall use this naming convention for Appendix IV.**

4) In addition to the PDF submission, the following attachments and exhibits shall be submitted in Microsoft Excel 2016, utilizing the Agency provided templates and shall be saved on the USB flash drive.

- **Exhibit A-4-a-1**, SRC# 10 – Dental Quality Measurement Tool;
- **Exhibit A-4-a-2**, SRC# 15 –Expanded Benefits Tool;
- **Exhibit A-4-a-3**, SRC# 36 – Provider Network Agreements Tool;
- **Exhibit A-5**, Summary of Respondent Commitments; and
- **Attachment C,** Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, **Appendix IV,** Prepaid Dental Health Program Cost Proposal Template – Respondent Name. **Note: Respondents shall use this naming convention for Appendix IV.**

5) Electronic Redacted Copies

a) The respondent shall submit an electronic redacted copy of the response suitable for release to the public in one (1) PDF document on the USB flash drive. The electronic copy shall be saved in a separate file folder on the USB flash drive from the rest of the response. The file folder shall be identified as "Redacted Version Suitable for Public Release".

b) The PDF document must be searchable, allow printing, and must not be password protected (unlocked).

c) Any confidential or trade secret information covered under Section 812.081, Florida Statutes, should be redacted as described below. The redacted response shall be marked as the "redacted" copy.

2. Confidential or Exempt Information

a. All submittals received by the date and time specified in **Section A.,** Overview, **Sub-Section 6.,** Solicitation Timeline, become the property of the State of Florida and are public records subject to the provisions of Chapter 119, Florida Statutes. The State of Florida shall have the right to use all ideas, or adaptations of the ideas, contained in any response received in relation to this solicitation. Selection or rejection of the response shall not affect this right.

b. A respondent that asserts that any portion of the response is confidential or exempt from disclosure under Chapter 119, Florida Statutes, shall clearly mark each page of such portion as follows:

1) Pages containing trade secret shall be marked "Trade secret as defined in Section 812.081, Florida Statutes" Respondents who fail to identify trade secret as directed herein acknowledge and agree that they waive any right or cause of action, civil or criminal, against the Agency, its employees, and its representatives, for the release or disclosure of trade secret information not so identified. Respondents shall not mark their entire response as trade secret. The Agency may reject a response that is so marked.

2) Pages that do not contain trade secret but are otherwise exempt or confidential shall be marked "exempt" or "confidential," followed by the statutory basis for such claim. For example: "The information on this page is exempt from disclosure pursuant to Section 119.071(3)(b), Florida Statutes." Failure to identify and mark such portions as directed above shall constitute a waiver of any claimed exemption and the Agency will provide any unmarked records in response to public records requests for those records without notifying the respondent. Designating material simply as "proprietary" will not necessarily protect it from disclosure under Chapter 119, Florida Statutes.

c. All information included in the response (including, without limitation, technical and cost information) and any resulting Contract that incorporates the successful response (fully, in part, or by reference) shall be a matter of public record regardless of copyright status. Submission of a response to this solicitation that contains material for which the respondent holds a copyright shall constitute permission for the Agency to reproduce and disclose such material for the Agency's internal use, and to make such material available for inspection pursuant to a public records request.

d. If a public records request is submitted to the Agency for responses submitted to this solicitation, the respondent agrees that the Agency may release the redacted Response without conducting any pre-release review of the redacted Response.

e. Unless otherwise prohibited by law, the Agency will notify the respondent if a requestor contests the respondent's determination that information is confidential or exempt and asserts a right to the information under Chapter 119, Florida Statutes or other law. The respondent bears sole responsibility for supporting and defending its determination. If an action is brought against the Agency in any appropriate judicial forum contesting the respondent's determination of confidentiality or the redactions made by the respondent to its response, the respondent agrees that the Agency has no duty to defend against such claims and may elect not to do so, and may elect to release an un-redacted version of the response. By submitting a response, the respondent agrees to protect, defend, hold harmless and

indemnify the Agency for any and all claims arising from or relating to the respondent's determinations of confidentiality or redaction, including the payment of any attorneys' fees or costs assessed against the Agency.

D. Response Evaluation, Negotiations, and Contract Award

1. Response Clarification

The Agency reserves the right to seek written clarification from a respondent of any information contained in the response or to request missing items from a response. However, it is a respondent's obligation to submit an adequately written reply for the Agency to evaluate. The Agency shall have no duty to conduct discussions or attempt to clarify ambiguities in the respondent's reply if the respondent is not in the competitive range of respondents selected for negotiations.

2. Responsive Reply Determination

A "responsive reply" means a reply submitted by a **responsive and responsible vendor**, which conforms in all material aspects to the solicitation [Section 287.012(26), Florida Statutes]. A "responsible vendor" means a vendor who has the capacity in all respects to fully perform the Contract requirements and the integrity and reliability that will assure good faith performance [287.012(25), Florida Statutes]. The Procurement Officer may rely on any facts available to make a determination at any time prior to award as to whether a vendor is a responsible vendor. The Agency reserves the right to contact sources outside the reply to obtain information regarding past performance or other matters relevant to responsibility.

3. Non-Scored Requirements

a. Transmittal (Cover) Letter

The Procurement Office and other Agency staff will review responses to this solicitation to determine if the respondent included in its response, a Transmittal (Cover) Letter from each required party that contains all required information as specified in **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item a.**

b. Required Certifications and Statements

The Procurement Office and other Agency staff will review responses to this solicitation to determine if the respondent included in its response, the following, as specified in **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item b.**:

- **Exhibit A-2-a,** Qualification of Plan Eligibility;
- **Exhibit A-2-b**, Additional Required Certifications and Statements

c. Milliman Organizational Conflict of Interest Mitigation Plan

The Procurement Office and other Agency staff will review responses to this solicitation to determine if the respondent included in its response, the following, as specified in **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item c.**:

- **Exhibit A-3-a**, Milliman Organizational Conflict of Interest Mitigation Plan
- **Exhibit A-3-b**, Milliman Employee Organizational Conflict of Interest Affidavit

d. Original Proposal Guarantee

The Procurement Office and other Agency staff will review responses to this solicitation to determine if the respondent included in its response, an original proposal guarantee in the amount specified in **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item d.**

e. Summary of Respondent Commitments

The Procurement Office and other Agency staff will review responses to this solicitation to determine if the respondent included in its response, **Exhibit A-5**, Summary of Respondent Commitments, as specified in **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item h.**

f. Cost Proposal

The Procurement Office and other Agency staff will review responses to this solicitation to determine if the respondent included in its response, **Attachment C,** Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, including applicable appendices/exhibits.

The Agency will review and consider the cost proposals submitted by respondents who are invited to negotiations during the negotiation phase. The Agency intends to negotiate common base rates for each region.

4. Scored Requirements – Evaluation Criteria

a. Financial Evaluation

1) A Certified Public Accountant will evaluate each respondent's financial information, as required by **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item e.** Respondents can receive a maximum score of twenty (20) points based on an analysis in **Table 2**, Financial Information Evaluation Point Scale, below:

Table 2 Financial Information Evaluation Point Scale		
Criteria	**Scale**	**Points**
What is the likelihood that the respondent will be able to meet minimum financial requirements?	Likely	20
	Questionable	10
	Unlikely	0

2) Respondents determined to have insufficient financial resources to perform the Contract requirements outlined in this solicitation will be disqualified at the Agency's sole discretion.

b. Technical Response Evaluation

1) Responses will be independently evaluated and awarded points based on the criteria and points scale indicated in **Exhibit A-4**, Submission Requirements and Evaluation Criteria Instructions and **Exhibit A-4-a,** Submission Requirements and Evaluation Criteria, for the detailed evaluation criteria components.

2) Each response will be individually scored by at least three (3) evaluators, who collectively have experience and knowledge in the program areas and service requirements for which contractual services are sought by this solicitation. The Agency reserves the right to have specific sections of the responses evaluated by less than three (3) individuals.

3) The scores of independent evaluators will be computed for each score sheet(s) to determine a total score based on the detailed evaluation criteria components indicated in **Exhibit A-4-a**, Submission Requirements and Evaluation Criteria and the weight factor specified in **Table 3,** Summary Score Sheet below:

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Table 3 Summary Score Sheet			
	Maximum Raw Score Possible	**Weight Factor**	**Maximum Points Available**
Financial Information	20	10	200
Technical Response			
1. Respondent Background & Experience	60	4	240
2. Agency Goals	310	3	930
3. Recipient Experience	185	5	925
4. Provider Experience	125	5	625
5. Delivery System Coordination	210	3.5	735
6. Oversight & Accountability	330	1	330
Total	1240		3985

c. Ranking of Responses

1) A total score will be calculated for each response based the total maximum points available as included in **Table 3,** Summary Score Sheet, above.

2) The total point scores will be used to rank the responses.

5. Negotiation Process

a. The scores from the evaluation process shall be used to determine the respondents with whom the negotiation team will negotiate. The negotiation team shall not utilize the evaluation scores in determining best value.

b. The Agency's negotiation team will conduct negotiation strategy sessions pursuant to Section 286.0113, Florida Statutes. Negotiation strategy includes determining best value criteria and developing award recommendation(s). During its strategy sessions, the Agency's negotiation team will develop a recommendation as to the award that will provide the best value (as defined in Section 287.012(4), Florida Statutes) to the State.

c. Negotiation sessions will include discussions of the scope of services to be provided by the respondent until acceptable terms and conditions are agreed upon, or it is determined that an acceptable agreement cannot be reached. The Agency will negotiate the terms and conditions determined to be the best value to the State, including, but not limited to price/cost, quality, design, and service delivery.

d. The actuary from Milliman may participate in discussions during the negotiation process and review and provide consultation to Agency staff on the respondents' cost proposal submissions. After negotiation sessions are concluded with respondents, Milliman will not participate in the decision-making process of determining which respondents are awarded Contracts.

e. The Agency reserves the right at any time during the negotiation process to:

1) Negotiate concurrently or sequentially with competing respondents.

2) Schedule additional negotiation sessions with any or all responsive respondents.

3) Require any or all responsive respondents to provide additional, revised, or final written replies addressing specific topics, including modifications to the solicitation specifications, terms or conditions, or business references.

4) Require any or all responsive respondents to provide a written best and final offer or offers.

5) Require any or all responsive respondents to address services, prices, or conditions offered by any other respondents.

6) Decline to conduct further negotiations with any respondent.

7) Re-open negotiations with any responsive respondent.

8) Take any additional, administrative steps deemed necessary in determining the final award, including additional fact-finding, evaluation or negotiations where necessary and consistent with the terms of this solicitation.

9) Review and rely on relevant information contained in the responses.

10) Request pricing options or models different from the initial Cost Proposal submission. This information may be used in negotiations to determine the best pricing solution to be used in the Contract.

f. The Agency has sole discretion in deciding whether and when to take any of the foregoing actions, the scope and manner of such actions, the responsive respondent or respondents affected and whether to provide concurrent public notice of such decision.

g. The Agency intends to invite the top six (6) ranking respondents to negotiation but reserves the right to invite a greater or smaller number of respondents to negotiate.

h. In the event the Agency cannot reach agreement with a respondent who has been invited to negotiation and/or a respondent withdraws its response during the negotiation phase, the Agency reserves the right to invite the next top ranking respondent to negotiations.

6. Selection Criteria for Determining Best Value

In addition to the criteria established in Section 409.968(5), Florida Statutes, the Agency's negotiation team shall determine the best value selection criteria which include, but are not limited to:

a. Whether a respondent negotiates a rate acceptable to the Agency.

b. Whether a respondent proposes and negotiates acceptable terms and conditions in the following areas:

- Innovations and evidence-based practices that assist in achieving the Agency's goals;
- Expanded benefits;
- Provider network;
- Service authorization timeliness;
- Value-based purchasing;
- Provider engagement; and
- Enrollee engagement.

7. Number of Awards

The Agency intends to select up to four (4) eligible Prepaid Dental Health Plans to provide services statewide.

8. Posting of Notice of Intent to Award

Tabulation of Results, with the recommended Contract award, will be posted and will be available for review by interested parties at the time and location specified in **Section A.,** Overview, **Sub-Section 6.,** Solicitation Timeline, and will remain posted for a period of seventy-two (72) hours, not including weekends or State observed holidays. Any respondent desiring to protest the recommended Contract award must file a notice of protest to the Procurement Officer identified in **Section A.** Overview, **Sub-Section 5.,** Procurement Officer, and any formal protest with the Agency for Health Care Administration, Agency Clerk, 2727 Mahan Drive, Mail Stop 3, Building 3, Room 3407C, Tallahassee, Florida 32308, within the time prescribed in Section 120.57(3) Florida Statutes and Rule 28-110, Florida Administrative Code. Failure to file a protest within the time prescribed in Section 120.57(3), Florida Statutes, or failure to post the bond or other security required by law, shall constitute a waiver of proceedings under Chapter 120, Florida Statutes

9. Contract Execution

a. The Agency shall incorporate the following documents, which are included in **Exhibit A-7,** Standard Contract, in the final Contract document prepared for execution by the successful respondent:

- Standard Contract;
- Business Associate Agreement;
- Certification Regarding Lobbying Certification for Contracts, Grants, Loans and Cooperative Agreements;
- Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Contracts/Subcontracts; and
- Vendor Certification Regarding Scrutinized Companies Lists.

b. The Agency will not consider modifications proposed by the respondent to the documents listed in **Exhibit A-7,** Standard Contract.

c. This solicitation, including all its addenda, the Agency's written response to questions, and the successful respondent's response, including information provided through negotiations, shall be incorporated by reference in the final Contract document.

d. The successful respondent shall perform its contracted duties in accordance with the resulting Contract, this solicitation, including all addenda, the successful respondent's response to this solicitation, and information provided through the negotiations. In the event of conflict among resulting Contract documents, any identified inconsistency in the resulting Contract shall be resolved by giving precedence in the following order:

1) The resulting Contract, including all attachments, exhibits and any subsequent amendments;

2) This solicitation, including all addenda; and

3) The successful respondent's response to this solicitation, including information provided through negotiations.

e. The successful respondent shall be registered with the Florida Department of State as an entity authorized to transact business in the State of Florida by the effective date of the resulting Contract.

f. The Agency reserves the right to amend the resulting Contract within the scope set forth in this solicitation (to include original Contract and all attachments) in order to clarify requirements or if it is determined by the Agency that modifications are necessary to better serve or provide covered services to the eligible population.

g. The State of Florida's performance and obligation to pay under the Contract resulting from this solicitation is contingent upon an annual appropriation by the Legislature.

E. Contract Implementation

1. Proposed Implementation Schedule

a. The Agency anticipates implementing (i.e., rolling-out) new statewide Contracts for the PDHP program. The 67 Florida counties are divided into 11 regions pursuant to s. 409.966(2), F.S.

b. The Agency will establish a roll-out schedule which outlines regional implementation dates between October 2018 – January 2019; statewide deadlines for plan readiness documentation and plan readiness; and enrollment effective dates.

c. The Agency will provide successful respondents (herein referred to as “Prepaid Dental Health Plans”) with the proposed rollout schedule and plan readiness review tools prior to the anticipated Contract execution date. The schedule may be subject to change and is provided for planning purposes only.

2. Readiness Review

a. Prior to enrolling recipients in a Prepaid Dental Health Plan, the Agency will conduct a plan-specific readiness review to assess the Prepaid Dental Health Plan’s readiness and ability to provide services to enrollees.

b. The scope of the plan readiness review may include any and all Contract requirements, as determined by the Agency.

c. If a Prepaid Dental Health Plan does not meet the plan readiness deadlines established by the Agency, the Agency may grant an extension for the Prepaid Dental Health Plan to correct deficiencies. The Agency has no obligation to modify the proposed implementation schedule to accommodate the time needed for a Prepaid Dental Health Plan to address deficiencies.

d. The Agency will not enroll recipients into a Prepaid Dental Health Plan until the Agency has determined that the Prepaid Dental Health Plan meets all plan readiness review requirements.

e. The Agency reserves the right, at its sole discretion, to terminate the Contract with the Prepaid Dental Health Plan if the plan fails to meet the plan readiness deadlines.

3. Enrollment Levels

The Agency does not guarantee that any Prepaid Dental Health Plan will receive any particular enrollment level.

4. Transition Enrollment

As part of the readiness review and at least sixty (60) days prior to the implementation (i.e., roll-out) date in a region, the Prepaid Dental Health Plan will be required to demonstrate that it has an adequate network of providers to provide all covered services to enrollees.

a. Enrollees Who Make an Active Plan Choice

The Agency will provide Medicaid recipients with an enrollment packet in the mail informing them of the available plan options in their region. Medicaid recipients will have an opportunity to select the plan of their choice as long as he or she meets all of the eligibility criteria for the plan type.

b. Enrollees Who Do Not Make an Active Plan Choice

1) For the purposes of this Sub-Section, existing plan means a Prepaid Dental Health Plan that was subcontracted as a dental benefits manager for a Managed Care Plan under the SMMC 2014-2019 contracts and was awarded a Contract to provide services under the resulting Contract from this solicitation.

2) For the purposes of this Sub-Section, new plan means a Prepaid Dental Health Plan that was not subcontracted as a dental benefits manager for a Managed Care Plan under the SMMC 2014-2019 contracts, but was awarded a Contract to provide services under the resulting Contract from this solicitation.

3) The Agency will assign SMMC enrollees to who do not make an active plan choice into their existing plan if that plan was awarded a Contract to provide services under the resulting Contract from this solicitation.

4) The Agency will automatically enroll into a new or existing prepaid dental health plan those Medicaid recipients who do not voluntarily choose a plan. When automatically enrolling recipients in new or existing prepaid dental health plans, the Agency shall automatically enroll based on the following criteria:

- Whether the plan has sufficient network capacity to meet the needs of the recipients.

- Whether the recipient has previously received services from one of the plan's primary dental providers.

- Whether primary dental providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

- A newborn of a mother enrolled in a plan at the time of the child's birth shall be enrolled in the mother's plan. Upon birth, such a newborn is deemed enrolled in the Prepaid Dental Health Plan, regardless of the administrative enrollment procedures, and the managed care plan is responsible for providing Medicaid services to the newborn. The mother may choose another plan for the newborn within 90 days after the child's birth.

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EXHIBIT A-1
QUESTIONS TEMPLATE

Exhibit A-1, Questions Template, is available for respondents to download at:

http://ahca.myflorida.com/procurements/index.shtml.

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EXHIBIT A-2-a
QUALIFICATION OF PLAN ELIGIBILITY

RESPONDENT NAME: _____

1. IDENTIFICATION OF PLAN TYPES

I hereby certify that my company is submitting a response to AHCA ITN 012-17/18 to operate as a **Statewide Medicaid Prepaid Dental Health Plan**.

2. QUALIFICATION OF PLAN ELIGIBILITY

I hereby certify my company currently operates as one (1) of the following:

☐ HMO Health Maintenance Organization licensed pursuant to Part I of Chapter 641, Florida Statutes, and possess in at least one (1) Florida county a current Florida Certificate of Authority and Health Care Provider Certificate issued by the Florida Department of Financial Services, Office of Insurance Regulation.

OR

☐ Prepaid Limited Health Service Organization licensed pursuant to Part I of Chapter 626, Florida Statutes, and possess a current Florida Certificate of Authority issued by the Florida Department of Financial Services, Office of Insurance Regulation.

OR

☐ Prepaid Limited Health Service Organization not domesticated in the State of Florida and possess a Certificate of Compliance and Certificate of Deposit issued by the Florida Department of Financial Services, Office of Insurance Regulation.

Signature below indicates the respondent's full acknowledgement of, understanding of, and agreement with the certification identified above as written and without caveat.

_____
Respondent Name

____ ________________________
Authorized Official Signature **Date**

_____
Authorized Official Printed Name

_____
Authorized Official Title

Failure to submit, Exhibit A-2-a, Qualification of Plan Eligibility, signed by an authorized official may result in the rejection of response.

EXHIBIT A-2-b
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS

RESPONDENT NAME: _____

1. ACCEPTANCE OF SOLICITATION REQUIREMENTS

I hereby certify that I understand and agree that my organization has read all requirements and Agency specifications provided in this solicitation, accepts said requirements, and that this response is made in accordance with the provisions of such requirements and specifications. By my written signature below, I guarantee and certify that all items included in this response shall meet or exceed any and all such requirements and Agency specifications. I further agree, if awarded a Contract resulting from this solicitation, to deliver services that meet or exceed the requirements and specifications provided in this solicitation.

AND

2. ACCEPTANCE OF CONTRACT TERMS AND CONDITIONS

I hereby certify that should my organization be awarded a Contract resulting from this solicitation, it will comply with all terms and conditions as specified in this solicitation and in the Agency Standard Contract (**Exhibit A-7, including Attachments II - V**).

AND

3. STATEMENT OF NO-INVOLVEMENT

I hereby certify that neither my organization nor any person with an interest in the organization had any prior involvement in performing a feasibility study of the implementation of the subject Contract, in drafting of this solicitation or in developing the subject program.

AND

4. PROHIBITION OF GRATUITIES

I hereby certify that no elected official or employee of the State of Florida has or shall benefit financially or materially from such my organization's response or subsequent Contract in violation of the provisions of Chapter 112, Florida Statutes. I understand that any Contract issued as a result of this solicitation may be terminated if it is determined that gratuities of any kind were either offered or received by any of the aforementioned parties.

AND

5. NON-COLLUSION CERTIFICATION

I hereby certify that all persons, companies, or parties interested in the response as principals are named therein, that the response is made without collusion with any other person, persons, organization, or parties submitting a response; that it is in all respects made in good faith; and as the signer of the response, I have full authority to legally bind the prospective respondent to the provisions of this solicitation.

AND

6. PERFORMANCE OF SERVICES

I hereby certify my organization shall ensure all services, provided directly or indirectly under the Contract resulting from this solicitation, will be performed within the borders of the United States and its territories and protectorates.

AND

7. ORGANIZATIONAL CONFLICT OF INTEREST CERTIFICATION

The standards on organizational conflicts of interest in Title 48, Code of Federal Regulations, Subpart 9.5 – Organizational and Consultant Conflicts of Interest and Section 287.057(17), Florida Statutes, apply to this solicitation. A respondent with an actual or potential organizational conflict of interest shall disclose the conflict. If the respondent believes the conflict of interest can be mitigated, neutralized or avoided, the respondent shall submit a Conflict of Interest Mitigation Plan with its response, that shall, at a minimum:

a) Identify any relationship, financial interest or other activity which may create an actual or potential organizational conflict of interest.
b) Describe the actions the respondent intends to take to mitigate, neutralize, or avoid the identified organizational conflicts of interest.
c) Identify the official within the respondent's organization responsible for making conflict of interest determinations.

The Conflict of Interest Mitigation Plan will be evaluated as acceptable or not acceptable. The Agency reserves the right to request additional information from the respondent or other sources, as deemed necessary, to determine whether or not the plan adequately neutralizes, mitigates, or avoids the identified conflicts.

Pursuant to the aforementioned requirements, I hereby certify that, to the best of my knowledge, my organization (including its subcontractors, subsidiaries and partners):

Please check the applicable paragraph below. Do not check more than one of the paragraphs below.

☐ Has no existing relationship, financial interest or other activity which creates any actual or potential organizational conflicts of interest relating to the award of a Contract resulting from this solicitation.

☐ Has included information in its response to this solicitation detailing the existence of actual or potential organizational conflicts of interest and has provided a "Conflict of Interest Mitigation Plan", as outlined above.

AND

8. RESPONDENT ATTESTATION FOR EXHIBIT A-4

I hereby certify that no modification and/or alteration has been made to the template, narrative and/or instructions contained in **Exhibit A-4**, Submission Requirements and Evaluation Criteria, including **Exhibit A-4-a,** including all exhibits/attachments, as applicable.

I understand the Agency may not consider supplemental response narrative for evaluation which is not contained within the Response Sections contained in **Exhibit A-4,** Submission Requirements and Evaluation Criteria.

AND

9. RESPONDENT ATTESTATION FOR ATTACHMENT C, COST PROPOSAL INSTRUCTIONS AND RATE METHODOLOGY NARRATIVE

I hereby certify that no modification and/or alteration has been made to the template, narrative and/or instructions contained in **Attachment C**, Data Book, Cost Proposal Instructions, and Rate Methodology Narrative**, including all applicable appendices/exhibits**.

AND

10. RESPONDENT ATTESTATION REGARDING SCRUTINIZED COMPANIES LIST

I hereby certify that my company is not listed on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, created pursuant to Section 215.473, Florida Statutes. Pursuant to Section 287.135(5), Florida Statutes, the respondent agrees the Agency may immediately terminate the resulting Contract for cause if the respondent is found to have submitted a false certification or if the respondent is

placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List during the term of the resulting Contract.

AND

11. NAMES OF OPERATION

I hereby certify the following is a list of all names under which my organization has operated during the past five (5) years (since October 16, 2012).

____

____

____

____

____

AND

12. BUSINESS RELATIONSHIP

☐ The respondent shall disclose any business relationship (as defined in Section 409.966(3)(e), Florida Statutes) with any other eligible Managed Care Plan that is a potential respondent to this solicitation. Such disclosure shall include identifying information for each Managed Care Plan, the nature of the business relationship, the current service area of each Managed Care Plan (by line of business), and the signature of the authorized representative for each Managed Care Plan.

The respondent must disclose any business relationship(s) in the space provided below:

AND

13. COMPLETE MEDICAID PROVIDER ENROLLMENT PACKAGE SUBMISSION

I hereby certify my organization, if awarded a Contract, shall provide the Agency with an accurate and complete Medicaid Provider Enrollment Application, including all ownership and principal fingerprint cards and processing fees, within thirty (30) days after the Contract award is complete.

AND

14. REQUIRED PLAN READINESS DOCUMENTATION

I hereby certify my organization, if awarded a Contract, shall submit to the Agency all required Plan Readiness documentation within established timeframes as required in **Attachment A**, Instructions and Special Conditions, **Section E.**, Contract Implementation.

I hereby certify my organization, if a foreign prepaid limited health services organization that is awarded a Contract, shall submit within thirty (30) days, the application for a Certificate of Compliance and for a Certificate of Deposit, as provided for in Part I of Chapter 636, Florida Statutes.

AND

15. CERTIFICATION REGARDING TERMINATED CONTRACTS

I hereby certify that my organization (including its subsidiaries and affiliates) has not unilaterally or willfully terminated any previous contract prior to the end of the contract with a State or the Federal government and has not had a contract terminated by a State or the Federal government for cause, prior to the end of the contract, within the past five (5) years (since October 16, 2012), other than those listed on **Page 7** of this Exhibit.

AND

16. LIST OF TERMINATED CONTRACTS

List the terminated contracts in chronological order and provide a brief description (half-page or less) of the reason(s) for the termination. Additional pages may be submitted; however, no more than five (5) additional pages should be submitted in total.

The Agency is not responsible for confirming the accuracy of the information provided.

The Agency reserves the right within its sole discretion, to determine the respondent to be an non-responsible vendor based on any or all of the listed contracts and therefore may reject the respondent's reply.

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EXHIBIT A-2-b
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS

Respondent Name:

Client's Name:

Term of Terminated Contract:

Description of Services:

Brief Summary of Reason(s) for Contract Termination:

Respondent Name:

Client's Name:

Term of Terminated Contract:

Description of Services:

Brief Summary of Reason(s) for Contract Termination:

EXHIBIT A-2-b
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS

Signature below indicates the respondent's full acknowledgement of; understanding of; and agreement with all of the certifications and statements identified above in Items 1 through 16 as written and without caveat.

_____
Respondent Name

______________________________ ______________________
Authorized Official Signature **Date**

_____
Authorized Official Printed Name

_____
Authorized Official Title

Failure to submit, Exhibit A-2-b, Additional Required Certifications and Statements, signed by an authorized official may result in the rejection of response.

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EXHIBIT A-3-a
MILLIMAN ORGANIZATIONAL
CONFLICT OF INTEREST MITIGATION PLAN

RESPONDENT NAME: _____

The Agency for Health Care Administration ("Agency" or "AHCA") "must avoid, neutralize, or mitigate significant potential organizational conflicts of interest (OCI) before a Contract is awarded. If the Agency elects to mitigate the significant potential organizational conflict or conflicts of interest, an adequate mitigation plan, including organizational, physical, and electronic barriers, shall be developed. [Section 287.057(17)(a)(1), Florida Statutes]

The Agency has determined that in order to evaluate proposals and negotiate a Contract that is in the best interests of the State, it is necessary to use the services of Milliman, Inc. ("Milliman") to act as an actuary and advisor throughout all stages of the "Statewide Medicaid Prepaid Dental Health Program" competitive solicitation. The Agency reasonably anticipates one or more prospective respondents may also use Milliman. The Agency has determined that all reasonably anticipated OCIs relating to Milliman may be mitigated by the following mitigation plan, which has been agreed to by Milliman:

I. Milliman

a. All Milliman personnel who will perform services under the "Statewide Medicaid Prepaid Dental Health Program (PDHP)" competitive solicitation shall be part of a separate internal Milliman working group (the "Milliman AHCA Group") with its own internal electronic and hard folders.

b. All documents or communications received or generated by the Milliman AHCA Group that relate in any way to this solicitation shall be placed only in this Group's separate files.

c. Each member of the Milliman AHCA Group shall submit **Exhibit A-3-b**, Milliman Employee Organizational Conflict of Interest Affidavit indicating they will provide actuarial services to the Agency.

d. No Milliman personnel, other than the Milliman AHCA Group personnel shall have access to the Milliman AHCA's Groups files.

e. The above-listed personnel shall not discuss any information relating to the PDHP ITN Services with any other Milliman personnel.

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EXHIBIT A-3-a
MILLIMAN ORGANIZATIONAL
CONFLICT OF INTEREST MITIGATION PLAN

II. Respondents

a. Any actual or prospective respondent who is using Milliman for this procurement must disclose this fact in its initial reply to the solicitation. Specifically, a respondent wishing to use Milliman must:

i. Identify itself and its intent to use Milliman;
ii. Identify the specific Milliman personnel that will be assisting the respondent in the procurement;
iii. Submit **Exhibit A-3-b, Milliman Employee Organizational Conflict of Interest Affidavit** forms, completed by each identified Milliman personnel.

b. All replies submitted in response to this solicitation must include the completed declaration in **Section IV.** of this Exhibit, signed by the authorized official who signed the reply on behalf of the respondent.

c. Any actual or prospective respondent who learns there is a reasonable basis to believe there has or may have been a violation of the Milliman OCI Mitigation Plan shall, within seventy-two (72) hours, notify the Agency of the facts and circumstances of the possible violation.

III. Protests

a. **Actual or prospective respondents are advised they have a burden to diligently investigate and challenge potential OCIs relating to Milliman**.

b. All challenges to the Milliman OCI Mitigation Plan must be timely filed as a challenge to the specifications of this solicitation. Similarly, challenges to amendments to the Milliman OCI Mitigation Plan must be timely filed as specifications challenges.

c. All challenges to Milliman-related information provided by actual or prospective respondents and posted by the Agency must be timely filed as specifications challenges.

d. **All protests filed after a Notice of Intent to Award has been posted which allege a Milliman-related OCI shall be limited to alleged violations of the Milliman OCI Mitigation Plan**.

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EXHIBIT A-3-a
MILLIMAN ORGANIZATIONAL
CONFLICT OF INTEREST MITIGATION PLAN

IV. Declaration

Declaration of _____
Authorized Official Printed Name

Pursuant to Section 92.525, Florida Statutes, _____
Authorized Official Printed Name
declares that:

1. I am over the age of 21 and am competent to testify as to the matters stated in this declaration.

2. I declare that I have read the Milliman Organizational Conflict of Interest Mitigation Plan, and that _____
Respondent Name

will directly and indirectly fully comply with the Milliman Organizational Conflict of Interest Mitigation Plan through all stages of the procurement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this _____day of _____ 2018.

____
Authorized Official Signature

_____
Authorized Official Printed Name

Failure to submit, Exhibit A-3-a, Milliman Organizational Conflict of Interest Mitigation Plan, certified by an authorized official may result in the rejection of response.

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EXHIBIT A-3-b
MILLIMAN EMPLOYEE
ORGANIZATIONAL CONFLICT OF INTEREST AFFIDAVIT

Declaration of _____
Milliman Employee Name

Pursuant to Section 92.525, Florida Statutes, _____
Milliman Employee Name
declares that:

1. I am over the age of 21 and am competent to testify as to the matters stated in this declaration.

2. I am an employee of Milliman at Milliman's business office located in _____ and have been assigned to provide actuarial services to _____
Respondent Name

3. I declare that I have read the Milliman Organizational Conflict of Interest Mitigation Plan, and that I will fully comply with it through all stages of the procurement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this _____day of _____ 2017.

____
Signature

_____
Printed Name

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EXHIBIT A-4
SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA INSTRUCTIONS

Instructions to respondents for the completion of Exhibit A-4-a:

All respondents to this solicitation shall utilize **Exhibit A-4-a,** Submission Requirements and Evaluation Criteria, for submission of its response as specified in **Attachment A.**, Instructions and Special Conditions, **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item f.**, Submission Requirements and Evaluation Criteria. Respondents shall adhere to the instructions below for each Submission Requirement Component (SRC).

Respondents shall not include website links, embedded links and/or cross references between SRCs.

Each SRC contains form fields. Population of the form fields with text will allow the form field to expand and cross pages. There is no character limit.

Attachments are acceptable for any SRC but must be referenced in the form field for the respective SRC and located behind each respective SRC response. Respondents shall name and label attachments to refer to respective SRCs by SRC identifier number.

Agency evaluators will be instructed to evaluate the responses based on the narrative contained in the SRC form fields and the associated attachment(s), if applicable.

Each response will be independently evaluated and awarded points based on the criteria and points scale using the Standard Evaluation Criteria Scale below unless otherwise identified in each SRC contained within **Exhibit A-4-a**.

STANDARD EVALUATION CRITERIA SCALE	
Point Score	**Evaluation**
0	The component was not addressed.
1	The component contained significant deficiencies.
2	The component is below average.
3	The component is average.
4	The component is above average.
5	The component is excellent.

The SRCs in **Exhibit A-4-a** may not be retyped and/or modified and must be submitted in the original format.

Exhibit A-4-a is available for respondents to download at:

http://ahca.myflorida.com/procurements/index.shtml.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

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EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

RESPONDENT NAME: _____

A. RESPONDENT BACKGROUND/EXPERIENCE

SRC# 1 – Managed Care Experience:

The respondent, including respondent's parent, affiliate(s), and subsidiary(ies), shall provide a list of all current and/or recent (since October 16, 2012) contracts for managed dental health care services.

The respondent shall provide the following information for each identified contract:

a. The Medicaid population served (such as TANF, ABD, medically needy, and home and community-based waiver populations);
b. The name and address of the client;
c. The name of the contract;
d. The specific start and end dates of the contract;
e. The geographic service area (e.g., regional, statewide);
f. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services;
g. Whether as a direct contractor or as a subcontractor;
h. The use of administrative and/or delegated subcontractor(s) and their scope of work;
i. The annual contract amount (payment to the respondent) and annual claims payment amount;
j. The scheduled and actual completion dates for contract implementation;
k. The barriers encountered that hindered implementation (if applicable) and the resolutions;
l. Accomplishments and achievements;
m. Number of enrollees, by health plan type (e.g., commercial, Medicaid); and
n. Whether the contract was capitated, fee-for-service, or other payment method.

In addition, the respondent shall describe its experience in delivering managed dental health care services to Medicaid populations similar to the target population (such as TANF, ABD, medically needy, and home and community-based waiver populations) identified in this solicitation.

For this Submission Requirement, the respondent may include experience as a subcontractor for a Managed Care Plan operating under the Statewide Medicaid Managed Care program.

Response:

Evaluation Criteria:

1. The extent of the respondent's experience with delivering coordinated oral health services.

2. The extent of experience of the respondent's subcontractor(s) in coordinating or providing services to Medicaid recipients.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

3. The extent to which the respondent has outlined clear resolutions to barriers to implementation.

4. The extent to which the respondent has listed accomplishments and achievements that are relevant to this solicitation.

5. The extent to which the respondent's Medicaid populations served are similar to the populations served by the Statewide Medicaid Prepaid Dental Health Program.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 2 –Required Florida Presence:

The respondent shall provide information regarding whether each operational function will be based in the State of Florida and the extent to which operational functions will be conducted by staff in-house or through contracted arrangements located in the State of Florida. This includes:

a. Specifying the location of where the respondent's corporate headquarters will be located;
b. Indicating whether the respondent is a subsidiary of, or a joint venture with, any other entity whose principal office will not be located in the State of Florida; and
c. Identifying the number of full-time staff, by operational function, that will be located in the State of Florida and out of state.

Response:

Evaluation Criteria:

1. Whether the respondent's corporate headquarters will be located in Florida (it is not a subsidiary of or a joint venture with any other entity whose principal office will be located outside of Florida).

2. The extent to which operational functions (claims processing, enrollee/member services, provider relations, utilization and prior authorization, case management, quality functions, and finance and administration) will be performed in the State of Florida.

Score: This section is worth a maximum of 15 raw points. Each of the above components are worth a maximum of 5 points each as described below. 5 additional points will be awarded if respondent meets Items 1(a) <u>and</u> 2(a) below.

For Item 1:

(a) 5 points for corporate headquarters in Florida and no parent or joint venture organization outside Florida;
(b) 0 points if no relevant corporate headquarters in Florida.

For Item 2:

(a) 5 points if all functions will be performed in Florida.
(b) 4 points for 6-7 functions to be performed in Florida.
(c) 3 points for 4-5 functions to be performed in Florida.
(d) 2 points for 2-3 functions to be performed in Florida.
(e) 1 point for 1 function to be performed in Florida.
(f) 0 points for no functions to be performed in Florida.
(g) 0 points if only community outreach, dental director, and State administrative functions will be performed in Florida.

SRC# 3 – Contract Performance:

The respondent shall state whether, in the past five (5) years (since October 16, 2012), it has voluntarily terminated all or part of a managed care contract under which it provided dental health care services as the insurer or as a subcontractor; has had such a contract partially or fully terminated before the contract end date (with or without cause); has withdrawn from a contracted service area; or has requested a reduction of enrollment levels. If so, describe the contract; the month and year of the contract action; the reason(s) for the termination, withdrawal, or enrollment level reduction; the parties involved; and provide the name, address, and telephone number of the client/other party. If the Contract was terminated based on the respondent's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination. Include information for the respondent as well as the respondent's affiliates and subsidiaries and its parent organization, and the parent organization's affiliates and subsidiaries.

Response:

Evaluation Criteria:

1. The extent to which the respondent or parent or subsidiary or affiliates have requested enrollment level reductions or voluntarily terminated all or part of a contract.

2. The extent to which the respondent or parent or subsidiary or affiliates has had contract(s) terminated due to performance.

3. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to patient care rather than administrative concerns (e.g., reporting timeliness).

4. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to provider network management, claims processing, or solvency concerns.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each as described below.

For Item 1:

(a) 5 points for no voluntary termination of all or part of a contract, no requests for enrollment level reduction. and no service area withdrawals.
(b) 0 points for any voluntary terminations, requests for enrollment level reductions, or service area withdrawals.

For Item 2:

(a) 5 points for no involuntary terminations.

(b) 0 points for any involuntary termination based on performance.

For Item 3:

(a) 5 points for no contract terminations related to patient care.
(b) 0 points if termination related to patient care.

For Item 4:

(a) 5 points for no contract terminations related to provider network management, claims processing or solvency concerns.
(b) 0 points if termination related to performance issues related to provider network management, claims processing or solvency concerns.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

B. AGENCY GOALS

SRC# 4 – Oral Health Promotion and Disease Prevention:

The respondent shall describe its approach for engaging enrollees to improve oral health literacy and knowledge of dental benefits to include access to dental providers (e.g., transportation, language translation, and school-based dental services). The respondent shall also describe its approach for engaging providers in providing care to Medicaid children, including an understanding of the special needs of this population and willingness to address those needs.

Response:

Evaluation Criteria:

1. The extent to which the respondent described how it will utilize technology and advanced outreach strategies (e.g., social media, texting, and smartphone apps), and current Agency resources (e.g., Florida Medicaid Dental logo, consumer website link and Social Media Campaign) to improve oral health literacy and promote improved health outcomes.

2. The extent to which the respondent provides data that supports the efficacy of the proposed approach in achieving the intended goals/health outcomes (e.g., increase in appointment compliance) for the target population.

3. The extent to which the respondent describes how it will engage enrollees and stakeholders to enhance their understanding of resources to overcome barriers to accessing care and its efforts to improve utilization of dental benefits (e.g. member focus groups, provider focus groups, involvement in statewide and local oral health stakeholder groups).

4. The extent to which the respondent describes how school-based sealant, fluoride varnish, and prevention programs (health access setting programs, section 466.003, Florida Statutes) will be utilized to increase oral health literacy and prevent dental caries.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 5 – Potentially Preventable Emergency Department Visits:

The respondent shall describe its organizational commitment to quality improvement as it relates to reducing potentially preventable emergency department visits for treatment of dental-related issues. More specifically, the respondent shall describe its overall approach and specific strategies that will be used to ensure a reduction in the use of the emergency department for non-emergent/ urgent visits. The respondent's approach shall also include:

- A description of the respondent's assessment (using available data sources) of emergency department utilization rates and the potential for improvement;
- A description of performance benchmarks for the area of focus;
- A description of incentives that will be implemented for providers and enrollees aimed at diverting care to more appropriate and cost-effective settings; and
- A description of evidence-based interventions and strategies that the respondent will use to target super-utilizers, particularly related to repeat utilization of emergency departments for dental emergencies and related conditions.

Response:

Evaluation Criteria:

1. The extent to which the respondent's approach identifies specific localized opportunities for improvement in achieving a reduction in potentially preventable emergency department visits and subsequent steps the respondent will implement to overcome any barriers across and within different systems of care (i.e., transportation, medical).

2. The extent to which the respondent's approach provides strategies to improve data exchanges and communications between primary dental health care providers and primary care providers to improve care coordination efforts for high-risk enrollees, using specific local examples.

3. The viability of the respondent's plans to include the use of the Agency's Event Notification System as a means to extract relevant data from hospitals.

4. The extent to which the respondent's approach for including specific indicators or measures that will be used to evaluate the effectiveness of evidenced-based programs and interventions that target super-utilizers.

5. The extent to which the respondent's approach includes financial and non-financial provider and enrollee incentives that are aimed at diverting care to more appropriate and cost-effective settings (e.g., incentives for dental care providers that agree to extended or after-hours clinic care for their Medicaid patients).

6. The extent to which the respondent has described a methodology (e.g., quality improvement process – rapid cycle improvement) for evaluating the impact of professional

integration strategies and provided results/data based on previous experience that supports the reduction in potentially preventable emergency department utilization.

7. The extent to which the respondent proposed local performance benchmarks for:

- **(a)** Reducing use of the emergency department for non-emergent/urgent visits.
- **(b)** Improving after-hours access to dental care services.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

SRC# 6 – Dental Homes:

The respondent shall describe its experience with dental homes including the respondent's efforts toward the solicitation of dental home models and recognized practices to improve access and facilitate care integration and improvement in quality measures. Specifically, the respondent shall describe programs and initiatives utilizing dental homes to promote the Agency's goals.

Response:

Evaluation Criteria:

1. The extent to which the respondent's description demonstrates experience that includes contracts with dental homes in the network serving populations similar to the target population of this solicitation and demonstrates:

- **(a)** Enhanced access;
- **(b)** Coordinated care; and
- **(c)** Achievement of improved quality outcomes.

2. The extent to which the respondent's description of recognizing, adopting, and promoting dental homes to address the reduction of potentially preventable emergency department visits for enrollees assigned to a dental home for their dental care.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 7 – Telemedicine:

The respondent shall describe its overall approach to utilizing telemedicine services as a mechanism for delivery of dental services and to promote the Agency's goals, in particular as it relates to enhanced access to the following providers within the plan's network:

a. Endodontists;
b. Orthodontists;
c. Pediatric dentists (Pediodontist);
d. Oral surgeons; and
e. Dental practitioners with a sedation permit.

The respondent shall describe any limitations placed on telemedicine-provided dental services within its network and the percentage of providers with the network that are authorized to provide telemedicine services for the specialty types referenced above and those actually providing telemedicine.

Response:

Evaluation Criteria:

1. The extent to which the respondent describes an approach on the use of telemedicine as a mechanism for delivery of dental services within its provider network that supports achievement of the Agency's goals.

2. The extent to which the respondent describes the methodology it will use to identify providers eligible for participation, limitations/barriers in its proposed use of telemedicine and proposed strategies to overcome those limitations/barriers.

3. The extent to which the respondent has already made significant achievements in the deployment of telemedicine within its network as evidenced by:

(a) The percentage of providers authorized to provide dental services through telemedicine for the provider types referenced; and
(b) The percentage and type of authorized providers that provided dental services through telemedicine during the 2016 calendar year.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 8 – Provider Network Development:

The respondent shall submit a draft network development and management plan demonstrating how it will ensure timely access to primary and specialty care services, necessary to promote the Agency's goals, including:

a. Identification of network gaps (time/distance standards, after-hours clinic availability, closed panels, etc.);

b. Strategies that will be deployed to increase provider capacity and meet the needs of enrollees where network gaps have been identified;

c. Strategies (including a description of data sources utilized) for measuring timely access to appointments with the following provider types:

  (1) General dentists;
  (2) Endodontists;
  (3) Orthodontists;
  (4) Pediatric dentists (Pediodontist);
  (5) Oral surgeons; and
  (6) Dental practitioners with a sedation permit.

d. Strategies for recruitment and retention efforts planned for each provider type, including the quality and/or performance metrics that will be used to determine a provider's success in making progress towards the Agency's goals.

e. Strategies for recruitment and retention of providers willing to provide after-hours care, or collaborate with mobile dental vans, county health departments or other entities that share the same goal to ensure members have access to dental care at every opportunity.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's methodology for identifying and resolving barriers and network gaps, including ongoing activities for network development based on identified gaps and future needs projection.

2. The adequacy of the respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network, including immediate, short-term and long-term interventions.

3. The adequacy of the respondent's approach for measuring timely access for the specified provider types and the extent to which the respondent's approach includes clear methodology for determining the following:

  (a) Average wait time for an urgent appointment;
  (b) Average distance to travel to a routine appointment; and
  (c) Average wait time for a routine appointment.

4. The extent to which the recruitment efforts outline the frequency and specific measures to be used to track the need to deploy recruitment activities for the provider types listed.

5. The extent to which the retention efforts outline the approach to keeping providers satisfied and in good-standing with the respondent.

6. The extent to which the quality and/or performance metrics it will use to gauge the respondent's progress toward the Agency's goals are transparent to providers, including the frequency with which providers will be able to access their progress.

Score: This section is worth a maximum of 45 raw points. Each of the above components are worth a maximum of 5 points each.

5 additional points will be awarded to respondents who demonstrate that providers shall have real-time access to their progress in achieving quality and/or performance metrics.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 9 – Vignette:

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

> ***Samuel is an 11-year-old recipient with quadriplegia and cerebral palsy. His doctor points out that his teeth are in bad shape with substantial dental caries, tartar (dental calculus) buildup, and gingivitis. His poor oral health condition is likely due to his dependence on gastronomy tube feedings to meet his fluid and nutritional needs. In addition, he suffers with gastroesophageal reflux, which exposes his teeth to acidic gastric contents.***
>
> ***His mother, Ramona, a single Hispanic woman with two other children and minimal English proficiency, concurs with the doctor. However, Ramona states, "Taking him to the dentist is not worth the hassle." She explains her challenges in transporting him safely to the dentist, when she already has to take him to so many other appointments. She cannot afford additional childcare for her other children. She also said that she was not happy with Samuel's dental provider, claiming she could not communicate well with him and felt very uncomfortable in the waiting room. Not only were other patients staring, but one of the receptionists came and asked her to move Samuel to a corner so he would not disturb other people. Furthermore, the dentist was not patient with Samuel when he became hyperactive and stated he needed to be provided general anesthesia for all dental work.***

The respondent shall describe its approach to coordinating care for an enrollee with Samuel's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

a. Health Risk Assessment
b. Care Coordination/Case Management
c. Availability of Other Treatment Options
d. Availability of Dental Providers (general and specialty)
e. Service Planning
f. Transportation Arrangements
g. Grievance and Appeals

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:

(a) Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
(b) Application of the respondent's case management risk stratification protocol;
(c) Identification of service needs (covered and non-covered) and a description for service referral processes;
(d) Description of the interventions and strategies that would be used to facilitate compliance with the plan of care;
(e) Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;
(f) Description of the assessment of provider capacity to meet the specific needs of enrollees;
(g) Identification of strategies that promote enrollee self-management and treatment adherence; and
(h) Motivational interviewing and use of various effective active and passive behavioral management techniques.

2. The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process.

3. The extent to which the respondent demonstrates innovative and evidence-based processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).

4. The extent to which the respondent demonstrates innovative and evidence-based alternative treatment options (e.g. silver diamine fluoride).

5. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary emergency department use.

6. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs or intellectual and developmental disabilities and provides evidence of strategies utilized that resulted in improved health outcomes.

7. The extent to which the respondent demonstrates a system of coordinated dental health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.

8. The extent to which the respondent describes innovative and evidence-based strategies to integrate information across all systems/processes into its workflows.

9. The extent to which the respondent's narrative includes provider (practicing and dental educational facility) education regarding motivational interviewing and evidence-based behavioral and case management options.

10. The extent to which the respondent's narrative includes a description of evidence-based interventions and strategies that will be used to serve enrollees in need of sedation services and behavioral management support.

Score: This section is worth a maximum of 85 raw points with each component being worth a maximum of 5 points each.

SRC# 10 –Dental Quality Measurement Experience:

The respondent shall describe its experience in achieving quality standards with populations similar to the target population described in this solicitation. Include in table format, the respondent's results for the performance measures specified below for each of the last two (2) years (Calendar Year 2015/Federal Fiscal Year 2014-15 and Calendar Year 2016/Federal Fiscal Year 2015-16) for the respondent's three (3) largest Medicaid contracts (measured by number of enrollees).

The respondent shall provide the data requested in **Exhibit A-4-a-1**, Dental Quality Measurement Tool to provide results for the following performance measures:

- Annual Dental Visit (HEDIS)
- Preventive Dental Services (Child Core Set/CMS-416)

Response:

Evaluation Criteria:

1. The extent of experience (e.g., number of contracts, enrollees or years) in achieving quality standards with similar target populations for the performance measures included in this submission requirement.

2. The extent to which the respondent exceeded the national mean for each of the quality measures reported and showed improvement from the first year to the second year reported. The national mean for Annual Dental Visit is the National Medicaid Mean as calculated and published by NCQA for the year prior to the year being reported (e.g., CY 2015 data are compared to the CY 2014 mean). The national mean for Preventive Dental Services is the most recently posted national mean calculated by the Centers for Medicare and Medicaid Services (CMS) based on CMS-416 data submitted by the states.

Score: This section is worth a maximum of 40 raw points with component 1 worth a maximum of 10 points and component 2 worth a maximum of 30 points as described below.

For each of the two (2) measure rates, a total of 3 points is available per state reported (for a total of 18 points available). The respondent will be awarded 1 point if their reported plan rate exceeded the national Medicaid mean for each available year, for each available state. The respondent will be awarded an additional 1 point for each measure rate where the second year's rate is an improvement over the first year's rate, for each available state.

An aggregate score will be calculated and the respondents will receive a final score of 0 through 30 corresponding to the number and percentage of points received out of the total available points, rounded to the nearest whole number. For example, if a respondent receives 100% of the available 18 points, the final score will be 30 points. If a respondent receives 15 (83.33%) of the available 18 points, the final score will be 25 points (83.33%). If a respondent receives 2 (11.11%)

of the available 18 points, the final score will be 3 points (11.11% of 30 is 3.33, rounded down to 3).

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
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SRC# 11 –Dental Performance Measure Experience – Part 1:

Describe any instances of failure to meet contractually-required quality standards for the measures listed below and actions taken to improve performance. Describe actions taken to improve quality performance when contract-required standards were met, but improvement was desirable.

- Annual Dental Visit
- Preventive Dental Services

Response:

Evaluation Criteria:

1. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and successfully remediate all failures for the dental performance measures included in this submission requirement.

2. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way even when contract-required standards were met but improvement was desirable for the performance measures included in this submission requirement.

Score: This section is worth a maximum of 10 raw points with each component worth a maximum of 5 points each.

SRC# 12 –Dental Performance Measure Experience – Part 2:

a. The respondent shall describe its experience in measuring performance and achieving quality standards with populations similar to the target population described in this solicitation. The respondent should describe experience with and performance on measures for the following elements of dental care:

(1) Dental Treatment Services (the percentage of individuals ages 1 to 20 who are enrolled in the plan for at least 90 continuous days, are eligible for EPSDT services, and who received at least one dental treatment service during the reporting period.

(2) Sealants for 6-9 Year-old Children at Elevated Caries Risk (the percentage of enrolled children in the age category of 6-9 years at elevated risk who received a sealant on a permanent first molar tooth within the reporting year).

(3) Oral Evaluation (the percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year).

(4) Topical Fluoride for Children at Elevated Caries Risk (the percentage of enrolled children 1-21 years who are at elevated risk who received at least 2 topical fluoride applications within the reporting year).

(5) Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children (the number of ED visits for caries-related reasons per 100,000 member months for all enrolled children)

(6) Follow-up after Emergency Department Visits for Dental Caries in Children (the percentage of ambulatory care sensitive ED visits for dental caries among children 0-20 years in the reporting period for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit)

b. The respondent shall describe any instances of failure to meet contract-required quality standards for these types of measures, actions taken to improve performance, and how improvement was measured.

c. The respondent shall describe its experience with and performance on other dental performance measures, any instances of failure to meet contract-required quality standards for these measures, actions taken to improve performance, and how improvement was measured.

d. The respondent shall describe the data sources used for collecting and reporting dental performance measures.

e. The respondent shall describe how the respondent has obtained data needed to track measures related to hospital admissions and discharges and emergency department visits.

Response:

Evaluation Criteria:

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

1. The extent of experience (e.g., number of contracts, enrollees, or years) in achieving quality standards with similar target populations for measures related to the elements of dental care identified as numbers a. through e.

2. The extent of experience (e.g., number of contracts, enrollees, or years) in achieving quality standards with similar target populations for other dental performance measures.

3. The extent to which the described experience demonstrates the ability to effectively measure quality improvement.

4. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way.

5. The extent to which the respondent met all quality measures or successfully remediated all failures.

6. The extent to which the respondent has used multiple data sources and has obtained data needed to collect and report on dental performance measures, including those that require information related to hospital admissions and discharges and emergency department visits.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

C. RECIPIENT EXPERIENCE

SRC# 13 – Primary Dental Provider Timely Access Standards:

The respondent shall describe the process and monitoring plan it uses to ensure compliance with the timely access standards as defined in **Exhibit B**, Statewide Medicaid Prepaid Dental Health Program, **Section VIII.**, Provider Services **Item A.**, Network Adequacy Standards, **Sub-Item 8.**, Timely Access Standards. The respondent shall also describe the process and methodology it uses for determining whether a PDP has the capacity to accept new patients.

Response:

Evaluation Criteria:

1. The extent to which the respondent's process and monitoring plan ensure that enrollees have access to services within the timely access standards defined in **Exhibit B**, Statewide Medicaid Prepaid Dental Health Program, **Section VIII.,** Provider Services, **Item A.**, Network Adequacy Standards, **Sub-Item 8.**, Timely Access Standards.

2. The extent to which the respondent's monitoring plan includes specific mitigation steps it will take if there is a potential accessibility issue identified.

3. The extent to which the respondent's process and methodology for determining PDP capacity clearly outline the steps and data used for determining whether a PDP has the capacity to accept new patients.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 14 – Provider Network – Network Development Plan:

The respondent shall submit a draft network development and management plan demonstrating how it will ensure timely access to the following services:

- Emergency dental services (pediatric)
- Preventive dental services (pediatric)
- Mobile dental services (pediatric and adult)

The respondent's approach shall include at a minimum:

a. Identification of network gaps (time/distance output reporting, after-hour clinic availability, open/closed panels, etc.);
b. Strategies that will be deployed to increase provider capacity where network gaps have been identified;
c. Strategies for ensuring timely access to services by measuring the time in-between when services are authorized and when they are received; and
d. Strategies for updating the network development and management plan, including the data that will be used to inform improvements to increase access to services.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's methodology for identifying and resolving barriers and network gaps, including ongoing activities or network development based on region-specific identified gaps and future needs projection.

2. The adequacy of the respondent's plan to meet the needs of enrollees if it is unable to provide the service(s) within its provider network, including immediate, short-term and long-term interventions.

3. The extent to which the respondent's plan includes strategies for measuring the time in-between when services are authorized and when they are received.

4. The extent to which the respondent's update of its network development and management plan is informed by multiple data sources (including complaints, grievances, etc.).

5. The extent to which the respondent's draft network development and management plan addresses the delegation of provider network functions to subcontractors and the oversight of these operations.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 15 – Expanded Benefits:

Based upon the expanded benefits listed in **Exhibit A-4-a-2**, Expanded Benefits Tool, the respondent shall identify the benefits it proposes to offer its enrollees for all eligible populations (TANF, ABD, medically needy, and home and community-based waiver populations)**. Exhibit A-4-a-2**, Expanded Benefits Tool outlines specific expanded benefits, including category, procedure code descriptions and procedure codes. When electing to offer expanded benefits included in **Exhibit A-4-a-2**, Expanded Benefits Tool, the respondent must offer the benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in **Exhibit A-4-a-2.**

Response: The respondent shall select the following expanded benefits it will offer, as listed in **Exhibit A-4-a-2**, Expanded Benefits Tool (Respondent shall check all that apply):

☐ Diagnostic dental benefits for adults
☐ Preventive dental benefits for adults
☐ Restorative dental benefits for adults
☐ Periodontics benefits for adults
☐ Oral and maxillofacial surgery benefits for adults
☐ Adjunctive general dental services for adults
☐ Pregnancy-related dental services
☐ Over-the-counter benefits
☐ Other dental benefits for adults

Evaluation Criteria:

Score: This section is worth a maximum of 90 raw points as outlined below.

(a)	Election of the Diagnostic Dental benefit for adults	10 pts
(b)	Election of the Preventive Dental benefit for adults	20 pts
(c)	Election of the Restorative Dental benefit for adults	10 pts
(d)	Election of the Periodontics benefit for adults	10 pts
(e)	Election of the Oral and Maxillofacial Surgery benefit for adults	10 pts
(f)	Election of the Over-the-counter benefit	10 pts
(g)	Election of the Pregnancy-related Dental benefit for adults	10 pts
(h)	Election of Other Dental benefits for adults	10 pts

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 16 – Online Provider Directory:

The respondent shall describe the provider search function for the online provider directory, including submission of:

a. A description outlining the transparency and accessibility of the online provider directory, including the parameters upon which enrollees may search. Include whether the online provider directory is mobile friendly.

b. Screen shots for each mouse click required from the start of the respondent's home page to actual search results for a provider, using pediatric dentists and zip code as the search elements.

c. A list of performance indicators the respondent will include for each provider type listed in its provider directory.

d. A description of the respondent's process for verification of provider information in the online provider directory and the method(s) the respondent uses to ensure the weekly network file submission to the Agency is accurate.

Response:

Evaluation Criteria:

1. The extent of the respondent's search functions for the respondent's online directory, dissemination of availability of the respondent's online directory to enrollees, and ease of access for enrollees' navigation of the online provider directory, including whether or not the online directory is mobile friendly.

2. The extent to which the number of clicks it takes recipients to access the search results, as indicated by the screen shots provided, is less than five (5).

3. The extent and relevance of the performance indicators available in the respondent's provider directory for each provider type listed.

4. The extent of the respondent's efforts to ensure information in the respondent's online provider directory is accurate, including type and frequency of monitoring activities, and delegated subcontractor provider information. Include the frequency of outreach efforts to remediate incorrect provider demographic information and accepting new patient status.

5. The extent to which the respondent's online provider directory updates are performed daily and the extent to which the updates are communicated to the Agency as required to ensure the information the respondent displays on its website align with the Agency's information.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

SRC# 17 – Enrollee Grievance and Appeal System:

The respondent shall provide a flowchart and written description of how the respondent will execute its enrollee grievance and appeal system, including identifying, tracking and analysis of enrollee complaints, grievances, appeals and Medicaid fair hearing data. The respondent shall include in the description detail regarding how data resulting from the grievance and appeal system are used to improve the operational performance of the respondent.

Response:

Evaluation Criteria:

1. The extent to which the respondent's grievance and appeal system flowchart reflects ease of access for individuals with complaints, grievances, and appeals, including ease of access for persons with disabilities or who speak other languages.

2. The extent to which the respondent's timelines for acknowledging and responding to complaints, grievances, and appeals are less than those specified in federal and State requirements.

3. The extent to which the respondent's complaint, grievance, appeal and Medicaid Fair Hearing data are aggregated so that results are actionable, protect enrollee privacy and are reviewed by the appropriate staff or committee for analysis and prioritization of corrective action and/or improvement initiatives.

4. The extent to which the respondent's complaint, grievance, and appeal process imposes deadlines on completion of corrective action plans implemented as a result of verified complaints, grievances or appeals and have set quality controls in place to review outcomes.

5. The extent to which the respondent is able to ensure all complaints (including those submitted to the respondent by the Agency or respondent's subcontractors) are tracked and resolved as part of the respondent's established complaint, grievance and appeal process.

6. The extent to which the respondent's grievance and appeal system data resulted in operational improvements of the respondent.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

D. PROVIDER EXPERIENCE

SRC# 18 – Provider Credentialing:

The respondent shall describe its proposed process to credential and recredential providers (including subcontractors' processes, if applicable), including credentialing timeframes, internal continuous quality improvement initiatives for recredentialing and reducing timelines and paperwork for submission, transparency for providers on their application status and the steps the respondent or its subcontractors will take to ensure the respondent and the Agency have accurate provider demographic information between credentialing cycles.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's description of its credentialing and recredentialing criteria, certified credential verification organization processes, and utilization of a third party credentialing vendor.

2. The extent to which the respondent's timeframes for processing credentialing applications is more expeditious than the industry standard processing timeline of one hundred twenty (120) days.

3. The adequacy of the respondent's approach to providing transparency to providers throughout the credentialing and recredentialing processes, including how providers will be informed at each step of the application process.

4. The extent to which the respondent uses information from provider complaints, monitoring, and recommendations from its Quality Improvement Committee in its recredentialing process.

5. The extent to which the respondent and its subcontractors incorporate the Agency's streamlined credentialing capability (via promotion of limited enrollment) in its credentialing and recredentialing processes.

6. The extent to which the respondent outlines steps the respondent and its subcontractors will take to ensure provider demographic or participation status changes are reported to the plan between credentialing cycles.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 19 – Provider Engagement Model:

The respondent shall describe in detail its provider engagement model. The respondent shall include the following elements in its description, at a minimum:

a. The respondent's staff that play a role in provider engagement;
b. The presence of local provider field representatives and their role;
c. The mechanism to track interactions with providers (electronic, physical, and telephonic);
d. How the respondent collects and analyzes utilization data and provider feedback, including complaints received, to identify specific training needs;
e. The metrics used to measure the overall satisfaction of network providers with the respondent; and
f. The approach and frequency of provider training on respondent and Agency requirements.

Response:

Evaluation Criteria:

1. The extent to which plan leadership are involved in provider engagement.

2. The extent to which local provider field representatives are incorporated into the model, including the ratio of local provider representatives to providers.

3. The extent to which the method the respondent uses to track interactions with providers is capable of producing meaningful data the respondent will use to address both clinical and administrative problem areas.

4. The extent to which the method the respondent uses to track interactions with providers addresses potential provider field representative training needs.

5. The extent to which the metrics used produce actionable data for measuring provider satisfaction, increasing provider performance, improving the provider engagement model, and identifying areas of improvement for provider related communications or written materials.

6. The extent to which the training includes service coverage guidelines, service authorization requirements, billing procedures, claims processing, payment timeframes, and respondent's dispute resolution process and timeframes, including corresponding requirements in scope of services.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 20 – Dispute Resolution:

The respondent shall describe in detail its provider dispute resolution process.

Response:

Evaluation Criteria:

1. The extent to which the respondent's process identifies claims related dispute trends and initiates process improvement activities/system enhancements.

2. The extent to which the respondent's process includes oversight to ensure appropriate plan dispute determinations and timely payments are made and claims disputes resolved within required timeframes.

3. The extent to which the respondent's process incorporates timely response to Agency requests related to complaint resolution in accordance with the scope of services.

4. The extent to which the respondent integrates all complaints, regardless of the complaint referral source (e.g., Agency, third party).

5. The extent to which the respondent's resolution process includes the respondent's participation in the Agency's claims dispute resolution program authorized in Section 408.7057, Florida Statutes, as well as includes the following:

  (a) Responding to requests for information from the State contracted independent dispute resolution organization;
  (b) A global process for analysis of arbitrated cases for possible identification of process improvement/system enhancements; and
  (c) Prompt payment of final orders issued by the Agency related to claims arbitration case determinations.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 21 – Claims Processing and Payment Process:

The respondent shall submit key components of its claims processing and payment process, addressing both paper and electronic claims submissions for both participating and non-participating providers.

The response shall include detailed information on the metrics to be employed by the vendor to track timeliness and accuracy of claims adjudication and payment for claims submitted by participating providers and how these metrics will be used by line level and management staff to improve processes and provide for rapid cycle improvement.

The response shall also include a detailed description of how the respondent will make data and metrics regarding claims and payment available to the Agency and will ensure that network providers have access to real-time and trend data regarding claims processing and payment by the respondent and all applicable proposed subcontractors.

Response:

Evaluation Criteria:

1. The extent to which the respondent has described key components of its claims processing and payment process in a format suitable for the public, including a description of the processes for claims submitted both on paper and electronically.

2. The extent to which the respondent has included detailed metrics to be employed by the respondent to track timeliness and accuracy of the claims processing and payment process.

3. The extent to which the respondent has included a detailed description of how metrics from the claims processing and payment process will be used throughout its organization to provide for rapid cycle improvement.

4. The extent to which the respondent has included a detailed description of its process to make data and metrics regarding the claims processing and payment process available to the Agency and that the described process provides sufficient opportunity for the Agency to access this data.

5. The extent to which the respondent has included a detailed description of its process to make data and metrics and trend data regarding claims processing and payment process available to network providers on a real-time basis and that the described process provides sufficient opportunities for network providers to access this data.

6. The extent to which the respondent has included its applicable proposed subcontractors in its response, with each component addressed for each applicable proposed subcontractor.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

E. DELIVERY SYSTEM COORDINATION

SRC# 22 – Coordination of Carved Out Services:

The respondent shall describe its approach to coordinating services that are not covered by the respondent but are covered by Florida Medicaid either through the fee-for-service delivery system (i.e., transportation, outpatient prescribed drugs, and facility-based services) or through a Managed Care Plan.

Response:

Evaluation Criteria:

1. The extent to which the respondent describes effective and efficient processes for reciprocal referral for needed services.

2. The adequacy of the respondent's approach to engage and educate enrollees in understanding the difference in benefits covered by the respondent and those that are available through other Medicaid delivery systems.

3. The extent to which the respondent's description includes a process for ensuring the respondent's staff and subcontractors are aware of and effectively communicate the appropriate information on services available through other Medicaid delivery systems.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 23 – Utilization Management:

The respondent shall describe the following related to its utilization management (UM) approach:

a. A description of the process used to determine whether a procedure should be prior authorized and that the UM criteria for each service have been evaluated to determine their appropriateness for administering a Medicaid benefit.

b. A description of how the respondent will ensure consistent application of the review criteria for authorization decisions including how the respondent will ensure preventive dental services, tooth reimplantation, stainless steel crowns, and extractions (simple and surgical) bypass authorization for children under 21 years of age.

c. A description of how the respondent will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope.

d. A description of the approach used to determine authorization of multi-session procedures for an enrollee, specifically highlighting any differences in the respondent's service authorization approach (if any exists) based on the number of sessions that must be authorized for the enrollee to complete the treatment series.

e. To the extent that a service requires multiple sessions, a description of the strategies that the respondent utilizes to ensure continuity of care and safeguards that are in place to reduce gaps in authorization.

f. A description and example of how the respondent will detect, monitor, and evaluate under-utilization, over-utilization, and inappropriate utilization as well as processes to identify and address opportunities for improvement.

Response:

Evaluation Criteria:

1. The extent to which the respondent describes the process and data sources utilized to determine whether a service should be prior authorized, including reviewing complaints or feedback from providers regarding burdensome or unnecessary prior authorization criteria.

2. The adequacy of the processes used by the respondent to determine whether the utilization management criteria selected are appropriate and consistent with policy requirements for a Medicaid benefit.

3. The adequacy of the respondent's approach to ensure the consistent application of review criteria for authorization decisions (e.g., inter-rater reliability studies and training for plan staff and network providers).

4. The adequacy of the review processes (data collection and analysis) deployed by the respondent to ensure services are not arbitrarily being denied or reduced.

5. The adequacy of the review processes (data collection and analysis) deployed by the respondent to identify aberrant utilization patterns (under and over utilization).

6. The adequacy of the respondent's approach in differentiating between UM protocols for authorization of services that are needed short-term (e.g., one-time authorization) vs. long-term (ongoing maintenance services/therapies).

7. The adequacy of the respondent's approach at ensuring continuity of care, particularly as it relates to multi-session procedures and special needs populations.

8. The extent to which the respondent provides a specific example of how its review processes resulted in successful interventions to alter unfavorable utilization patterns in the system.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

SRC# 24 – Utilization Management – Ease of Use (Providers):

The respondent shall describe the following related to its utilization management systems:

a. A description of how the respondent will ensure that the UM processes are designed so that service authorization requests are completed efficiently and with minimum administrative burden on network providers and enrollees;

b. A description of software capabilities that facilitate ease in requesting service authorization and support data exchanges between providers, specialty providers, subcontractors and the respondent (to the extent any UM functions are delegated);

c. A description of the respondent's experience meeting timeliness standards for service authorization requests;

d. A description of the approach that the respondent will use to educate enrollees and providers about the process for seeking authorization; and

e. A detailed workflow of how "special service" requests are processed for enrollees under the age of 21 years. Special services are requests that are made to the plan to exceed the limit on a Medicaid covered service or to cover a medically necessary service that is not listed in the Florida Medicaid handbook(s)/coverage policy(ies) or the associated fee schedule(s).

Response:

Evaluation Criteria:

1. The extent to which the respondent proposes the use of interoperable systems that will seamlessly integrate information from providers to the respondent and its subcontractors (to the extent any UM functions are delegated) and the extent to which the respondent describes how that information will be used to enhance care coordination services and to ensure there are no delays in authorization or gaps in care.

2. The extent to which the respondent uses strategies to reduce administrative burdens for the provider (e.g., software capabilities) in requesting authorization and its approach is streamlined with little to no redundancies between and across departments which could contribute to delayed service authorizations.

3. The extent to which the respondent has demonstrated experience with meeting timeliness standards for service authorization requests.

4. The adequacy of the respondent's education and training plan providers on the service authorization processes.

5. The extent to which the respondent ensures transparency in service authorization processes (e.g., makes available all utilization management protocols and criteria in an accessible location for service providers).

6. The extent to which the workflow describing the respondent's process for handling "special service" requests is consistent with EPSDT requirements.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 25 – Care Coordination:

The respondent shall describe its approach for identifying, assessing, and implementing interventions for enrollees that present with the following:

- Complex medical and/or behavioral health needs;
- Intensive dental health care needs; and
- Consistently accessing services at the highest level of care.

The respondent's approach shall include:

a. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level;
b. A description of minimum contact frequencies and contact type for each severity and/or risk level;
c. A description of evidence-based guidelines utilized in the approach to coordination of care, including interventions deployed to improve enrollee engagement and improve treatment adherence; and
d. A description of performance metrics used to evaluate the efficacy of the care coordination, including cost-savings, reduction in the use of higher cost services, etc.

Response:

Evaluation Criteria:

1. The extent to which the respondent's approach provides specific care coordination protocols, including a well-defined description of the respondent's algorithm and risk stratification approach and the incorporation of data elements other than diagnosis.

2. The extent to which the respondent describes data sources that are incorporated into the risk stratification process that is used for new enrollees.

3. The extent to which the respondent's approach includes the use of predictive modeling.

4. The extent to which the frequency and intensity of the care coordination services (i.e., minimum contact requirements) are aligned with the respondent's risk stratification process and proportional to the clinical and psychosocial needs of the target population.

5. The extent to which the respondent's approach includes innovative strategies for addressing the unique needs of highly resistant or difficult to serve populations.

6. The adequacy of the respondent's description of evidence-based interventions in achieving improved outcomes and enhancing enrollee engagement.

7. The efficacy of the respondent's approach in achieving cost savings, cost avoidance, emergency department diversion, increased utilization of ambulatory care settings, etc.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 26 – Early and Periodic Screening, Diagnosis and Treatment (EPSDT):

The respondent shall describe its approach to education and monitoring of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements, including:

a. A description of outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements and to improve compliance with the periodicity schedule and treatment recommendations that are identified as a result of a screening.

b. A training plan that includes descriptions of strategies that will be used to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the plan (case management, utilization management, provider relations, etc.) as well as subcontractors.

c. A description of the monitoring approach that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the plan and with subcontractors.

d. A plan for ensuring greater transparency among external stakeholders (e.g., advocacy groups) in the respondent's approach towards coverage of the EPSDT benefit.

e. A description of enhanced periodicity schedules as medically needed by enrollees under age 21.

f. A description of enhanced coverage of dental services by specialty providers as medically needed by enrollees under age 21.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's approach related to outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements.

2. The adequacy of the enrollee engagement approach and strategies that will be deployed to improve compliance with the periodicity schedule and treatment recommendations, including identification of the data sources that will be used to monitor compliance.

3. The adequacy of the respondent's training and education approach to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the plan/subcontractors. The respondent must illustrate a commitment to ongoing training and retraining of staff/subcontractors utilizing an array of mediums to earn all points for this component.

4. The adequacy of the respondent's monitoring approach, including all data sources that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the respondent and with subcontractors.

5. The extent to which the respondent's overall outreach approach identifies opportunities to improve upon the level of transparency for external stakeholders.

6. The extent to which the respondent's overall enhanced periodicity schedules and dental services coverage addresses medically needed services for enrollees under age 21.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 27 – Dental and Medical Health Coordination:

The respondent shall describe its proposed approach to integration between dental providers, medical providers, Statewide Medicaid Managed Care (SMMC) plans (Comprehensive Long-term Care Plan, Long-term Care Plus Plan, Managed Medical Assistance Plan, and Specialty Plan), and community entities (e.g., case managers, community health workers, community resources agencies, coalitions, organizations, or groups, school health programs, and school-based programs) to assure that the enrollee receives a continuum of preventive and curative services according to their needs over time and across different levels of the oral health system. The respondent shall demonstrate how this strategy plan will advance the goals of the Agency. The respondent's description shall include:

a. A description of the process designed to facilitate coordination of services between the dental home medical providers, the SMMC plan, and community partners.

b. A description of how the respondent's methodology to identify and stratify enrollees based on their specific needs is utilized to identify and implement service coordination opportunities.

c. A description of the reporting capabilities the respondent will utilize to collect, record, analyze, and report data to monitor and oversee the effectiveness of the dental plan's coordination efforts in meeting the Agency's goals.

Response:

Evaluation Criteria:

1. The extent to which the respondent has described a structured/uniform referral process/system between entities (provider network, medical providers, and managed care plans) for services related to dental care.

2. The extent to which the respondent has demonstrated a reporting tool and process to be used monthly to provide and receive updates between the dental plan and the managed care plan for tracking and coordination of care services as needed.

3. A description of formal processes to coordinate transportation services with the SMMC plan based on enrollee care needs.

4. A description of formal processes to coordinate and prevent emergency dental services with providers and the enrollee's managed care plan based on enrollee care needs.

5. The extent to which the respondent has described a structured/uniform referral process/system between community entities (e.g., case managers, community health workers, community resources agencies, coalitions, organizations or groups, school health programs, and school-based programs).

6. The extent to which the respondent describes sources of data and the use of those data sources to stratify populations to address oral health disparities, improve community

collaboration, and enhance care coordination between the provider network, physicians, and medical assistance managed care plans.

7. The extent to which the respondent demonstrates experience in coordination of care with School-Based Sealant and Prevention Programs (Section 466.003, Florida Statutes) and mobile dental units (Section 409.906, Florida Statutes).

8. The extent to which the respondent provides training to network providers on the importance of processes to support professional integration of care services (e.g., mailings, onsite training with oral health plan staff, trainings/webinars with CE opportunities, and statewide oral health conferences).

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 28 – Vignette:

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

> ***Deiondre is 19 years old. She was auto-assigned to your plan and enrolled effective January 1, 2019. Deiondre's enrollment information did not include a telephone number and listed a local area homeless shelter as her last place of residence. She left the shelter on December 27, 2018, and the shelter does not know her current whereabouts.***

The respondent shall describe the process it will use to attempt to contact Deiondre by March 29, 2019.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:

- **(a)** Identification of strategies for identifying new enrollees; and
- **(b)** Description of the sources of data/information that will be utilized to identify enrollees with special health care needs or circumstances.

2. The extent to which the respondent describes its process for contacting enrollees, including the data sources.

3. A description of how network providers and community partners will be engaged in the identification process.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

F. OVERSIGHT AND ACCOUNTABILITY

SRC# 29 – Subcontractor Oversight:

The respondent shall list any proposed subcontractors to which it will delegate the management of:

- Utilization management;
- Provider networks or third party payers; and
- Credentialing.

The respondent shall describe how it will oversee and monitor the performance of subcontractors in general, as well as any specific oversight planned for certain subcontractors, including any corresponding service level agreements. The respondent shall include in its response the schedule and type of monitoring and how findings are reported, remediated, and used for process improvements.

Response:

Evaluation Criteria:

1. The extent to which the respondent provides a list of subcontractors it proposes to use under the Statewide Medicaid Prepaid Dental Health Program for the delegation of work as described above.

2. The adequacy of the respondent's oversight structure, including the extent of executive level staff participation.

3. The extent to which the respondent uses and monitors for service level agreements consistent with the Statewide Medicaid Prepaid Dental Health Program Scope of Services.

4. The adequacy of the respondent's approach to monitoring the quality of work performed by subcontractors, including the frequency and type of monitoring.

5. The adequacy of the respondent's processes for addressing performance issues, including the triggers for increased monitoring activities, interventions and Contract compliance action.

6. The extent to which the respondent provides monitoring activities it will use to ensure the financial stability of the subcontractor, including the required financial reporting frequency for subcontractors.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each. Respondents not delegating any functions to a subcontractor will receive 30 raw points.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 30 - System Modification Protocol:

The respondent shall describe, in detail the following change control IT processes:

a. How the respondent will initiate and coordinate internal modifications for any of its core systems (including, but not limited to, encounter submission, EDI/Clearinghouse, and financial reporting) or any potential subcontractor's core systems,

b. How the respondent will accommodate Agency-directed IT modifications; and

c. How the respondent will identify, track, communicate, and resolve IT production issues that affect internal or external stakeholders.

For each of the descriptions, the respondent shall also include the expected timeframes for making modifications, the prioritization process employed, the communication processes used for planned or unplanned changes, as well as status updates provided to employees, Agency staff, and providers. The descriptions shall also address testing procedures, production control procedures, and any applicable claims/encounter reprocessing for historical or retroactive system changes.

Response:

Evaluation Criteria:

1. The adequacy of the respondent’s IT processes addressing internal modifications for its core systems and subcontractor’s systems.

2. The extent to which the respondent’s IT processes documented for implementing Agency-directed modifications is less than ninety (90) days.

3. The adequacy of the respondent’s processes documented for handling production IT system issues.

4. The adequacy of the respondent's communication process used when system issues/updates are identified and resolved by the respondent and/or its subcontractors throughout the change control process.

5. The adequacy of the respondent's approach to system internal testing to ensure the respondent's and/or subcontractors' system changes/updates are accurate.

6. The adequacy of the respondent's approach to integration testing to ensure the respondent's and/or subcontractors' system changes/updates do not adversely affect other systems, including systems operated by Florida Medicaid and subcontractors' systems.

7. The adequacy of the respondent's approach to applicable claims reprocessing for retroactive system changes, including processing performed by its subcontractor(s).

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

SRC# 31 – Encounter Data Submission:

a. The respondent shall submit a flow chart and narrative description of its encounter data submission process including, but not limited to, how accuracy, timeliness, and completeness are ensured.

b. Completeness of encounter submissions requires that key fields are populated accurately for every encounter submission. The respondent must describe quality control processes that will ensure key fields including, but not limited to, recipient Medicaid ID, provider Medicaid ID, claim type, place of service, revenue code, diagnosis codes, amount billed, amount paid, and all procedure codes are accurately populated when encounters are submitted.

c. The respondent shall demonstrate quality control procedures to ensure documentation and coding of encounters are consistent throughout all records and data sources (ASR, FMMIS, special submissions) and across providers and provider types. The description should include tracking, trending, reporting, process improvement, and monitoring of encounter submissions, encounter revisions, and methodology to eliminate duplicate data.

d. The respondent shall include any feedback mechanisms to improve encounter accuracy, timeliness and completeness.

e. The respondent shall include documentation of the most recent three (3) years of encounter data submission compliance ratings, corrective actions, if indicated, and timeframe for completing corrective actions for Florida Medicaid.

f. The respondent shall submit documentation describing the tools and methodologies used to determine compliance with encounter data submission requirements.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's process to ensure accurate, timely, and complete encounter data.

2. Demonstrated knowledge of the combination of key fields needed to identify services.

3. Adequacy of procedures, including quality control procedures, to identify key fields and ensure they are accurately populated during encounter data submission.

4. Adequacy of procedures to ensure encounters are coded consistently across providers and provider types.

5. Adequacy of procedures to ensure encounters (volume, categorization, dollar amounts, dates) are consistent across data sources, including applicable subcontractors.

6. The completeness of the respondent's flowcharts describing its encounter data submission process.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

7. The adequacy of the respondent’s mechanisms for tracking, trending, and monitoring encounter submissions and revisions, including the type and frequency of activities, and methodology to eliminate duplicate data.

8. The adequacy of the respondent’s encounter data submission historical compliance ratings.

9. The adequacy of the respondent’s ability to implement timely corrective actions to compliance ratings, if indicated.

10. The adequacy of the tools and methodologies used to determine compliance.

11. The adequacy of the respondent’s process for converting paper claims to electronic encounter data.

12. The adequacy of the respondent’s approach to identifying and correcting specific processing/systems issues that could result in invalid data being submitted to the State.

13. The adequacy of the tool to ensure that all encounters are submitted.

Score: This section is worth a maximum of 65 raw points with each of the above components being worth a maximum of 5 points each.

SRC# 32 – Encounter Submission for Sub-Capitated, Subcontracted, and Non-Participating Providers:

The respondent shall describe how it will work with providers, including subcapitated providers, subcontractors, and non-participating providers to ensure the accuracy, timeliness, and completeness of encounter data.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's approach to ensure that all network providers, including subcapitated providers, are known to the Florida Medicaid Management Information System (FMMIS) for the purposes of encounter data submission.

2. The adequacy of the respondent's approach to educating all providers about the importance of key field combinations in accurately identifying the service/s provided, the importance of populating all key fields, and the importance of consistency in coding across all records, providers, and provider types on encounter data submissions.

3. The adequacy of the respondent's approach to ensuring that all providers, including subcapitated providers and subcontractors, provide an amount or cost of the Medicaid service provided.

4. The adequacy of the respondent's approach to educating and supporting providers who submit paper claims.

5. The adequacy of the respondent's approach to encouraging providers, particularly subcapitated providers, subcontractors, and non-participating providers to submit accurate, timely, and complete encounter data, including the type and frequency of activities and any incentives/penalties.

6. The adequacy of the respondent's description of how it will connect with providers to revise encounter submissions in a timely manner.

7. The adequacy of the respondent's approach to work with providers to comply with correct coding.

8. The adequacy of the respondent's approach to ensure that all encounters are included in submissions.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 33 – Fraud and Abuse/Compliance Office:

The respondent shall describe its compliance program including the compliance officer's level of authority and reporting relationships. The respondent shall describe its experience in identifying subcontractor fraud and internal fraud and abuse in managed care programs. The respondent shall include a résumé or curriculum vitae for the compliance officer. The respondent shall also include an organizational chart that specifies which staff are involved in compliance, along with staff levels of authority.

Response:

Evaluation Criteria:

1. The extent to which the respondent's compliance program complies with all State and federal requirements.

2. The extent to which the respondent has identified a qualified individual with sufficient authority and adequate corporate governance reporting relationships to effectively implement and maintain the compliance program.

3. The extent to which there are sufficient staff to implement the compliance program.

4. The extent to which the respondent's compliance program has experience identifying subcontractor fraud and internal fraud and abuse in managed care programs.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 34 – Fraud and Abuse Special Investigations Unit (SIU):

The respondent shall describe its Special Investigations Unit (SIU) program and its controls for prevention and detection of potential or suspected fraud and abuse and overpayment, including the use of biometric or other technology to ensure that services are provided to the correct enrollee to ensure those services are being appropriately provided and that services billed were received by the correct enrollee.

Response:

Evaluation Criteria:

1. The extent to which the respondent uses various types of controls and automated approaches as part of a comprehensive approach to prevent and detect potential or suspected fraud and abuse and overpayment.

2. The extent to which the respondent uses biometric or other technology at the point of service delivery to prevent and detect potential or suspected fraud and abuse and overpayment.

3. The extent to which the respondent conducts clinical reviews and SIU investigations to detect potential or suspected fraud and abuse and overpayment.

4. The extent to which the respondent uses innovative technology for the purposes of verifying home-based visits and services.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 35 – Disaster Recovery Requirements:

The respondent shall demonstrate its capability and approach to meet the requirements described in **Attachment B**, Scope of Services, **Section X.D.4.h.**

Response:

Evaluation Criteria:

1. The adequacy of the respondent's proposed approach and capability to develop and maintain a disaster recovery plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed.

2. The adequacy of the respondent's proposed approach and capability to ensure the disaster recovery plan limits service interruption to a period of twenty-four (24) hours and ensures compliance with all requirements under the resulting Contract.

3. The adequacy of the respondent's proposed approach and capability to ensure the records backup standards and a comprehensive disaster recovery plan are developed and maintained by the respondent for the entire period of the resulting Contract and submitted for review annually by the anniversary date of the resulting Contract.

4. The adequacy of the respondent's proposed approach and capability to ensure it maintains a disaster recovery plan for restoring day-to-day operations including alternative locations for the vendor to conduct the requirements of the resulting Contract.

5. The adequacy of the respondent's proposed approach and capability to ensure it maintains database backups in a manner that eliminates disruption of service or loss of data due to system or program failures or destruction.

6. The adequacy of the respondent's proposed approach and capability to ensure the disaster recovery plan is finalized no later than thirty (30) calendar days prior to the resulting Contract effective date.

7. The adequacy of the respondent's proposed approach and capability to ensure it amends or updates its disaster recovery plan in accordance with the best interests of the Agency and at no additional cost to the Agency.

8. The adequacy of the respondent's proposed approach and capability to ensure it makes all aspects of the disaster recovery plan available to the Agency at all times.

9. The adequacy of the respondent's proposed approach and capability to ensure it conducts an annual Disaster Recovery Plan test and submits the results for review to the Agency.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 36 – Provider Network Agreements:

The respondent shall submit **Exhibit A-4-a-3**, Provider Network Agreements to demonstrate its progress with executing agreements by submitting **Exhibit A-4-a-3**.

Response:

Evaluation Criteria:

Percentage of agreements for each service provider type	Points
0.0%	0
1.0% - 25%	10
25.1%- 50%	20
50.1%- 75%	30
75.1% or greater	40

Score: This section is worth a maximum of 40 raw points based on the above point scale.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 37 – Organizational Commitment to Quality:

The respondent shall describe its organizational commitment to quality improvement, including active involvement by the respondent's dental, professional, and administrative leadership, and document its achievements with two (2) examples of completed quality improvement projects, including description of interim measurement and rapid cycle improvement processes, and a summary of results.

Response:

Evaluation Criteria:

1. The extent to which the respondent's description demonstrates that the dental director has substantial oversight in the assessment and enhancement of quality improvement activities, and the Chief Executive Officer is actively involved in quality management.

2. The adequacy of the respondent's approach to incorporating quality improvement activities into the culture and operations of the organization.

3. The extent to which the respondent describes proactive processes and strategies that are utilized to recognize and solve problems before they occur or are exacerbated.

4. The extent to which the respondent provides two examples of completed quality improvement projects that incorporated a data-driven quality improvement cycle.

5. The extent to which the respondent provides data on the results of the quality improvement projects that demonstrates the efficacy of the interventions.

6. The extent to which one of the quality improvement projects described by the respondent is related to reducing potentially preventable emergency department visits, improving dental outcomes, or improving delivery of services to individuals with intellectual and developmental disabilities.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 38 – Health Plan Accreditation:

The respondent shall specify its current accreditation status by a nationally recognized accreditation body. This shall include the name of the accrediting body, the most recent date of accreditation, the effective date of the accreditation, the type and/or level of accreditation, and the status of accreditation (i.e., provisional, conditional, etc.). The respondent shall attach documentation that supports this information.

Response:

Evaluation Criteria:

1. Evidence that the respondent has:

- **(a)** Full health plan accreditation by a nationally recognized accrediting body; e.g., full three (3) year accreditation for the National Committee for Quality Assurance (NCQA), full three (3) year accreditation for Utilization Review Accreditation Commission (URAC), or full three (3) year accreditation for Accreditation Association for Ambulatory Health Care, Inc. (AAAHC); or
- **(b)** Partial/conditional health plan accreditation (e.g., provisional for NCQA, conditional or provisional for URAC, or one (1) year or six (6) months for AAAHC); or
- **(c)** No health plan accreditation or denied accreditation.

Score: This section is worth a maximum of 5 raw points as outlined below:

- **(a)** 5 points for full health plan accreditation.
- **(b)** 3 points for partial/conditional health plan accreditation.
- **(c)** 0 points if health plan accreditation denied or no accreditation.

EXHIBIT A-4-a-1
SRC# 10 – DENTAL QUALITY MEASUREMENT TOOL

Exhibit A-4-a-1, SRC# 10 – Dental Quality Measurement Tool, is available for respondents to download at:

http://ahca.myflorida.com/procurements/index.shtml.

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EXHIBIT A-4-a-2
SRC# 15 – EXPANDED BENEFITS TOOL

Exhibit A-4-a-2, SRC# 15 – Expanded Benefits Tool, is available for respondents to download at:

http://ahca.myflorida.com/procurements/index.shtml.

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EXHIBIT A-4-a-3
SRC# 36 – PROVIDER NETWORK AGREEMENTS

Exhibit A-4-a-3, SRC# 36 – Provider Network Agreements, is available for respondents to download at:

http://ahca.myflorida.com/procurements/index.shtml.

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EXHIBIT A-5
SUMMARY OF RESPONDENT COMMITMENTS

PURPOSE: The Agency will review and utilize this Exhibit during the negotiation process, for respondents who are invited to negotiations, to capture commitments made by the respondent in response to this solicitation.

INSTRUCTIONS: The respondent shall identify each commitment made/proposed in the solicitation. Commitments include, but are not limited to: innovations that assist in achieving the Agency goals, improvements in service delivery coordination and quality outcomes for enrollees, improving the enrollee experience, commitments made in the respondent's provider engagement approach which result in an improved provider experience, and commitments reducing overall costs to the Medicaid program. The respondent shall identify the solicitation section/sub-section (Attachment X, Exhibit Y, Subsection Z), as applicable where the commitment can be found.

Category	Commitment (Brief Summary/Description)	Solicitation Section Reference
Example: Agency Goals	(Respondent to complete)	Exhibit A-4-a, Section B., Agency Goals, SRC# 4 - Oral Health Promotion and Disease Prevention

Respondent Name

Authorized Official Signature **Date**

Authorized Official Printed Name

Authorized Official Title

EXHIBIT A-6
CERTIFICATION OF DRUG-FREE WORKPLACE PROGRAM

In the event of Identical or Tie Bids/Proposals: Preference shall be given to businesses with drug-free workplace programs. Whenever two or more bids which are equal with respect to price, quality, and service are received by the State or by any political subdivision for the procurement of commodities or contractual services, a bid received from a business that certifies that it has implemented a drug-free work place program shall be given preference in the award process. Established procedures for processing tied awards will be followed if none of the tied vendors have a drug-free workplace program. In order to have a drug-free workplace program, a business shall:

1) Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.

2) Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.

3) Give each employee engaged in providing the commodities or contractual services that are under bid a copy of the statement specified in subsection (1).

4) In the statement specified in subsection (1), notify the employees that, as a condition of working on the commodities or contractual services that are under bid, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of chapter 893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.

5) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program if such is available in the employee's community by, any employee who is so convicted.

6) Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

As the person authorized to sign the statement, I certify that this firm complies fully with the above requirements.

_____
Respondent Name

________________________________ ____________________
Authorized Official Signature **Date**

_____
Authorized Official Printed Name

_____
Authorized Official Title

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
STANDARD CONTRACT

All respondents should review the proposed contract language contained below. In responding to this solicitation, a respondent has agreed to accept the terms and conditions of the Contract contained in this Exhibit. Note: If the resulting Contract is funded with Federal funds, additional terms and conditions may be included at the time of contract award based on the specific Federal requirements.

THIS CONTRACT is entered into between the State of Florida, **AGENCY FOR HEALTH CARE ADMINISTRATION**, hereinafter referred to as the "**Agency**", whose address is 2727 Mahan Drive, Tallahassee, Florida 32308, and **VENDOR NAME** hereinafter referred to as the "**Vendor**", whose address is **VENDOR ADDRESS**, a (type of entity), to provide service description.

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I. THE VENDOR HEREBY AGREES:

A. General Provisions

1. To provide services according to the terms and conditions set forth in this Contract, **Attachment I**, Scope of Services, and all other attachments named herein which are attached hereto and incorporated by reference (collectively referred to herein as this "Contract").

2. To perform as an independent vendor and not as an agent, representative or employee of the Agency.

3. To recognize that the State of Florida, by virtue of its sovereignty, is not required to pay any taxes on the services or goods purchased under the terms of this Contract.

B. Florida Department of State

To be registered with the Florida Department of State as an entity authorized to transact business in the State of Florida by the effective date of this Contract.

C. MyFloridaMarketPlace

1. Each Vendor doing business with the State of Florida for the sale of commodities or contractual services as defined in Section 287.012, Florida Statutes (F.S.), shall register in MyFloridaMarketPlace, in compliance with Rule 60A-1.030, Florida Administrative Code (F.A.C.), unless exempt under Rule 60A-1.030(3), F.A.C.

2. This Contract has been exempted by the Florida Department of Management Services from paying the transaction fee per Rule 60A-1.032(2)(a and b), F.A.C.

D. Federal Laws and Regulations

1. This Contract contains Federal funds, therefore, the Vendor shall comply with all applicable Federal requirements pertaining to procurement, including but not limited to Chapter 2 of the Code of Federal Regulations (CFR) and any other final or interim rules.

2. This Contract contains Federal funding in excess of **$100,000.00**, therefore, the Vendor must, upon Contract execution, complete the Certification Regarding Lobbying Form, **Attachment III.** If a Disclosure of Lobbying Activities Form, Standard Form LLL, is required, it may be obtained from the Agency's Contract Manager. All disclosure forms as required by the Certification Regarding Lobbying Form must be completed and returned to the Agency's Procurement Office.

3. Pursuant to 2 CFR 376, the Vendor must, upon Contract execution, complete the Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion Contracts/Subcontracts Form, **Attachment IV.**

E. Prohibition of Gratuities

To certify that no elected official or employee of the State of Florida has or shall benefit financially or materially from this Contract in violation of the provisions of Chapter 112, F.S. This Contract may be terminated if it is determined that gratuities of any kind were either offered or received by any of the aforementioned parties.

F. Audits/Monitoring

1. The Agency may conduct, or have conducted, performance and/or compliance reviews, reviews of specific records or other data as determined by the Agency. The Agency may conduct a review of a sample of analyses performed by the Vendor to verify the quality of the Vendor's analyses. Reasonable notice shall be provided for reviews conducted at the Vendor's place of business.

2. Reviews may include, but shall not be limited to, reviews of procedures, computer systems, recipient records, accounting records, and internal quality control reviews. The Vendor shall work with any reviewing entity selected by the Agency.

3. During this Contract period, these records shall be available at the Vendor's office at all reasonable times. After this Contract period and for ten (10) years following, the records shall be available at the Vendor's chosen location subject to the approval of the Agency. If the records need to be sent to the Agency, the Vendor shall bear the expense of delivery. Prior approval of the disposition of the Vendor and subcontractor records must be requested and approved by the Agency. This obligation survives termination of this Contract.

4. The Vendor shall comply with all applicable Federal requirements pertaining to procurement, including but not limited to Chapter 2 of the CFR and any other final or interim rules with respect to audit requirements of Federal contracts administered through State and local public agencies.

5. The Vendor shall maintain and file with the Agency such progress, fiscal and inventory reports as specified in **Attachment I**, Scope of Services, and other reports as the Agency may require within the period of this Contract. In addition, access to relevant computer data and applications which generated such reports should be made available upon request.

6. The Vendor shall ensure that all related party transactions are disclosed to the Agency Contract Manager.

7. The Vendor shall provide a financial and compliance audit to the Agency as specified in Attachment **Number,** Name and to ensure that all related party transactions are disclosed to the Agency Contract Manager. Additional audit requirements are specified in **Attachment I**, Scope of Services, **Section Number,** Name.

8. The Vendor shall include these aforementioned audit and record keeping requirements in all approved subcontracts and assignments.

G. Inspection of Records and Work Performed

1. The Agency and its authorized representatives shall, at all reasonable times, have the right to enter the successful Vendor's premises, or other places where duties under this Contract are performed. All inspections and evaluations shall be performed in such a manner as not to unduly delay work. Persons duly authorized by the Agency and federal auditors, pursuant to 45 CFR, Part 74 and/or 45 CFR, Part 92, shall have full access to and the right to examine any of said records and documents.

2. The Vendor shall retain all financial records, medical records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to performance under this Contract for a period of ten (10) years after termination of this Contract, or if an audit has been initiated and audit findings have not been resolved at the end of ten (10) years, the records shall be retained until resolution of the audit findings.

4. Refusal by the Vendor to allow access to all records, documents, papers, letters, other materials or on-site activities related to this Contract performance shall constitute a breach of this Contract.

5. The right of the Agency and its authorized representatives to perform inspections shall continue for as long as the Vendor is required to maintain records.

6. The Vendor shall be responsible for all storage fees associated with all records maintained under this Contract. The Vendor is also responsible for the destruction of all records that meet the retention schedule noted above.

7. Failure to retain all records as required may result in cancellation of this Contract. The Agency shall give the Vendor advance notice of cancellation pursuant to this provision and shall pay the Vendor only those amounts that are earned prior to the date of cancellation in accordance with the terms and conditions of this Contract. Performance by the Agency of any of its obligations under this Contract shall be subject to the successful Vendor's compliance with this provision.

8. In accordance with Section 20.055, F.S., the Vendor and its subcontractors shall cooperate with the Office of the Inspector General in any investigation, audit, inspection, review or hearing; and shall grant access to any records, data or other information the Office of the Inspector General deems necessary to carry out its official duties.

9. The rights of access in this Section must not be limited to the required retention period but shall last as long as the records are retained.

H. Accounting

1. To maintain an accounting system and employ accounting procedures and practices that conform to generally accepted accounting principles and standards. All charges applicable to this Contract shall be readily ascertainable from such records.

2. To submit annual financial audits (or parent organization's annual financial audits with organizational chart) to the Agency within thirty (30) calendar days of receipt.

I. Public Records Requests

1. To comply with Section 119.0701, F.S., if applicable, and all other applicable parts of the Florida Public Records Act.

2. To keep and maintain public records that ordinarily and necessarily would be required in order to perform services under this Contract.

3. To provide the public with access to public records on the same terms and conditions that the Agency would provide the records and at a cost that does not exceed the cost provided in Section 119.07, F.S., or as otherwise provided by law.

4. To upon request from the appropriate Agency custodian of public records, provide the Agency with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost in Section 119.07, F.S., or as otherwise provided by law.

5. To ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of this Contract term and following completion of this Contract if the Vendor does not transfer the records to the Agency.

6. To not collect an individual's social security number unless the Vendor has stated in writing the purpose for its collection. The Vendor collecting an individual's social security number shall provide a copy of the written statement to the Agency and otherwise comply with applicable portions of Section 119.071(5), F.S.

7. To meet all requirements for retaining public records and transfer, at no cost, to the Agency all public records in possession of the Vendor upon termination of this Contract and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. All records stored electronically must be provided to the Agency in a format that is compatible with the information technology systems of the Agency.

8. If the Vendor does not comply with a public records request, the Agency shall enforce Contract provisions in accordance with this Contract.

9. **IF THE VENDOR HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE VENDOR'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS CONTRACT, CONTACT THE AGENCY CUSTODIAN OF PUBLIC RECORDS FOR THIS CONTRACT. THE AGENCY CUSTODIAN OF PUBLIC**

RECORDS FOR THIS CONTRACT IS THE CONTRACT MANAGER.

J. Communications

1. Notwithstanding any term or condition of this Contract to the contrary, the Vendor bears sole responsibility for ensuring that its performance of this Contract fully complies with all State and Federal law governing the monitoring, interception, recording, use or disclosure of wire, oral or electronic communications, including but not limited to the Florida Security of Communications Act, Section 934.01, et seq., F.S.; and the Electronic Communications Privacy Act, 18 U.S.C. Section 2510 et seq. (hereafter, collectively, "Communication Privacy Laws").

2. Prior to intercepting, recording or monitoring any communications which are subject to Communication Privacy Laws, the Vendor must:

   a. Submit a plan which specifies in detail the manner in which the Vendor will ensure that such actions are in full compliance with Communication Privacy Laws (the "Privacy Compliance Plan"); and

   b. Obtain written approval, signed and notarized by the Agency Contract Manager, approving the Privacy Compliance Plan.

3. No modifications to an approved Privacy Compliance Plan may be implemented by the Vendor unless an amended Privacy Compliance Plan is submitted to the Agency, and written approval of the amended Privacy Compliance Plan is signed and notarized by the Agency Contract Manager. Agency approval of the Vendor's Privacy Compliance Plan in no way constitutes a representation by the Agency that the Privacy Compliance Plan is in full compliance with applicable Communication Privacy Laws, or otherwise shifts or diminishes the Vendor's sole burden to ensure full compliance with applicable Communication Privacy Laws in all aspects of the Vendor's performance of this Contract. Violation of this term may result in sanctions to include termination of this Contract and/or liquidated damages.

4. The Vendor agrees that it is the custodian of any and all recordings for purposes of the Public Records Act, Chapter 119, F.S., and is solely responsible for responding to any public records requests for recordings. This responsibility includes gathering, redaction, duplication and provision of the recordings as well as defense of any actions for enforcement brought pursuant to Section 119.11, F.S.

K. Background Screening

1. To ensure that all Vendor employees including managing employees that have direct access to personally identifiable information (PII), protected health information (PHI), or financial information have a County, State, and Federal criminal background screening comparable to a level 2 background screening as described in Section 435.04, F.S., completed with results prior to employment.

2. Per Section 435.04(1)(a), F.S., level 2 screening standards include, but need not be limited to, fingerprinting for statewide criminal history records checks through the Department of Law Enforcement, and national criminal history records checks through the Federal Bureau of Investigation, and may include local criminal records checks through local law enforcement agencies.

3. If the Vendor employee or managing employee was employed prior to the execution of this Contract, the Vendor shall ensure that the County, State, and Federal criminal background screening comparable to a level 2 background screening is completed with results prior to the employee accessing any PII, PHI, or financial information.

4. Any Vendor employee or managing employee with background results that are unacceptable to the State as described in Section 435.04, F.S., or related to the criminal use of PII as described in Section 817, F.S., or has been subject to criminal penalties for the misuse of PHI under 42 U.S.C. 1320d-5, or has been subject to criminal penalties for the offenses described in Section 812.0195, F.S., Section 815, F.S., Section 815.04, F.S., or Section 815.06, F.S., shall be denied employment or be immediately dismissed from performing services under this Contract by the Vendor unless an exemption is granted.

5. Direct access is defined as having, or expected to have, duties that involve access to PII, PHI, or financial information by any means including, but not limited to, network shared drives, email, telephone, mail, computer systems, and electronic or printed reports.

6. To ensure that all Vendor employees including managing employees that have direct access to any PII, PHI or financial information have a County, State, and Federal criminal background screening comparable to a level 2 background screening completed with results every five (5) years.

7. To develop and submit policies and procedures related to this criminal background screening requirement to the Agency for review and approval within thirty (30) calendar days of this Contract execution. The Vendor's policies and procedures shall include a procedure to grant an exemption from disqualification for disqualifying offenses revealed by the background screening, as described in Section 435.07, F.S.

8. To keep a record of all background screening records to be available for Agency review upon request.

9. Failure to comply with background screening requirements shall subject the Vendor to liquidated damages as described **Attachment I,** Scope of Services.

L. Monitoring

1. To provide reports as specified in **Attachment I**, Scope of Services. These reports will be used for monitoring progress or performance of the contractual services as specified in **Attachment I**, Scope of Services.

2. To permit persons duly authorized by the Agency to inspect any records, papers, documents, facilities, goods and services of the Vendor which are relevant to this Contract.

3. To ensure that each of its employees or subcontractors who performs activities related to the services associated with this Contract will report to the Agency any health care facility that is the subject of these services that may have violated the law. To report concerns pertaining to a health care facility, the Vendor employee or subcontractor may contact the Agency Complaint Hotline by calling 1-888-419-3456 or by completing the online complaint form found at https://apps.ahca.myflorida.com/hcfc.

4. To ensure that each of its employees or subcontractors who performs activities related to the services associated with this Contract, will report to the Agency areas of concern relative to the operation of any entity covered by this Contract. To report concerns, the Vendor employee or subcontractor may contact the Agency Complaint Hotline by calling 1-877-254-1055 or by completing the online complaint form found at https://apps.ahca.myflorida.com/smmc_cirts/.

5. Reports which represent individuals receiving services are at risk for, or have suffered serious harm, impairment, or death shall be reported to the Agency immediately and no later than twenty four (24) clock hours after the observation is made. Reports that reflect noncompliance that does not rise to the level of concern noted above shall be reported to the Agency within ten (10) calendar days of the observation.

M. Indemnification

The Vendor agrees to indemnify, defend, and hold harmless the Agency, as provided in this Clause.

1. Scope. The Duty to Indemnify and the Duty to Defend, as described herein (collectively known as the "Duty to Indemnify and Defend"), extend to any completed, actual, pending or threatened action, suit, claim or proceeding, whether civil, criminal, administrative or investigative (including any action by or in the right of the Vendor), and whether formal or informal, in which the Agency is, was or becomes involved and which in any way arises from, relates to or concerns the Vendor's acts or omissions related to this Contract (inclusive of all attachments, etc.) (collectively "Proceeding").

a. Duty to Indemnify. The Vendor agrees to hold harmless and indemnify the Agency to the full extent permitted by law against any and all liability, claims, actions, suits, judgments, damages and costs of whatsoever name and description, including attorneys' fees, arising from or relating to any Proceeding.

b. Duty to Defend. With respect to any Proceeding, the Vendor agrees to fully defend the Agency and shall timely reimburse all of the Agency's legal fees and costs; provided, however, that the amount of such payment for attorneys' fees and costs is reasonable pursuant to rule 4–1.5, Rules Regulating The Florida Bar. The Agency retains the exclusive right to select, retain and direct its defense through defense counsel funded by the Vendor pursuant to the Duty to Indemnify and Defend the Agency.

2. Expense Advance. The presumptive right to indemnification of damages shall include the right to have the Vendor pay the Agency's expenses in any Proceeding as such expenses are incurred and in advance of the final disposition of such Proceeding.

3. Enforcement Action. In the event that any claim for indemnity, whether an Expense Advance or otherwise, is made hereunder and is not paid in full within sixty (60) calendar days after written notice of such claim is delivered to the Vendor, the Agency may, but need not, at any time thereafter, bring suit against the Vendor to recover the unpaid amount of the claim (hereinafter "Enforcement Action"). In the event the Agency brings an Enforcement Action, the Vendor shall pay all of the Agency's attorneys' fees and expenses incurred in bringing and pursuing the Enforcement Action.

4. Contribution. In any Proceeding in which the Vendor is held to be jointly liable with the Agency for payment of any claim of any kind (whether for damages, attorneys' fees, costs or otherwise), if the Duty to Indemnify provision is for any reason deemed to be inapplicable, the Vendor shall contribute toward satisfaction of the claim whatever portion is or would be payable by the Agency in addition to that portion which is or would be payable by the Vendor, including payment of damages, attorneys' fees and costs, without recourse against the Agency. No provision of this part or of any other section of this Contract (inclusive of all attachments, etc.), whether read separately or in conjunction with any other provision, shall be construed to: (i) waive the State or the Agency's immunity to suit or limitations on liability; (ii) obligate the State or the Agency to indemnify the Vendor for the Vendor's own negligence or otherwise assume any liability for the Vendor's own negligence; or (iii) create any rights enforceable by third parties, as third party beneficiaries or otherwise, in law or in equity.

N. Insurance

1. To the extent required by law, the Vendor shall be self-insured against, or shall secure and maintain during the life of this Contract, Worker's Compensation Insurance for all its employees connected with the work of this Contract and, in case any work is subcontracted, the Vendor shall require the subcontractor similarly to provide Worker's Compensation Insurance for all of the latter's employees unless such employees engaged in work under this Contract are covered by the Vendor's self-insurance program. Such self-insurance or insurance coverage shall comply with the Florida Worker's Compensation law. In the event hazardous work is being performed by the Vendor under this Contract and any class of employees performing the hazardous work is not protected under Worker's Compensation statutes, the Vendor shall provide, and cause each subcontractor to provide, adequate insurance satisfactory to the Agency, for the protection of its employees not otherwise protected.

2. The Vendor shall secure and maintain Commercial General Liability insurance including bodily injury, property damage, personal and advertising injury and products and completed operations. This insurance will provide coverage for all claims that may arise from the services and/or operations completed under this Contract, whether such services and/or operations are by the Vendor or anyone directly, or indirectly employed by it. Such insurance shall include a Hold Harmless Agreement in favor of the State of Florida and also include the State of Florida as an Additional Named Insured for the entire length of this Contract

and hold the State of Florida harmless from subrogation. The Vendor shall set the limits of liability necessary to provide reasonable financial protections to the Vendor and the State of Florida under this Contract.

3. All insurance policies shall be with insurers licensed or eligible to transact business in the State of Florida. The Vendor's current insurance policy(ies) shall contain a provision that the insurance will not be canceled for any reason except after thirty (30) calendar days written notice. The Vendor shall provide thirty (30) calendar days written notice of cancellation to the Agency's Contract Manager.

4. The Vendor shall submit insurance certificates evidencing such insurance coverage prior to execution of this Contract.

O. Assignments and Subcontracts

To neither assign the responsibility of this Contract to another party nor subcontract for any of the work contemplated under this Contract without prior written approval of the Agency. No such approval by the Agency of any assignment or subcontract shall be deemed in any event or in any manner to provide for the incurrence of any obligation of the Agency in addition to the total dollar amount agreed upon in this Contract. All such assignments or subcontracts shall be subject to the conditions of this Contract and to any conditions of approval that the Agency shall deem necessary.

P. Subcontracting

1. To not subcontract, assign, or transfer any work identified under this Contract, without prior written consent of the Agency.

2. All subcontracts must comply with applicable State and/or Federal law.

3. The Agency encourages Vendors to partner with subcontractors who can provide best value and the best in class solutions. However, the Vendor is responsible for all work performed under this Contract. No subcontract that the Vendor enters into with respect to performance under this Contract shall in any way relieve the Vendor of any responsibility for performance of its duties. The Vendor shall assure that all tasks related to the subcontract are performed in accordance with the terms of this Contract. If the Agency determines, at any time, that a subcontract is not in compliance with a Contract requirement, the Vendor shall promptly revise the subcontract to bring it into compliance. In addition, the Vendor may be subject to sanctions and/or liquidated damages pursuant to this Contract and Section 409.912(6), F.S. (related to sanctions).

4. All payments to subcontractors will be made by the Vendor.

5. To be responsible for monitoring the subcontractor's performance. The results of the monitoring shall be provided to the Agency's Contract Manager, fourteen (14) business days after the end of each month or as specified by the Agency. If the subcontractor's performance does not meet the Agency's performance standard according to the Agency's monitoring report or the Vendor's monitoring report, an improvement plan must be submitted to the Vendor and the Agency within fourteen (14) business days of the deficient report.

6. The State supports and encourages supplier diversity and the participation of

small and minority business enterprises in State contracting, both as Vendors and subcontractors. The Agency supports diversity in its Procurement Program and requests that all subcontracting opportunities afforded by this Contract enthusiastically embrace diversity. The award of subcontracts should reflect the full diversity of the citizens of the State of Florida. Vendors can contact the Office of Supplier Diversity at (850) 487-0915 or online at http://osd.dms.state.fl.us/ for information on minority Vendors who may be considered for subcontracting opportunities.

7. A minority owned business is defined as any business enterprise owned and operated by the following ethnic groups: African American (Certified Minority Code H or Non-Certified Minority Code N); Hispanic American (Certified Minority Code I or Non-Certified Minority O); Asian American (Certified Minority Code J or Non-Certified Minority Code P); Native American (Certified Minority Code K or Non-Certified Minority Code Q); or American Woman (Certified Minority Code M or Non-Certified Minority Code R).

Q. Return of Funds

To return to the Agency any overpayments due to unearned funds or funds disallowed pursuant to the terms of this Contract that were disbursed to the Vendor by the Agency. The Vendor shall return any overpayment to the Agency within forty (40) calendar days after either discovery by the Vendor, its independent auditor, or notification by the Agency, of the overpayment.

R. Purchasing

1. P.R.I.D.E.

It is expressly understood and agreed that any articles which are the subject of, or required to carry out, this Contract shall be purchased from the corporation identified under Chapter 946, F.S., if available, in the same manner and under the same procedures set forth in Section 946.515(2) and (4), F.S.; and for purposes of this Contract the person, firm, or other business entity carrying out the provisions of this Contract shall be deemed to be substituted for this Agency insofar as dealings with such corporation are concerned.

The “Corporation identified” is PRISON REHABILITATIVE INDUSTRIES AND DIVERSIFIED ENTERPRISES, INC. (P.R.I.D.E.) which may be contacted at:

P.R.I.D.E.
12425 28th Street North, Suite 300
St. Petersburg, FL 33716
info@pride-enterprises.org
(727) 556-3300
Toll Free: 1-800-643-8459
Fax: (727) 570-3366

2. RESPECT of Florida

It is expressly understood and agreed that any articles that are the subject of, or required to carry out, this Contract shall be purchased from a nonprofit agency for the blind or for the severely handicapped that is qualified pursuant to Chapter

413, F.S., in the same manner and under the same procedures set forth in Section 413.036(1) and (2), F.S.; and, for purposes of this Contract the person, firm, or other business entity carrying out the provisions of this Contract shall be deemed to be substituted for this Agency insofar as dealings with such qualified nonprofit agency are concerned.

The "nonprofit agency" identified is RESPECT of Florida which may be contacted at:

RESPECT of Florida
2475 Apalachee Parkway, Suite 205
Tallahassee, Florida 32301-4946
(850) 487-1471
www.respectofflorida.org

S. Procurement of Products or Materials with Recycled Content

It is expressly understood and agreed that any products which are required to carry out this Contract shall be procured in accordance with the provisions of Section 403.7065, F.S.

T. Civil Rights Requirements/Vendor Assurance

The Vendor assures that it will comply with:

1. Title VI of the Civil Rights Act of 1964, as amended, 42 United States Code (U.S.C.) 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin.

2. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap.

3. Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex.

4. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age.

5. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs.

6. The Americans with Disabilities Act of 1990, Public Law (P.L.) 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities.

7. Chapter 409, F.S.

8. Rule 62-730.160, F.A.C. pertaining to standards applicable to generators of hazardous waste.

9. All applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 United States Code (U.S.C.) 7401 et seq.

10. The Medicare-Medicaid Fraud and Abuse Act of 1978.

11. Other Federal omnibus budget reconciliation acts.

12. The Balanced Budget Act of 1997.

13. All regulations, guidelines, and standards as are now or may be lawfully adopted under the above statutes.

The Vendor agrees that compliance with this assurance constitutes a condition of continued receipt of or benefit from funds provided through this Contract, and that it is binding upon the Vendor, its successors, transferees, and assignees for the period during which services are provided. The Vendor further assures that all contractors, subcontractors, subgrantees, or others with whom it arranges to provide services or benefits to participants or employees in connection with any of its programs and activities are not discriminating against those participants or employees in violation of the above statutes, regulations, guidelines, and standards.

U. Equal Employment Opportunity (EEO) Compliance

To not discriminate in its employment practices with respect to race, color, religion, age, sex, marital status, political affiliation, national origin, or handicap.

V. Discrimination

Pursuant to Section 287.134(2)(a), F.S., an entity or affiliate who has been placed on the discriminatory vendor list may not submit a Bid, Proposal, or Reply on a contract to provide any goods or services to a public entity; may not submit a Bid, Proposal, or Reply on a contract with a public entity for the construction or repair of a public building or public work; may not submit Bids, Proposals, or Replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and may not transact business with any public entity. The Florida Department of Management Services is responsible for maintaining the discriminatory vendor list. Questions regarding the discriminatory vendor list may be directed to the Florida Department of Management Services, Office of Supplier Diversity at (850) 487-0915.

W. Requirements of Section 287.058, Florida Statutes

1. To submit bills for fees or other compensation for services or expenses in detail sufficient for a proper pre-audit and post-audit thereof.

2. Where applicable, to submit bills for any travel expenses in accordance with Section 112.061, F.S. The Agency may establish rates lower than the maximum provided in Section 112.061, F.S.

3. To provide units of deliverables, including reports, findings, and drafts, in writing and/or in an electronic format agreeable to both Parties, as specified in **Attachment I**, Scope of Services**,** to be received and accepted by the Contract Manager prior to payment.

4. To comply with the criteria and final date, as specified herein, by which such

criteria must be met for completion of this Contract.

5. This Contract shall begin upon execution by both Parties or **BEGIN DATE**, (whichever is later) and end on **END DATE**, inclusive.

6. In accordance with Section 287.057(13), F.S., this Contract may be renewed for a period that may not exceed three (3) years or the term of the original Contract, whichever period is longer. Renewal of this Contract shall be in writing and subject to the same terms and conditions set forth in the initial Contract. A renewal Contract may not include any compensation for costs associated with the renewal. Renewals are contingent upon satisfactory performance evaluations by the Agency, are subject to the availability of funds, and optional to the Agency.

7. If this Contract is renewed, it is the Agency's policy to reduce the overall payment amount by the Agency to the Vendor by at least five percent (5%) during the period of this Contract renewal, unless it would affect the level and quality of services.

8. The Vendor agrees that the Agency may unilaterally cancel this Contract for refusal by the Vendor to allow public access to all documents, papers, letters, or other material made or received by the Vendor in conjunction with this Contract, unless the records are exempt from Section 24(a) of Article I of the State Constitution and the Florida Public Records Act, Chapter 119, F.S.

9. To comply with Patents, Royalties, Copyrights, Right to Data, and Works for Hire/Software requirements as follows:

   a. The Vendor, without exception, shall indemnify and hold harmless the Agency and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or unattended invention, process, or article manufactured or supplied by the Vendor. The Vendor has no liability when such claim is solely and exclusively due to the combination, operation or use of any article supplied hereunder with equipment or data not supplied by the Vendor or is based solely and exclusively upon the Agency's alteration of the article.

   b. The Agency will provide prompt written notification of a claim of copyright or patent infringement and shall afford the Vendor full opportunity to defend the action and control the defense. Further, if such a claim is made or is pending, the Vendor may, at its option and expense procure for the Agency the right to continue the use of, replace or modify the article to render it non-infringing (if none of the alternatives is reasonably available, the Agency agrees to return the article on request to the Vendor and receive reimbursement, if any, as may be determined by a court of competent jurisdiction).

   c. If the Vendor brings to the performance of this Contract a pre-existing patent, patent-pending and/or copyright, at the time of Contract execution, the Vendor shall retain all rights and entitlements to that pre-existing patent, patent-pending and/or copyright, unless this Contract provides otherwise.

d. If the Vendor uses any design, device, or materials covered by letter, patent, or copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or cost arising from the use of such design, device, or materials in any way involved in the work. Prior to the initiation of services under this Contract, the Vendor shall disclose, in writing, all intellectual properties relevant to the performance of this Contract which the Vendor knows, or should know, could give rise to a patent or copyright. The Vendor shall retain all rights and entitlements to any pre-existing intellectual property which is so disclosed. Failure to disclose will indicate that no such property exists. The Agency will then have the right to all patents and copyrights which arise as a result of performance under this Contract as provided in this Sub-Section.

e. If any discovery or invention arises or is developed in the course of, or as a result of, work or services performed under this Contract, or in any way connected herewith, the Vendor shall refer the discovery or invention to the Agency for a determination whether patent protection will be sought in the name of the State of Florida. Any and all patent rights accruing under or in connection with the performance of this Contract are hereby reserved to the State of Florida. All materials to which the Agency is to have patent rights or copyrights shall be marked and dated by the Vendor in such a manner as to preserve and protect the legal rights of the Agency.

f. Where activities supported by this Contract produce original writing, sound recordings, pictorial reproductions, drawings or other graphic representation and works of any similar nature, the Agency has the right to use, duplicate and disclose such materials in whole or in part, in any manner, for any purpose whatsoever and to have others acting on behalf of the Agency to do so. If the materials so developed are subject to copyright, trademark, or patent, legal title and every right, interest, claim, or demand of any kind in and to any patent, trademark or copyright, or application for the same, shall vest in the State of Florida, Department of State for the exclusive use and benefit of the State. Pursuant to Section 286.021, F.S., no person, firm, corporation, including parties to this Contract shall be entitled to use the copyright, patent, or trademark without the prior written consent of the Florida Department of State.

g. The Agency will have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Vendor under this Contract.

h. All rights and title to works for hire under this Contract, whether patentable or copyrightable or not, shall belong to the Agency and shall be subject to the terms and conditions of this Contract.

i. The computer programs, data, materials and other information furnished by the Agency to the Vendor hereunder shall be and remain the sole and exclusive property of the Agency, free from any claim or right of retention by or on behalf of the Vendor. The services and products listed in this Contract shall become the property of the Agency upon the Vendor's

performance and delivery thereof. The Vendor hereby acknowledges that said computer programs, materials and other information provided by the Agency to the Vendor hereunder, together with the products delivered and services performed by the Vendor hereunder, shall be and remain confidential and proprietary in nature to the extent provided by Chapter 119, F.S., and that the Vendor shall not disclose, publish or use same for any purpose other than the purposes provided in this Contract; however, upon the Vendor first demonstrating to the Agency's satisfaction that such information, in part or in whole, (1) was already known to the Vendor prior to its receipt from the Agency; (2) became known to the Vendor from a source other than the Agency; or (3) has been disclosed by the Agency to third parties without restriction, the Vendor shall be free to use and disclose same without restriction. Upon completion of the Vendor's performance or otherwise cancellation or termination of this Contract, the Vendor shall surrender and deliver to the Agency, freely and voluntarily, all of the above-described information remaining in the Vendor's possession.

j. The Vendor warrants that all materials produced hereunder shall be of original development by the Vendor and shall be specifically developed for the fulfillment of this Contract and shall not knowingly infringe upon or violate any patent, copyright, trade secret or other property right of any third party, and the Vendor shall indemnify and hold the Agency harmless from and against any loss, cost, liability or expense arising out of any breach or claimed breach of this warranty.

k. The terms and conditions specified in this Sub-Section shall also apply to any subcontract made under this Contract. The Vendor shall be responsible for informing the subcontractor of the provisions of this Sub-Section and obtaining disclosures.

10. The financial consequences that the Agency must apply if the Vendor fails to perform in accordance with this Contract are outlined in **Attachment I**, Scope of Services.

X. Sponsorship

Pursuant to Section 286.25, F.S., all non-governmental Vendors must assure that all notices, information pamphlets, press releases, advertisements, descriptions of the sponsorship of the program, research reports, and similar public notices prepared and released by the Vendor shall include the Statement: "Sponsored by (name of Vendor) and the State of Florida, Agency for Health Care Administration." If the sponsorship reference is in written material, the words, "State of Florida, Agency for Health Care Administration" shall appear in the same size letters or type as the name of the organization.

Y. Final Invoice

The Vendor must submit the final invoice for payment to the Agency no more than NUMBER calendar days after this Contract ends or is terminated. If the Vendor fails to do so, all right to payment is forfeited and the Agency will not honor any requests submitted after the aforesaid time period. Any payment due under the terms of this Contract may be withheld until all reports due from the Vendor and necessary

adjustments thereto have been approved by the Agency.

Z. Use Of Funds For Lobbying Prohibited

To comply with the provisions of Section 216.347, F.S., which prohibits the expenditure of Contract funds for the purpose of lobbying the Legislature, the judicial branch or a State agency.

AA. Public Entity Crime

A person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in Section 287.017, F.S., for category two, for a period of thirty six (36) months from the date of being placed on the convicted vendor list.

BB. Health Insurance Portability and Accountability Act

1. To comply with the Department of Health and Human Services Privacy Regulations in the CFR, Title 45, Sections 160 and 164, regarding disclosure of protected health information as specified in **Attachment II**, Business Associate Agreement.

2. The Vendor must ensure it meets all Federal regulations regarding required standard electronic transactions and standards for privacy and individually identifiable health information as identified in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 and associated regulations.

3. The Vendor shall conduct all activities in compliance with 45 CFR 164 Subpart C to ensure data security, including, but not limited to encryption of all information that is confidential under Florida or Federal law, while in transmission and while resident on portable electronic media storage devices. Encryption is required and shall be consistent with Federal Information Processing Standards (FIPS), and/or the National Institute of Standards and Technology (NIST) publications regarding cryptographic standards.

CC. Confidentiality of Information

1. The Vendor shall not use or disclose any confidential information, including social security numbers that may be supplied under this Contract pursuant to law, and also including the identity or identifying information concerning a Medicaid recipient or services under this Contract for any purpose not in conformity with State and Federal laws, except upon written consent of the recipient, or his/her guardian.

2. All personally identifiable information, including Medicaid information, obtained by the Vendor shall be treated as privileged and confidential information and shall be used only as authorized for purposes directly related to the administration of this Contract. The Vendor must have a process that specifies

that patient-specific information remains confidential, is used solely for the purposes of data analysis or other Vendor responsibilities under this Contract, and is exchanged only for the purpose of conducting a review or other duties outlined in this Contract.

3. Any patient-specific information received by the Vendor can be shared only with those agencies that have legal authority to receive such information and cannot be otherwise transmitted for any purpose other than those for which the Vendor is retained by the Agency. The Vendor must have in place written confidentiality policies and procedures to ensure confidentiality and to comply with all Federal and State laws (including the HIPAA and HITECH Acts) governing confidentiality, including electronic treatment records, facsimile mail, and electronic mail).

4. The Vendor's subcontracts must explicitly state expectations about the confidentiality of information, and the subcontractor is held to the same confidentiality requirements as the Vendor. If provider-specific data are released to the public, the Vendor shall have policies and procedures for exercising due care in compiling and releasing such data that address statutory protections of quality assurance and confidentiality while assuring that open records requirements of Chapter 119, F.S., are met.

5. The Vendor and its subcontractors shall comply with the requirements of Section 501.171, F.S. and shall, in addition to the reporting requirements therein, report to the Agency any breach of personal information.

6. Any releases of information to the media, the public, or other entities require prior approval from the Agency.

DD. Employment

The Vendor shall comply with Section 274Aof the Immigration and Nationality Act. The Agency will consider the employment by any contractor of unauthorized aliens a violation of this Act. If the Vendor knowingly employs unauthorized aliens, such violation shall be cause for unilateral cancellation of this Contract. The Vendor shall be responsible for including this provision in all subcontracts with private organizations issued as a result of this Contract.

EE. Work Authorization Program

The Immigration Reform and Control Act of 1986 prohibits employers from knowingly hiring illegal workers. The Vendor shall only employ individuals who may legally work in the United States (U.S.) – either U.S. citizens or foreign citizens who are authorized to work in the U.S. The Vendor shall use the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system, https://e-verify.uscis.gov/emp, to verify the employment eligibility of all new employees hired by the Vendor during the term of this Contract and shall also include a requirement in its subcontracts that the subcontractor utilize the E-Verify system to verify the employment eligibility of all new employees hired by the subcontractor performing work or providing services pursuant to this Contract.

FF. Scrutinized Companies Lists

The Vendor shall complete **Attachment V**, Vendor Certification Regarding Scrutinized Companies Lists, certifying that it is not listed on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, created pursuant to Section 215.473, F.S. Pursuant to Section 287.135(5), F.S., the Vendor agrees the Agency may immediately terminate this Contract for cause if the Vendor is found to have submitted a false certification or if the Vendor is placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List during the term of this Contract.

II. THE AGENCY HEREBY AGREES:

A. Contract Amount

To pay for contracted services according to the conditions of **Attachment I**, Scope of Services, in an amount not to exceed **$AMOUNT**, subject to the availability of funds. The State of Florida's performance and obligation to pay under this Contract is contingent upon an annual appropriation by the Legislature.

B. Contract Payment

Section 215.422, F.S., provides that agencies have five (5) business days to inspect and approve goods and services, unless bid specifications, Contract or Purchase Order specifies otherwise. With the exception of payments to health care providers for hospital, medical, or other health care services, if payment is not available within forty (40) calendar days, measured from the latter of the date the invoice is received or the goods or services are received, inspected and approved, a separate interest penalty set by the Comptroller pursuant to Section 55.03, F.S., will be due and payable in addition to the invoice amount. To obtain the applicable interest rate, please contact the Agency's Fiscal Section at (850) 412-3858, or utilize the Department of Financial Services website at www.myfloridacfo.com/aadir/interest.htm. Payments to health care providers for hospital, medical or other health care services, shall be made not more than thirty five (35) calendar days from the date eligibility for payment is determined, and the daily interest rate is .0003333%. Invoices returned to a vendor due to preparation errors will result in a payment delay. Invoice payment requirements do not start until a properly completed invoice is provided to the Agency. A Vendor Ombudsman, whose duties include acting as an advocate for vendors who may be experiencing problems in obtaining timely payment(s) from a State agency, may be contacted at (850) 413-5516 or by calling the State Office of Financial Regulation Consumer Helpline, 1-877-693-5236.

III. THE VENDOR AND AGENCY HEREBY MUTUALLY AGREE:

A. Termination

1. Termination at Will

This Contract may be terminated by the Agency upon no less than thirty (30) calendar days written notice, without cause, unless a lesser time is mutually agreed upon by both Parties. Said notice shall be delivered by certified mail,

return receipt requested, or in person with proof of delivery.

2. Termination Due To Lack of Funds

In the event funds to finance this Contract become unavailable, the Agency may terminate this Contract upon no less than twenty four (24) clock hours' written notice to the Vendor. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. The Agency will be the final authority as to the availability of funds. The Vendor shall be compensated for all acceptable work performed up to the time notice of termination is received.

3. Termination for Breach

a. Unless the Vendor's breach is waived by the Agency in writing, the Agency may, by written notice to the Vendor, terminate this Contract upon no less than twenty four (24) clock hours' written notice. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. If applicable, the Agency may employ the default provisions in Rule 60A-1.006(3), F.A.C.

b. Waiver of breach of any provisions of this Contract shall not be deemed to be a waiver of any other breach and shall not be construed to be a modification of the terms of this Contract. The provisions herein do not limit the Agency's right to remedies at law or to damages.

B. Contract Managers

1. The Agency's Contract Manager's contact information is as follows:

Name
Agency for Health Care Administration
Address
City, State Zip Code
Phone Number

2. The Vendor's Contract Manager's contact information is as follows:

Name
Address
City, State Zip Code
Phone Number

3. All matters shall be directed to the Contract Managers for appropriate action or disposition. A change in Contract Manager by either Party shall be reduced to writing through an amendment to this Contract by the Agency.

C. Renegotiation or Modification

1. Modifications of provisions of this Contract shall only be valid when they have been reduced to writing and duly signed during the term of this Contract. The Parties agree to renegotiate this Contract if Federal and/or State revisions of any applicable laws, or regulations make changes in this Contract necessary.

2. The rate of payment and the total dollar amount may be adjusted retroactively to reflect price level increases and changes in the rate of payment when these have been established through the appropriations process and subsequently identified in the Agency's operating budget.

3. **Preferred Pricing**

The Vendor represents and warrants that the prices and terms for its services under this Contract are no less favorable to the Agency than those for similar services under any existing contract with any other party. The Vendor further agrees that, within ninety (90) calendar days of the Vendor entering into a contract or contract amendment or offering to any other party services similar to those under this Contract under prices or terms more favorable than those provided in this Contract, the Vendor will report such prices and terms to the Agency, which prices or terms shall be effective as an amendment to this Contract upon the Agency's written acceptance thereof. Should the Agency discover such other prices or terms, the same shall be effective as an amendment to this Contract retroactively to the earlier of the effective date of this Contract (for other contracts in effect as of that date) or the date they were first contracted or offered to the other party (for subsequent contracts, amendments or offers) and any payment in excess of such pricing shall be deemed overpayments. The Vendor shall submit an affidavit no later than July 31st of each year during the term of this Contract attesting that the Vendor is in compliance with this provision, as required by Section 216.0113, F.S.

D. Name, Mailing and Street Address of Payee

1. The name (Vendor name as shown on Page 1 of this Contract) and mailing address of the official payee to whom the payment shall be made:

Name
Address
City, State Zip Code

2. The name of the contact person and street address where financial and administrative records are maintained:

Name
Address
City, State Zip Code

E. All Terms and Conditions

This Contract and its attachments as referenced herein contain all the terms and conditions agreed upon by the Parties.

This Contract is and shall be deemed jointly drafted and written by all Parties to it and shall not be construed or interpreted against the Party originating or preparing it. Each Party has the right to consult with counsel and has either consulted with counsel or knowingly and freely entered into this Contract without exercising its right to counsel.

IN WITNESS THEREOF, the Parties hereto have caused this number page Contract, which includes any referenced attachments, to be executed by their undersigned officials as duly authorized. This Contract is not valid until signed and dated by both Parties.

VENDOR NAME	**STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION**
SIGNED BY: SAMPLE	**SIGNED BY:** SAMPLE
NAME: NAME	**NAME: NAME**
TITLE: TITLE	**TITLE: TITLE**
DATE: ____________________	**DATE:** ____________________

FEDERAL ID NUMBER (or SS Number for an individual): **NUMBER**

VENDOR FISCAL YEAR ENDING DATE: **DATE**

List of Attachments included as part of this Contract:

Specify Type	Letter/ Number	Description
Attachment	**I**	Scope of Services (NUMBER Pages)
Attachment	**II**	Business Associate Agreement (4 Pages)
Attachment	**III**	Certification Regarding Lobbying (1 Page)
Attachment	**IV**	Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Contracts/Subcontracts (1 Page)
Attachment	**V**	Vendor Certification Regarding Scrutinized Companies Lists (1 Page)

ATTACHMENT II

BUSINESS ASSOCIATE AGREEMENT

The parties to this Attachment agree that the following provisions constitute a business associate agreement for purposes of complying with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Attachment is applicable if the Vendor is a business associate within the meaning of the Privacy and Security Regulations, 45 C.F.R. 160 and 164.

The Vendor certifies and agrees as to abide by the following:

1. Definitions. Unless specifically stated in this Attachment, the definition of the terms contained herein shall have the same meaning and effect as defined in 45 C.F.R. 160 and 164.

   1a. Protected Health Information. For purposes of this Attachment, protected health information shall have the same meaning and effect as defined in 45 C.F.R. 160 and 164, limited to the information created, received, maintained or transmitted by the Vendor from, or on behalf of, the Agency.

   1b. Security Incident. For purposes of this Attachment, security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system and includes any event resulting in computer systems, networks, or data being viewed, manipulated, damaged, destroyed or made inaccessible by an unauthorized activity.

2. Applicability of HITECH and HIPAA Privacy Rule and Security Rule Provisions. As provided by federal law, Title XIII of the American Recovery and Reinvestment Act of 2009 (ARRA), also known as the Health Information Technology Economic and Clinical Health (HITECH) Act, requires a Business Associate (Vendor) that contracts with the Agency, a HIPAA covered entity, to comply with the provisions of the HIPAA Privacy and Security Rules (45 C.F.R. 160 and 164).

3. Use and Disclosure of Protected Health Information. The Vendor shall comply with the provisions of 45 CFR 164.504(e)(2)(ii). The Vendor shall not use or disclose protected health information other than as permitted by this Contract or by federal and state law. The sale of protected health information or any components thereof is prohibited except as provided in 45 CFR 164.502(a)(5). The Vendor will use appropriate safeguards to prevent the use or disclosure of protected health information for any purpose not in conformity with this Contract and federal and state law. The Vendor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information the Vendor creates, receives, maintains, or transmits on behalf of the Agency.

4. Use and Disclosure of Information for Management, Administration, and Legal Responsibilities. The Vendor is permitted to use and disclose protected health information received from the Agency for the proper management and administration of the Vendor or to carry out the legal responsibilities of the Vendor, in accordance with 45 C.F.R. 164.504(e)(4). Such disclosure is only permissible where required by law, or where the Vendor obtains reasonable assurances from the person to whom the protected health information is disclosed that: (1) the protected health information will be held confidentially, (2) the protected health information will be used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and (3) the person notifies the Vendor of any instance of which it is aware in which the confidentiality of the protected health information has been breached.

5. Disclosure to Third Parties. The Vendor will not divulge, disclose, or communicate protected health information to any third party for any purpose not in conformity with this Contract without prior written approval from the Agency. The Vendor shall ensure that any agent, including a subcontractor, to whom it provides protected health information received from, or created or received by the Vendor on behalf of, the Agency agrees to the same terms, conditions, and restrictions that apply to the Vendor with respect to protected health information. The Vendor's subcontracts shall fully comply with the requirements of 45 CFR 164.314(a)(2)(iii).

6. Access to Information. The Vendor shall make protected health information available in accordance with federal and state law, including providing a right of access to persons who are the subjects of the protected health information in accordance with 45 C.F.R. 164.524.

7. Amendment and Incorporation of Amendments. The Vendor shall make protected health information available for amendment and to incorporate any amendments to the protected health information in accordance with 45 C.F.R. 164.526.

8. Accounting for Disclosures. The Vendor shall make protected health information available as required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528. The Vendor shall document all disclosures of protected health information as needed for the Agency to respond to a request for an accounting of disclosures in accordance with 45 C.F.R. 164.528.

9. Access to Books and Records. The Vendor shall make its internal practices, books, and records relating to the use and disclosure of protected health information received from, or created or received by the Vendor on behalf of the Agency, available to the Secretary of the Department of Health and Human Services ("HHS") or the Secretary's designee for purposes of determining compliance with the HHS Privacy Regulations.

10. Reporting. The Vendor shall make a good faith effort to identify any use or disclosure of protected health information not provided for in this Contract.

    10a. To Agency. The Vendor will report to the Agency, within ten (10) business days of discovery, any use or disclosure of protected health information not provided for in this Contract of which the Vendor is aware. The Vendor will report to the Agency, within twenty-four (24) hours of discovery, any security incident of which the Vendor is aware. A violation of this paragraph shall be a material violation of this Contract. Such notice shall include the identification of each individual whose unsecured protected health

information has been, or is reasonably believed by the Vendor to have been, accessed, acquired, used, or disclosed during such breach.

10b. To Individuals. In the case of a breach of protected health information discovered by the Vendor, the Vendor shall first notify the Agency of the pertinent details of the breach and upon prior approval of the Agency shall notify each individual whose unsecured protected health information has been, or is reasonably believed by the Vendor to have been, accessed, acquired, used or disclosed as a result of such breach. Such notification shall be in writing by first-class mail to the individual (or the next of kin if the individual is deceased) at the last known address of the individual or next of kin, respectively, or, if specified as a preference by the individual, by electronic mail. Where there is insufficient, or out-of-date contract information (including a phone number, email address, or any other form of appropriate communication) that precludes written (or, if specifically requested, electronic) notification to the individual, a substitute form of notice shall be provided, including, in the case that there are 10 or more individuals for which there is insufficient or out-of-date contact information, a conspicuous posting on the Web site of the covered entity involved or notice in major print of broadcast media, including major media in the geographic areas where the individuals affected by the breach likely reside. In any case deemed by the Vendor to require urgency because of possible imminent misuse of unsecured protected health information, the Vendor may also provide information to individuals by telephone or other means, as appropriate.

10c. To Media. In the case of a breach of protected health information discovered by the Vendor where the unsecured protected health information of more than 500 persons is reasonably believed to have been, accessed, acquired, used, or disclosed, after prior approval by the Agency, the Vendor shall provide notice to prominent media outlets serving the State or relevant portion of the State involved.

10d. To Secretary of Health and Human Services (HHS). The Vendor shall cooperate with the Agency to provide notice to the Secretary of HHS of unsecured protected health information that has been acquired or disclosed in a breach.

(i) Vendors Who Are Covered Entities. In the event of a breach by a contractor or subcontractor of the Vendor, and the Vendor is a HIPAA covered entity, the Vendor shall be considered the covered entity for purposes of notification to the Secretary of HHS pursuant to 45 CFR 164.408.The Vendor shall be responsible for filing the notification to the Secretary of HHS and will identify itself as the covered entity in the notice. If the breach was with respect to 500 or more individuals, the Vendor shall provide a copy of the notice to the Agency, along with the Vendor's breach risk assessment for review at least 15 business days prior to the date required by 45 C.F.R. 164.408 (b) for the Vendor to file the notice with the Secretary of HHS. If the breach was with respect to less than 500 individuals, the Vendor shall notify the Secretary of HHS within the notification timeframe imposed by 45 C.F.R. 164.408(c) and shall contemporaneously submit copies of said notifications to the Agency.

10e. Content of Notices. All notices required under this Attachment shall include the content set forth Section 13402(f), Title XIII of the American Recovery and Reinvestment Act of 2009 and 45 C.F.R. 164.404(c), except that references therein to a "covered entity" shall be read as references to the Vendor.

10f. Financial Responsibility. The Vendor shall be responsible for all costs related to the notices required under this Attachment.

11. Mitigation. Vendor shall mitigate, to the extent practicable, any harmful effect that is known to the Vendor of a use or disclosure of protected health information in violation of this Attachment.

12. Termination. Upon the Agency's discovery of a material breach of this Attachment, the Agency shall have the right to assess liquidated damages as specified elsewhere in the contract to which this Contract is an attachment, and/or to terminate this Contract.

12a. Effect of Termination. At the termination of this Contract, the Vendor shall return all protected health information that the Vendor still maintains in any form, including any copies or hybrid or merged databases made by the Vendor; or with prior written approval of the Agency, the protected health information may be destroyed by the Vendor after its use. If the protected health information is destroyed pursuant to the Agency's prior written approval, the Vendor must provide a written confirmation of such destruction to the Agency. If return or destruction of the protected health information is determined not feasible by the Agency, the Vendor agrees to protect the protected health information and treat it as strictly confidential.

The Vendor has caused this Attachment to be signed and delivered by its duly authorized representative, as of the date set forth below.

Vendor Name:

SAMPLE

_________________________ ____________________

Signature Date

____

Name and Title of Authorized Signer

ATTACHMENT III

CERTIFICATION REGARDING LOBBYING
CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

SAMPLE SAMPLE

____________________________ ________________________
Signature D

____________________________ ________________________
Name of Aut u A Co t Number

____
Name and Address of Organization

ATTACHMENT IV

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION CONTRACTS/SUBCONTRACTS

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, signed February 18, 1986. The guidelines were published in the May 29, 1987, Federal Register (52 Fed. Reg., pages 20360-20369).

INSTRUCTIONS

1. Each Vendor whose contract/subcontract equals or exceeds $25,000 in federal monies must sign this certification prior to execution of each contract/subcontract. Additionally, Vendors who audit federal programs must also sign, regardless of the contract amount. The Agency for Health Care Administration cannot contract with these types of Vendors if they are debarred or suspended by the federal government.
2. This certification is a material representation of fact upon which reliance is placed when this contract/subcontract is entered into. If it is later determined that the signer knowingly rendered an erroneous certification, the Federal Government may pursue available remedies, including suspension and/or debarment.
3. The Vendor shall provide immediate written notice to the contract manager at any time the Vendor learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "debarred," "suspended," "ineligible," "person," "principal," and "voluntarily excluded," as used in this certification, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the contract manager for assistance in obtaining a copy of those regulations.
5. The Vendor agrees by submitting this certification that, it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this contract/subcontract unless authorized by the Federal Government.
6. The Vendor further agrees by submitting this certification that it will require each subcontractor of this contract/subcontract, whose payment will equal or exceed $25,000 in federal monies, to submit a signed copy of this certification.
7. The Agency for Health Care Administration may rely upon a certification of a Vendor that it is not debarred, suspended, ineligible, or voluntarily excluded from contracting/subcontracting unless it knows that the certification is erroneous.
8. This signed certification must be kept in the contract manager's contract file. Subcontractor's certifications must be kept at the contractor's business location.

CERTIFICATION

(1) The prospective Vendor certifies, by signing this certification, that neither he nor his principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract/subcontract by any federal department or agency.

(2) Where the prospective Vendor is unable to certify to any of the statements in this certification, such prospective Vendor shall attach an explanation to this certification.

SAMPLE

______________________________ ______________
Signature Date

____
Name and Title of Authorized Signer

AHCA Form 2100-0009 (JAN 03)

ATTACHMENT V
VENDOR CERTIFICATION REGARDING SCRUTINIZED COMPANIES LISTS

Vendor Name: ____

Vendor FEIN: ____________________

Vendor's Authorized Representative Name and Title: ____________________________________

Address: ____

City: ______________________ State: ______________________________ Zip: ______________

Telephone Number: _____________________________________

Email Address: ____

Section 287.135, Florida Statutes, prohibits agencies from contracting with companies, for goods or services over $1,000,000, that are on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List. Both lists are created pursuant to section 215.473, Florida Statutes.

As the person authorized to sign on behalf of the Vendor, I hereby certify that the company identified above in the section entitled "Vendor Name" is not listed on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List. I understand that pursuant to Section 287.135, Florida Statutes, the submission of a false certification may subject the company to civil penalties, attorney's fees, and/or costs.

Certified By: ____,

who is authorized to sign on behalf of the above referenced company.

Authorized Signature Print Name and Title:____

SAMPLE

ATTACHMENT B
SCOPE OF SERVICE - CORE PROVISIONS

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Section I. Definitions and Acronyms

A. Definitions

The Florida Medicaid Definitions Policy contains definitions of commonly used terms that are applicable to all sections of Rule Chapter 59G, Florida Administrative Code (F.A.C.), unless specifically stated otherwise in a service-specific coverage policy, rule, or this Contract. (Rule 59G-1.010, F.A.C.) The following terms as used in this Contract shall be used, unless this Contract otherwise expressly requires a different construction and/or interpretation. Some defined terms do not appear in all Contracts.

Abandoned Call — A call or other type of contact initiated to a call center that is ended before any conversation occurs.

Abuse, Neglect and Exploitation — As defined in Chapter 415, F.S., and Chapter 39, F.S.

Adjudicated Claim — A claim for which a determination has been made to pay, accept, deny, or reject the claim.

Adjudicated Date — The date the Prepaid Dental Health Plan processed for determination of payment, acceptance, denial, or rejection.

Advance Directive — A written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Adverse Benefit Determination — As defined in 42 CFR Part 438.400(b).

Adverse Incident — An injury of an enrollee occurring during delivery of Prepaid Dental Health Plan covered services that:

1. Is associated in whole or in part with service provision rather than the condition for which such service provision occurred; and,
2. Is not consistent with or expected to be a consequence of service provision; or
3. Occurs as a result of service provision to which the patient has not given his informed consent; or
4. Occurs as the result of any other action or lack thereof on the part of the staff of the provider.

After Hours — The hours between 5:00 p.m. and 8:00 a.m. local time, Monday through Friday inclusive, and all-day Saturday and Sunday. State holidays are included.

Agency — State of Florida, Agency for Health Care Administration (AHCA), its employees acting in their official capacity, or its designee.

Agent — A term that refers to certain independent contractors with the State that perform administrative functions, including but not limited to: fiscal agent activities; outreach, eligibility and enrollment activities; and systems and technical support. The term as used herein does

not create a principal-agent relationship.

Ancillary Dental Services — Secondary services in support of primary care dental services, such as dental hygiene and dental laboratory services.

Automated Phone Tree System — A telephone information system consisting of a fixed-menu of options that registers information or routes calls based on a programmed response. A phone tree prompts the caller to respond to a menu of options by pressing phone keys on a touch-tone telephone. A phone tree also includes interactive voice response (IVR) technology that allows the telephone information system to interact with a caller speaking words or short phrases and responds with prerecorded or dynamically generated audio to direct the caller further on how to proceed to available options.

Automatic Call Distribution — A device or system that manages incoming calls, handles incoming calls based on the number called and associated automated handling instructions, and distributes incoming calls to a specific group of terminals that agents use, based on caller need, call type, or agent skill set.

Biometric Technology — The use of computer technology to identify people based on physical or behavioral characteristics such as fingerprints, retinal or voice scans.

Blog (Web Blog) — A type of website, usually maintained by an individual with regular entries of commentary, description of events, or other materials such as graphics or video. Entries are commonly displayed in reverse-chronological order.

Branding — Marketing through mass communication in some form of print media, such as newspapers, magazines, billboards, etc., with the purpose of influencing a potential enrollee to enroll and to contact the Prepaid Dental Health Plan for more information.

Broadcast — Video, audio, text, or email messages transmitted through an internet, cellular, or wireless network for display on any device.

Broadcast Scripts — Written text of messages transferred or transmitted to a large group of people by Prepaid Dental Health Plan staff through a form of mass communication media, such as television, radio or social networking, designed to promote the Prepaid Dental Health Plan and influence individuals to enroll in the Prepaid Dental Health Plan.

Business Days — A day scheduled for regular State of Florida employees to work: Monday through Friday, except holidays observed by regular State of Florida employees. Timeframes requiring completion within a number of business days shall mean by 5:00 p.m. Eastern Time on the last workday.

Calendar Day — A period of twenty-four (24) hours from midnight to midnight.

Calendar Year — A twelve (12) month period of time beginning on January 1 and ending on December 31.

Call Center — A physical place equipped for receiving a large volume of requests by telephone and where telephone calls are handled, usually with some amount of computer automation, to respond to incoming inquiries from callers. Call centers may function as a component of a broader contact center, or as a customer interaction center from which all

customer contacts are managed via telephone, email, fax, online chat, or other means of communication.

Capitation Rate — The per-member, per-month amount, including any adjustments, that is paid by the Agency to a Prepaid Dental Health Plan for each Medicaid recipient enrolled under a Contract for the provision of Medicaid services during the payment period.

Care Coordination — Case Management as defined in Rule 59G-1.010, F.A.C.

Cause — Special reasons that allow mandatory enrollees to change their Prepaid Dental Health Plan choice outside their open enrollment period. May also be referred to as "good cause." (Rule 59G-8.600, F.A.C.)

Children/Adolescents — Enrollees under the age of twenty-one (21) years.

Claim — (1) A bill for services, (2) a line item of service, or (3) all services for one (1) recipient within a bill, pursuant to 42 CFR 447.45, in a format prescribed by the Agency through its Medicaid provider handbooks.

Clean Claim — A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 CFR 447.45.

Code on Dental Procedures and Nomenclature® — A systematic listing and coding of procedures and services published annually by the American Dental Association.

Cold-Call Marketing — Any unsolicited personal contact with a Medicaid recipient by the Prepaid Dental Health Plan, its staff, its volunteers, or its vendors with the purpose of influencing the Medicaid recipient to enroll in the Prepaid Dental Health Plan or either to not enroll in, or disenroll from, another Prepaid Dental Health Plan.

Complaint — Any oral or written expression of dissatisfaction by an enrollee submitted to the Prepaid Dental Health Plan or to a State agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or Prepaid Dental Health Plan employee, failure to respect the enrollee's rights, Prepaid Dental Health Plan administration, claims practices or provision of services that relates to the quality of care rendered by a provider pursuant to the Prepaid Dental Health Plan's Contract. A complaint is a subcomponent of the grievance and appeal system.

Continuous Quality Improvement — A management philosophy that mandates continually pursuing efforts to improve the quality of products and services produced by an organization.

Contract Manager — The Agency individual responsible for providing overall Contract direction, acting as liaison between the Prepaid Dental Health Plan and other Agency staff and monitoring the Prepaid Dental Health Plan's performance.

Contracting Officer — The Secretary of the Agency or designee.

Covered Services — Those services provided by the Prepaid Dental Health Plan in accordance with this Contract, and as outlined in Section VI., Coverage and Authorization of Services.

Date of Claim Receipt — The date the Prepaid Dental Health Plan receives the claim at its designated claims receipt location, as indicated by its date stamp on the claim. (42 CFR 447.45(d)(5)-(6))

Date of Claim Payment — The date of the check or other form of payment. (42 CFR 447.46)

Day (or Days) — All seven (7) days of the week. Unless otherwise specified, the term "days" in this Contract refers to calendar days.

Department of Children and Families (DCF) — The State agency responsible for overseeing programs involving behavioral health, childcare, family safety, domestic violence, economic self-sufficiency, refugee services, homelessness, and programs that identify and protect abused and neglected children and adults.

Direct Ownership Interest — The possession of equity in the capital, the stock, or the profits of the disclosing entity. (42 CFR 455.101)

Direct Secure Messaging (DSM) — Enables Managed Care Organizations and providers to securely send patient health information to many types of organizations.

Disclosing Entity — A Medicaid provider, other than an individual practitioner or group of practitioners, or a fiscal agent that furnishes services or arranges for funding of services under Medicaid, or health-related services under the social services program.

Disaster Recovery Plan — A plan to ensure continued business processing through adequate alternative facilities, equipment, backup files, documentation and procedures in the event that the primary processing site is lost to the Prepaid Dental Health Plan.

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) — As defined by 42 U.S.C. § 1396d(r)(5) and 42 CFR 440.40(b) or its successive regulation.

Educational Event — An event designed to inform Prepaid Dental Health Plan enrollees about Medicaid programs and does not include marketing.

Eligible Plan — In accordance with s. 409.973(5)(a)2., F.S.

Emergency Dental Services – In accordance with the Medicaid State Plan, medically necessary emergency procedures to relieve pain or infection, limited to emergency oral examinations, necessary radiographs, extractions, and the incision and drainage of an abscess.

Emergency Department Visit — Emergency services and care received in an emergency department or outpatient hospital.

Encounter Data — A record of diagnostic or dental treatment procedures or other allied services to the Prepaid Dental Health Plan's Medicaid enrollees, excluding services paid by the Agency through the FFS delivery system.

Enrollee Record — As used in reference to provider, a medical record, as defined in Rule 59G-1.010, F.A.C. As used in reference to the Prepaid Dental Health Plan, a comprehensive file containing information regarding the management of services for an enrollee including the plan of care and documentation of care coordination/case management activities.

Enrollment — The process by which an eligible Medicaid recipient signs up to participate in a Prepaid Dental Health Plan.

Enrollment Broker — The State's contracted or designated entity that performs functions related to outreach, education, enrollment, and disenrollment of potential enrollees into a Prepaid Dental Health Plan.

Enrollment Files — X-12 834 files sent by the Agency's Medicaid designee to the Prepaid Dental Health Plans to provide the Prepaid Dental Health Plans with their official Medicaid recipient enrollment.

Enrollment Specialists — Individuals, authorized through an Agency-approved process, who provide one-on-one information to Medicaid recipients to help them choose the Prepaid Dental Health Plan that best meets their dental health care needs.

Event Notification Service (ENS) — An automated alerting service that provides timely alert messages to subscribing Prepaid Dental Health Plan s and accountable care organizations when patients are discharged from a hospital or emergency department.

Excluded Services — As described in Section V.C. of this Contract.

Excluded Parties List System (EPLS) — The EPLS, or its equivalent is a federal database containing information regarding entities debarred, suspended, proposed for debarment, excluded, or disqualified under the non-procurement common rule, or otherwise declared ineligible from receiving federal contracts, certain subcontracts, and certain federal assistance and benefits.

Expanded Benefit — A benefit covered by the Prepaid Dental Health Plan for which the Prepaid Dental Health Plan receives no direct payment from the Agency.

Expedited Appeal Process — The process by which the appeal of a Prepaid Dental Health Plan's adverse benefit determination is accelerated because the standard timeframe for resolution of the plan appeal could seriously jeopardize the enrollee's life, health or ability to obtain, maintain or regain maximum function.

External Quality Review (EQR) — The analysis and evaluation by an external quality review organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that are furnished to Medicaid recipients by a Prepaid Dental Health Plan.

External Quality Review Organization (EQRO) — An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, other related activities as set forth in federal regulations, or both.

Federal Fiscal Year — The United States government's fiscal year, which starts October 1 and ends on September 30.

<u>Federally Qualified Health Center (FQHC)</u> — An entity that is receiving a grant under Section 330 of the Public Health Service Act, as amended. (Also see s. 1905(l)(2)(B) of the Social Security Act.)

<u>Fee Schedule</u> — A list of health services or products covered by the Florida Medicaid program in the FFS delivery system, which provide the associated reimbursement rates for each covered service or product and are promulgated into rule.

<u>Fiscal Year</u> — The State of Florida fiscal year is the twelve (12) month period beginning July 1 and ending June 30.

<u>Full-Time Equivalent (FTE) Position/Employee</u> — The equivalent of one (1) full-time employee who works forty (40) hours per week.

<u>Fully Enrolled Provider</u> — An enrollment type that is furnished to a provider that meets the full eligibility credentialing for participation in Florida Medicaid. Enrolled providers are eligible to provide services to recipients enrolled in either the FFS delivery system or the managed care delivery system.

<u>Functional Status</u> — The ability of an individual to perform self-care, self-maintenance and physical activities in order to carry on typical daily activities.

<u>Good Cause</u> — See Cause.

<u>Grievance and Appeal System</u> — As defined by 42 CFR 438.400(b).

<u>Health Assessment</u> — A complete health evaluation combining health history, physical assessment, and the monitoring of physical and psychological growth and development.

<u>Healthcare Effectiveness Data and Information Set (HEDIS)</u> — The data and information set developed and published by the National Committee for Quality Assurance. HEDIS includes technical specifications for the calculation of performance measures.

<u>Health Care Professional</u> — A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), a licensed clinical social worker, registered respiratory therapist, certified respiratory therapy technician, and licensed pharmacist.

<u>Health Information Exchange (HIE)</u> — The secure, electronic exchange of health information among authorized stakeholders in the health care community – such as care providers, patients, and public health agencies – to drive timely, efficient, high-quality, preventive, and patient-centered care.

<u>Health Insurance</u> — See health coverage in Rule 59G-1.010, F.A.C.

<u>Health Insurance Premium Payment (HIPP) Program</u> — A program that reimburses part or all of a Medicaid recipient's share of employer-sponsored health care coverage, if available and cost-effective.

<u>Health Maintenance Organization (HMO)</u> — An organization or entity licensed in accordance with Chapter 641, F.S.

<u>Healthy Behaviors</u> — A program offered by Prepaid Dental Health Plans that encourages and rewards behaviors designed to improve the enrollee's overall health.

<u>Health Information Technology for Economic and Clinical Health (HITECH) Act</u> — The Health Information Technology Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005.

<u>The Health Insurance Portability and Accountability Act of 1996 (HIPAA)</u> — A federal law that includes requirements to protect patient privacy, to protect security of electronic medical records, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers.

<u>Hospital Outpatient Care</u> — As defined in 42 CFR 440.20(a).

<u>Hospitalization</u> — Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

<u>Incentive</u> — Related to an Prepaid Dental Health Plan Healthy Behaviors Program, something offered to an enrollee that encourages or motivates him or her to take action. For example, an incentive may be offered for enrolling in a series of educational classes focused on the target behavior. Incentives should be linked to effective engagement strategies.

<u>Indirect Ownership</u> — An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. (42 CFR 455.101) See also as calculated in 42 CFR 455.102.

<u>Individual Marketing Appointments</u> — One-on-one appointments that typically take place in the potential enrollee's or enrollee's home; however, these appointments can also take place in other venues such as a library or coffee shop.

<u>Information</u> — As the term relates to Information Management and Systems, (a) Structured Data: Data that adhere to specific properties and validation criteria that are stored as fields in database records. Structured queries can be created and run against structured data, where specific data can be used as criteria for querying a larger data set; (b) Document: Information that does not meet the definition of structured data includes text files, spreadsheets, electronic messages and images of forms and pictures.

<u>Information System(s)</u> — A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data (which may include digitized audio and video) and documents as well as non-digitalized audio and video; and/or (b) the processing and/or calculating of information and non-digitalized audio and video for the purposes of enabling and/or facilitating a business process or related transaction.

<u>Injury</u> — Any of the following outcomes when caused by an adverse incident:

1. Death

2. Brain damage

3. Spinal damage

4. Permanent disfigurement

5. Fracture or dislocation of bones or joints

6. Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition

7. Any condition requiring surgical intervention to correct or control

8. Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care

Insolvency — A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets.

Insurer — Pursuant to s. 624.03, F.S., every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity.

Interactions — Conversational exchange of messages.

Intervention — Related to a Prepaid Dental Health Plan Healthy Behaviors Program, any measure or action intended to improve or restore health or alter the course of a disease.

Licensed — A facility, equipment, or an individual that has formally met State, county, and local requirements, and has been granted a license by a local, State or federal government entity.

Limited Enrolled Provider — An enrollment type that is furnished to a provider that meets the basic eligibility credentialing for participation in Florida Medicaid. Limited Enrollment providers are only eligible to provide services to recipients enrolled in managed care.

List of Excluded Individuals and Entities (LEIE) — A database maintained by the Department of Health & Human Services, Office of the Inspector General. The LEIE provides information to the public, health care providers, patients and others relating to parties excluded from participation in Medicare, Medicaid and all other federal health care programs.

Mandatory Assignment — The process the Agency uses to assign enrollees to a Prepaid Dental Health Plan. The Agency automatically assigns those enrollees required to be in a Prepaid Dental Health Plan who did not voluntarily choose one.

Mandatory Enrollee — The categories of eligible Medicaid recipients who must be enrolled in a Prepaid Dental Health Plan.

Mandatory Potential Enrollee — A Medicaid recipient who is required to enroll in a Prepaid

Dental Health Plan but has not yet made a choice.

Marketing — As defined in 42 CFR 438.104(a).

Marketing Agent — In accordance with s. 626.015, F.S., a Florida licensed health insurance agent who acts on behalf of the Prepaid Dental Health Plan to provide marketing activities to enrollees and potential enrollees.

Marketing Events — Any event conducted by or on behalf of any Prepaid Dental Health Plan with a Medicaid recipient who is not enrolled in the Prepaid Dental Health Plan or an individual potentially eligible for Medicaid that can reasonably be interpreted as intended to influence such individual to enroll in a particular Prepaid Dental Health Plan.

Marketing Materials — As defined in 42 CFR 438.104(a).

Marketing Scripts — Standardized text used by Prepaid Dental Health Plan staff in verbal interactions with potential enrollees designed to provide information and/or to respond to questions and requests, and that are intended to influence such individual to enroll in the Prepaid Dental Health Plan. Marketing scripts include any text included in interactive voice recognition (IVR) and on-hold messages.

Medicaid Fair Hearing — An administrative hearing conducted by the Agency to review an action taken by a Prepaid Dental Health Plan that limits, denies, or stops a requested service.

Medicaid Program Integrity (MPI) — The unit of the Agency responsible for preventing and identifying fraud and abuse in the Medicaid program.

Medicaid Recipient — Any individual whom DCF, or the Social Security Administration on behalf of DCF, determines is eligible, pursuant to federal and State law, to receive medical or allied care, goods or services for which the Agency may make payments under the Medicaid program, and who is enrolled in the Medicaid program.

Medicaid State Plan — A written plan between a State and the federal government that outlines the State's Medicaid eligibility standards, provider requirements, payment methods, and health benefit packages. A Medicaid State Plan is submitted by each State and approved by the Centers for Medicare & Medicaid Services (CMS).

Medically Necessary or Medical Necessity — As defined in Rule 59G-1.010, F.A.C.

Month — Also called calendar month, any of the twelve parts, such as January or February, into which the calendar year is divided. Unless otherwise specified, the term "month" in this Contract refers to calendar month.

National Correct Coding Initiative (NCCI) — A Centers for Medicare & Medicaid Services edit system that promotes national correct coding methodologies pursuant to applicable provisions of the Social Security Act, ss. 1903(r)(1)(B)(iv).

Network — As defined in s. 409.975(1), F.S.

Nominal Value — An individual item or service worth fifteen dollars (**$15**) or less (based on the retail value of the item), with a maximum aggregate of seventy-five dollars (**$75**) per

person, per year.

Non-Covered Service — A service that is not a benefit under either the Medicaid State Plan, the Prepaid Dental Health Plan, or a Medicaid managed care plan.

Non-Participating Provider — A person or entity eligible to provide Medicaid services that does not have a contractual agreement with the Prepaid Dental Health Plan to provide services.

Normal Business Hours — The hours between 8:00 a.m. and 5:00 p.m. local time, Monday through Friday inclusive. State holidays are excluded.

Office of Fair Hearing (Office) — The hearing authority within the Agency for Health Care Administration designated to conduct Medicaid fair hearings per s. 409.285(2), F.S.

Ongoing Course of Treatment — Services that were previously authorized or prescheduled prior to the enrollee's enrollment in the Prepaid Dental Health Plan.

Open Enrollment — The sixty (60)-day period before the end of certain enrollees' enrollment year, during which the enrollee may choose to change Prepaid Dental Health Plans for the following enrollment year.

Other Benefits — Service, excluding expanded benefits, covered by Prepaid Dental Health Plans for all or some enrollees (based upon criteria established by the Prepaid Dental Health Plan) that exceed coverage and limitations specified under the Medicaid State Plan, including services provided in accordance with Section VI., Coverage and Authorization of Services, of this Contract.

Participating Provider — A health care practitioner or entity authorized to do business in Florida and contracted with the Prepaid Dental Health Plan to provide services to the Prepaid Dental Health Plan's enrollees.

Peer Review — An evaluation of the professional practices of a provider by his or her peers. The evaluator assesses the necessity, appropriateness and quality of care furnished by comparing the care to that customarily furnished by the provider's peers and to recognized health care standards.

Physicians' Current Procedural Terminology (CPT®) — A systematic listing and coding of procedures and services published annually by the American Medical Association.

Plan Appeal — A formal request from an enrollee to seek a review of an adverse benefit determination made by the Prepaid Dental Health Plan pursuant to 42 CFR 438.400(b).

Plan Factor — A budget-neutral calculation using a Prepaid Dental Health Plan's available historical enrollee diagnosis data grouped by a health-based risk assessment model. A Prepaid Dental Health Plan's plan factor is developed from the aggregated individual risk scores of the Prepaid Dental Health Plan's prior month's enrollment. The plan factor modifies a Prepaid Dental Health Plan's monthly capitation payment to reflect the health status of its enrollees.

Post-Stabilization Dental Care Services — Covered dental services related to an

emergency medical condition that are provided under this Contract after an enrollee is stabilized in order to maintain, improve, or resolve the enrollee's condition pursuant to 42 CFR 422.113.

Potential Enrollee — Pursuant to 42 CFR 438.2, an eligible Medicaid recipient who is subject to mandatory assignment or who may voluntarily elect to enroll in a given Prepaid Dental Health Plan, but is not yet an enrollee of a specific Prepaid Dental Health Plan.

Potentially Preventable Emergency Room Visit (PPV) — Emergency room visits that may result from a lack of adequate access to care or ambulatory care coordination.

Pre-Enrollment Marketing Activities — The conduct of marketing, including the provision of marketing materials, to a potential enrollee prior to the potential enrollee's enrollment in the Prepaid Dental Health Plan.

Prepaid Limited Health Service Organization — An organization or entity licensed in accordance with part I of Chapter 636, F.S.

Preventive Dental Services — Services as described in rule 59G-4.060, F.A.C. and including CDT codes 1000-1999.

Primary Dental Care – Comprehensive, coordinated, and readily accessible dental care, including dental health promotion and maintenance, treatment of illness and injury, early detection of disease, and referral to specialists when appropriate.

Primary Dental Provider (PDP) — A Medicaid Prepaid Dental Health Plan staff or subcontracted dentist practicing as a general dentist or pediatric dentist who furnishes primary dental care and patient management services to an enrollee.

Prior Authorization — The act of authorizing specific services before they are rendered.

Protected Health Information (PHI) — For purposes of this Contract, PHI shall have the same meaning and effect as defined in 45 CFR 160 and 164, limited to the information created, received, maintained or transmitted by the Prepaid Dental Health Plan from, or on behalf of, the Agency.

Protocols — Written guidelines or documentation outlining steps to be followed for handling a particular situation, resolving a problem or implementing a plan of medical, nursing, psychosocial, developmental and educational services.

Provider — A person or entity eligible for a Medicaid provider agreement.

Provider Agreement — A contract between the Prepaid Dental Health Plan and a dental health care provider to serve Prepaid Dental Health Plan enrollees.

Public Event — An event planned or sponsored by an organization to benefit and educate or assist the community with information concerning health-related matters or public awareness. At least two (2) community organizations not affiliated under common ownership must actively participate in the public event.

Public Event Materials — Materials used by the Prepaid Dental Health Plan to educate or

assist the community by providing information concerning health-related topics or topics which require public awareness.

Quality Enhancements — Certain health-related, community-based services to which the Prepaid Dental Health Plan must offer and coordinate access to its enrollees. Prepaid Dental Health Plans are not reimbursed by the Agency/Medicaid for these types of services.

Quality Improvement (QI) — The process of monitoring that the delivery of health care services is available, accessible, timely, and medically necessary.

Readily Accessible — As defined in 42 CFR 438.10(a) in the context of information requirements.

Region — As described in s. 409.966(2), F.S.

Remediation — The act or process of correcting a fault or deficiency.

Residential Commitment Facilities — As applied to the Department of Juvenile Justice, refers to the out-of-home placement of adjudicated youth who are assessed and deemed by the court to be a low or moderate risk to their own safety and to the safety of the public; for use in a level 4, 6, 8, or 10 facility as a result of a delinquency disposition order. Also referred to as a residential commitment program.

Reward — Related to a Prepaid Dental Health Plan Healthy Behaviors Program, if used in the program, something that may be offered to an enrollee after successful completion of a milestone (meaningful step towards meeting the goal) or goal attainment. A reward should be linked to positive behavior change. For example, a reward may be offered after successful completion of a series of educational classes focused on a target behavior.

Risk Assessment — The process of collecting information from a person about hereditary, lifestyle and environmental factors to determine specific diseases or conditions for which the person is at risk.

Routine Dental Care – A well care (non-acute) dental visit for preventive services (e.g., screening, cleaning, check-up, evaluation) or follow up to a previously treated condition and any other routine visit for other than the treatment of a dental illness/condition (e.g., sick care).

Rural — An area with a population density of less than one hundred (100) individuals per square mile, or an area defined by the most recent United States Census as rural, i.e., lacking a metropolitan statistical area (MSA).

Sanctions — In relation to Section XIII., Sanctions; Any monetary or non-monetary penalty imposed upon a provider, entity, or person (e.g., a provider entity, or person being suspended from the Medicaid program).

Securities — United States Treasury Securities that are backed by the full faith and credit of the United States government. For purposes of this Contract, the term shall be limited to those securities approved by the Agency as specified in Section XII., Financial Requirements.

Service Authorization — The Prepaid Dental Health Plan's approval for services to be rendered.

Service Delivery Systems — Mechanisms that enable provision of certain health care benefits and related services for Medicaid recipients as provided in s. 409.973, F.S.

Sick Care — Non-urgent problems that do not substantially restrict normal activity, but could develop complications if left untreated (e.g., chronic disease).

Significant Change — As defined in s. 409.962(17), F.S.

Service Organization Control (SOC) 2 Type II Audit (SOC 2 Type II Audit) — An audit of the internal controls of a service organization according to specifications defined by the American Institute of Certified Public Accountants.

Social Networking — Web-based applications and services (excluding the Prepaid Dental Health Plan's State-mandated website content, member portal, and provider portal) that provide a variety of ways for users to interact, such as email, comment posting, image sharing, invitation and instant messaging services.

Span of Control — Information systems and telecommunications capabilities that the Prepaid Dental Health Plan itself operates or for which it is otherwise legally responsible according to the terms and conditions of this Contract. The span of control also includes systems and telecommunications capabilities outsourced by the Prepaid Dental Health Plan.

Special Health Care Needs — Enrollees who face physical, behavioral, or environmental challenges daily that place at risk their health and ability to function fully in society. This includes individuals with intellectual and developmental disabilities or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; and children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.

Spoken Script — Standardized text used by Prepaid Dental Health Plan staff in verbal interactions with enrollees and/or potential enrollees designed to provide information and/or to respond to questions and requests. Spoken scripts also include interactive voice recognition (IVR) and on-hold messages.

State — State of Florida.

Statewide Medicaid Prepaid Dental Health Plan Report Guide — A companion guide to the Prepaid Dental Health Plan Contracts that provides detailed information about standard reports required by this Contract to be submitted by the Prepaid Dental Health Plans to the Agency. Such detailed information includes report-specific format and submission requirements, instructions for completion, and report templates and supplemental tables

Statutory Accounting Principles — A set of accounting regulations as defined by the 2002 National Association of Insurance Commissioners Accounting Practices and Procedures Manual and as specified in s. 641.19, F.S.

Subcontract — An agreement entered into for provision of services on behalf of the Prepaid Dental Health Plan as related to this Contract.

Subcontractor — Any entity contracting with the Prepaid Dental Health Plan to perform services or to fulfill any of the requirements requested in this Contract or any entity that is a subsidiary of the Prepaid Dental Health Plan that performs services or fulfills the requirements requested in this Contract.

Surface Mail — Mail delivery via land, sea, or air, rather than via electronic transmission.

Surplus — Net worth (i.e., total assets minus total liabilities).

System Unavailability — As measured within the Prepaid Dental Health Plan's information systems' span of control, when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "enter" or other function key.

Systems — See Information Systems.

Tags/Tagging — Placing personal identification information within a picture or video.

Telemedicine — As defined in Rule 59G-1.057, F.A.C.

Temporary Assistance to Needy Families (TANF) — As described in 45 CFR 260.20.

Temporary Loss Period — Period in which an enrollee loses eligibility and regains it, allowing the recipient to be re-enrolled in the Prepaid Dental Health Plan in which the recipient was enrolled prior to the eligibility loss.

Temporary Management — State-imposed oversight of the operation of the Prepaid Dental Health Plan, upon a finding by the State that there is continued egregious behavior by the Prepaid Dental Health Plan or a substantial risk to the health of the Prepaid Dental Health Plan's enrollees, or to assure the health of the Prepaid Dental Health Plan's enrollees, in accordance with Section 1932(e)(2)(B) of the Social Security Act.

Timely Files — When an enrollee files for continuation of benefits on or before the later of the following:

a. Within ten (10) days of the Prepaid Dental Health Plan sending the notice of adverse benefit determination; or

b. The intended effective date of the Prepaid Dental Health Plan's proposed adverse benefit determination.

Urban — An area with a population density of greater than one hundred (100) individuals per square mile or an area defined by the most recent United States Census as urban, i.e., as having a metropolitan statistical area (MSA).

Urgent Care — Services for conditions, which, though not life threatening, could result in serious injury or disability unless medical attention is received or substantially restrict an enrollee's activity.

Urgent Medical — Any sudden or unforeseen situation that requires immediate action to prevent hospitalization or nursing facility placement.

Username — An identifying pseudonym associated with the author to messages or content generated.

Validation — The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Vendor — An entity submitting a proposal to become a Prepaid Dental Health Plan.

Violation — A determination by the Agency that a Prepaid Dental Health Plan failed to act as specified in this Contract or applicable statutes, rules or regulations governing Prepaid Dental Health Plan s. For the purposes of this Contract, each day that an ongoing violation continues shall be considered a separate violation. In addition, each instance of failing to furnish necessary and/or required medical services or items to each enrollee shall be considered a separate violation. As well, each day that the Prepaid Dental Health Plan fails to furnish necessary and/or required medical services or items to enrollees shall be considered a separate violation.

Waste — Overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.

Well Care Visit — A routine dental care visit.

Written Marketing Materials — Printed informational material targeted to potential enrollees, which promotes the Prepaid Dental Health Plan, including but not limited to brochures, flyers, leaflets or other printed information about the Prepaid Dental Health Plan. Written marketing material includes materials for circulation by dentists, other dental care providers, or third parties.

B. Acronyms

ACA — Patient Protection and Affordable Care Act

ACCESS — Automated Community Connection to Economic Self-Sufficiency, the DCFs' public assistance service delivery system

ADA — Americans with Disabilities Act of 1990

ANSI — American National Standards Institute

APD — Agency for Persons with Disabilities

ASR — Achieved Savings Rebate

BC — Business Continuity

BAA — Business Associate Agreement

CAHPS — Consumer Assessment of Healthcare Providers and Systems

CARC — Claim Adjustment Reason Code

CAP — Corrective Action Plan

CCP — Cultural Competency Plan

CDC — Centers for Disease Control and Prevention

CEO — Chief Executive Officer

CFO — Chief Financial Officer

CFR — Code of Federal Regulations (cites may be searched online at: http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR)

CHD — County Health Department

CMS — Centers for Medicare & Medicaid Services

CDT® — Code on Dental Procedures and Nomenclature

CPT® — Physicians' Current Procedural Terminology

DCA — District Court of Appeal

DCF — Department of Children and Families

DEA — Drug Enforcement Administration

DFS — Department of Financial Services

DHHS — United States Department of Health & Human Services

DOH — Department of Health

DR — Disaster Recovery

DRG — Diagnostic Related Group

DSM — Direct Secure Messaging

EDI — Electronic Data Interchange

ENS — Event Notification Service

EPLS — Excluded Parties List System

EPSDT — Early and Periodic Screening, Diagnosis and Treatment Program

EQR — External Quality Review

EQRO — External Quality Review Organization

EDT — Eastern Daylight Time

EST — Eastern Standard Time

F.A.C. — Florida Administrative Code

FAR — Florida Administrative Register

FFS — Fee-for-Service

FIPS — Federal Information Processing Standards Publication

FMMIS — Florida Medicaid Management Information System

FMV — Fair Market Value

FQHC — Federally Qualified Health Center

F.S. — Florida Statutes

FSFN — Florida Safe Families Network (formerly HomeSafeNet), also known as SACWIS, (Statewide Automated Child Welfare Information System)

FTE — Full-Time Equivalent Position

HCAC — Health Care-Acquired Condition

HCPCS — Healthcare Common Procedure Coding System

HCV — Hepatitis C Virus

HEDIS — Healthcare Effectiveness Data and Information Set

HIE — Health Information Exchange

HIPAA — Health Insurance Portability and Accountability Act

HIPP — Health Insurance Premium Payment

HIT — Health Information Technology

HITECH Act — Health Information Technology for Economic and Clinical Health Act

HIV — Human Immunodeficiency Virus

HMO — Health Maintenance Organization

IBNR — Incurred but Not Reported

ICD — International Classification of Diseases

IHCP — Indian Health Care Provider

IDD – Individuals with Intellectual and Developmental Disabilities

IMD — Institutions for Mental Disease

ISM — Information Security Manager

IT — Information Technology

ITN — Invitation to Negotiate

LEIE — List of Excluded Individuals & Entities

LOINC — Logical Observation Identifiers Names and Codes

MEDS — Medicaid Encounter Data System

MFCU — Medicaid Fraud Control Unit, Office of the Attorney General

MLR — Medical Loss Ratio

MMA — Managed Medical Assistance

MPI — Medicaid Program Integrity Bureau, Office of the AHCA Inspector General

MPO — Medicaid Program Oversight

NAIC — National Association of Insurance Commissioners

NCCI — National Correct Coding Initiative

NCQA — National Committee for Quality Assurance

NIST — National Institute of Standards and Technology

NPI — National Provider Identifier

ODBC — Open Database Connectivity

OIG — Office of the Inspector General

OIR — Office of Insurance Regulation

PCCB — Per Capita Capitation Benchmark

PCSB — Per Capita Services Benchmark

PCP — Primary Care Provider

PDHP — Prepaid Dental Health Program

PDL — Preferred Drug List

PDP – Primary Dental Care Provider

PDO — Participant Direction Option

PDP — Primary Dental Provider

PHI — Protected Health Information

PII — Personal Identifying Information

PIP — Performance Improvement Project

PM — Performance Measure

PNV – Provider Network Verification

PPS — Prospective Payment System

PPV — Potentially Preventable Emergency Room Visit

QE — Quality Enhancement

QI — Quality Improvement

RARC — Remittance Advice Reason Code

SACWIS — Statewide Automated Child Welfare Information System, also known as Florida Safe Families Network (FSFN, formerly HomeSafeNet)

SAM — System for Award Management

SFTP — Secure File Transfer Protocol

SMMC — Statewide Medicaid Managed Care Program

SNIP — Strategic National Implementation Process

SOBRA — Sixth Omnibus Budget Reconciliation Act

SOC — Service Organization Controls

SQL — Structured Query Language

SSI — Supplemental Security Income

SSN — Social Security Number

TANF — Temporary Assistance for Needy Families

TLS — Transport Layer Security

TPA — Third Party Administrator

UM — Utilization Management

U.S. — United States

U.S.C. — United States Code

USDA — United States Department of Agriculture

WEDI — Workgroup for Electronic Data Interchange

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Section II. General Overview

A. Purpose

1. Under the Prepaid Dental Health Program, the Agency for Health Care Administration (Agency) contracts with Prepaid Dental Health Plans, as defined in Section I., Definitions and Acronyms, to provide services to recipients.

2. The provisions in this Contract and the terms of the applicable federal waivers apply to all Prepaid Dental Health Plan types unless specifically noted otherwise.

3. The Prepaid Dental Health Plan shall comply with all provisions of this Contract and any amendments and shall act in good faith in the performance of this Contract provisions.

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Section III. Eligibility and Enrollment

A. General Provisions

1. The State has sole authority for determining eligibility for Medicaid. The DCF acts as the Agency's agent by enrolling recipients in the Medicaid program.

2. The Agency will have the sole authority for determining whether Medicaid recipients are required to enroll in, may volunteer to enroll in, may not enroll in a Prepaid Dental Health Plan, or are subject to annual open enrollment. The Agency or its enrollment broker shall be responsible for enrollment, including enrollment into the Prepaid Dental Health Plan, disenrollment, and outreach and education activities. The Agency will use an established algorithm to assign mandatory potential enrollees who do not select a Prepaid Dental Health Plan during their choice period.

3. The Prepaid Dental Health Plan shall accept Medicaid recipients without restriction in accordance with 42 CFR 438.3(d)(1) and Section 1903(m)(2)(A) of the Social Security Act. The Prepaid Dental Health Plan shall not discriminate on the basis of religion, gender identity, sex, sexual orientation, race, color, age or national origin, health status, pre-existing condition or need for health care services and shall not use any policy or practice that has the effect of such discrimination in accordance with 42 CFR 438.3(d)(4) and 438.3(q)(4).

4. The Prepaid Dental Health Plan shall coordinate with the Agency and its agent(s) as necessary for all enrollment and disenrollment functions.

5. The Prepaid Dental Health Plan or its subcontractors, providers, or vendors shall not provide or assist in the completion of enrollment or disenrollment requests or restrict the enrollee's right to disenroll voluntarily in any way. (42 CFR 438.56(b)(1), (2), and (3)).

B. Eligibility

1. In accordance with 409.973(5)(b), F.S., Medicaid recipients shall receive Medicaid covered dental services through the PDHP. The Agency will determine eligibility for enrollment under this Contract. The Agency will provide the Prepaid Dental Health Plan a list of recipient aid categories that are eligible to enroll in the Prepaid Dental Health Program.

2. Excluded Populations

The following categories describe Medicaid recipients who are not eligible to enroll in the Prepaid Dental Health Program:

a. Enrollees residing in one of the following institutional settings:

(1) A State Mental Health Hospital

(2) A correctional facility

(3) A residential commitment facility

(4) Nursing facility

(5) Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities

b. Individuals eligible through emergency medical assistance for aliens;

c. Presumptively eligible pregnant women;

d. Program for All-Inclusive Care for the Elderly (PACE);

e. Individuals eligible through the family planning waiver; and

f. Partial Dual Eligibles.

C. Enrollment

1. General Provisions

a. The Prepaid Dental Health Plan shall coordinate with the Agency and its agent(s) for all enrollment functions.

b. The Prepaid Dental Health Plan shall provide services to Medicaid recipients who meet eligibility requirements and reside in the State of Florida.

c. The Agency or its agents shall notify the Prepaid Dental Health Plan of an enrollee's selection or assignment to the Prepaid Dental Health Plan by file transfer or other Agency prescribed method. Enrollment in the Prepaid Dental Health Plan shall be effective at 12:01 a.m. on the effective date of enrollment provided on the Enrollment File.

d. Newborns will be enrolled in the Prepaid Dental Health Plan of the mother, unless the mother chooses another plan. The Prepaid Dental Health Plan shall be responsible for newborns of pregnant enrollees from the date of their birth.

2. Verification of Enrollment

a. The Prepaid Dental Health Plan shall review its X12-834 Enrollment File to ensure that all enrollees are eligible to receive services from the Prepaid Dental Health Plan.

b. The Prepaid Dental Health Plan shall notify the Agency within five (5) business days of receipt of the enrollment file of any discrepancies in enrollment, including enrollees not residing in the same region in which they were enrolled and enrollees not eligible for the Prepaid Dental Health Plan. (42 CFR 438.608(a)(3))

3. Temporarily Stopping or Limiting Enrollment

a. The Prepaid Dental Health Plan may ask the Agency to halt or reduce enrollment temporarily if continued enrollment would exceed the Prepaid Dental Health Plan's capacity to provide required services under this Contract.

b. The Agency may limit Prepaid Dental Health Plan enrollments when such action is considered to be in the Agency or enrollees' best interest in accordance with the provisions of this Contract.

D. Disenrollment

1. General Provisions

a. The Prepaid Dental Health Plan shall ensure that it does not restrict the enrollee's right to disenroll voluntarily in any way.

b. The Prepaid Dental Health Plan or its subcontractors, providers, or vendors shall not provide or assist in the completion of a disenrollment request, except as specified in the Statewide Medicaid Prepaid Dental Health Plan Report Guide. (42 CFR 438.56(b)(1))

c. The Agency will notify enrollees of their right to request disenrollment. The Agency will process all disenrollments from the Prepaid Dental Health Plan. The Agency or its agent shall make final determinations about granting disenrollment requests and shall notify the Prepaid Dental Health Plan by file transfer and the enrollee by surface mail of any disenrollment decision and the enrollee's right to request a Medicaid Fair Hearing if he or she is dissatisfied with an Agency determination.

d. In addition to the reasons cited in Rule 59G-8.600, F.A.C., the following reason constitutes cause for disenrollment from the Prepaid Dental Health Plan:

The enrollee is an American Indian or Alaskan Native as defined in 42 CFR 438.14(a).

2. Involuntary Disenrollment

a. With proper written documentation, the Prepaid Dental Health Plan may submit involuntary disenrollment requests to the Agency or its enrollment broker in a manner prescribed by the Agency and in accordance with 42 CFR 438.56(b)(1)-(3).

b. The following are acceptable reasons for which the Prepaid Dental Health Plan may submit an involuntary disenrollment request:

(1) Fraudulent use of the enrollee identification (ID) card.

(2) Falsification of prescriptions by an enrollee.

c. The Prepaid Dental Health Plan shall not request disenrollment of an enrollee due to:

(1) Health diagnosis

(2) Adverse changes in an enrollee's health status

(3) Utilization of medical services

(4) Diminished mental capacity

(5) Pre-existing medical condition

(6) Attempt to exercise rights under the Prepaid Dental Health Plan's grievance and appeal system

(7) Referral by a provider of an enrollee to a non-participating provider.

d. The Prepaid Dental Health Plan shall ensure that involuntary disenrollment documents are maintained in the enrollee record.

e. When the Prepaid Dental Health Plan requests an involuntary disenrollment, it shall notify the enrollee in writing that the Prepaid Dental Health Plan is requesting disenrollment, the reason for the request, and an explanation that the Prepaid Dental Health Plan is requesting that the enrollee be disenrolled in the next Contract month, or earlier if necessary, pending an Agency decision. Until the enrollee is disenrolled, the Prepaid Dental Health Plan shall be responsible for the provision of services to that enrollee.

f. The Agency will review all disenrollment requests on a case-by-case basis, and it is at the sole discretion of the Agency to approve or deny such requests. Any request not approved is final and not subject to Prepaid Dental Health Plan dispute or appeal.

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Section IV.Marketing

A. General Provisions

1. The Prepaid Dental Health Plan shall ensure compliance with all State and federal marketing requirements, including monitoring and overseeing the activities of its subcontractors and all persons acting for, or on behalf of, the Prepaid Dental Health Plan. (42 CFR 438.104; s. 409.912, F.S.; s. 641.3901, F.S.; s. 641.3903, F.S.; s. 641.386, F.S.; s. 626.112, F.S.; s. 626.342, F.S.; s. 626.451, F.S.; s. 626.471, F.S.; s. 626.511, F.S.; s. 626.611, F.S.; s. 626.9541, F.S., and s. 626.9521, F.S.)

2. The Prepaid Dental Health Plan shall not market nor distribute any marketing materials without first obtaining Agency approval. (42 CFR 438.104(b)(1)(i))

3. The Prepaid Dental Health Plan shall ensure that marketing, including marketing plans and materials, is accurate and does not mislead, confuse, or defraud recipients or the Agency. (42 CFR 438.104(b)(2)) The Prepaid Dental Health Plan shall not distribute marketing materials that are materially inaccurate, misleading, or otherwise make material misrepresentations.

4. The Prepaid Dental Health Plan may use social/electronic media (e.g., Facebook, Twitter, Scan Code, YouTube, LinkedIn, or QR Code) in accordance with the requirements of this Contract and federal and State law.

5. The Prepaid Dental Health Plan shall not engage in unfair methods of competition or unfair or deceptive acts or practices as defined in s. 641.3903, F.S., and s. 626.9541, F.S.

6. In compliance with s. 409.912, F.S., marketing to potential enrollees in State offices or any location where eligibility is determined is prohibited unless approved in writing and approved by the affected State agency when solicitation occurs in the office of another State agency. The Prepaid Dental Health Plan shall not use any other State office or any location where eligibility is determined in the recruitment of potential enrollees, except as authorized in writing by the Agency. Request for approval of activities at State offices must be submitted to the Agency at least thirty (30) days prior to the activity.

B. Prohibited Statements and Claims

The Prepaid Dental Health Plan shall not, whether orally or in writing:

1. Claim that a Medicaid recipient must enroll in the Prepaid Dental Health Plan in order to obtain or to not lose Medicaid benefits or any other health or welfare benefits. (42 CFR 438.104(b)(2)(i))

2. Claim that the Prepaid Dental Health Plan is recommended or endorsed by CMS, the federal or State government, or similar entity. (42 CFR 438.104(b)(2)(ii))

3. Claim that the State or the county recommends that a Medicaid recipient enroll with the Prepaid Dental Health Plan.

4. Claim that marketing agents are employees of the federal, State, or county government,

or of anyone other than the Prepaid Dental Health Plan or the organization by whom they are reimbursed.

C. Prohibited Activities

1. The Prepaid Dental Health Plan shall not enlist the assistance of any government employee, government officer, elected official, or the State's enrollment broker in recruitment of potential enrollees except as authorized in writing by the Agency.

2. The Prepaid Dental Health Plan shall not provide any gift, commission, or any form of compensation to the enrollment broker, including its full-time, part-time, or temporary employees and subcontractors.

3. The Prepaid Dental Health Plan shall not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities or market through unsolicited contacts. (42 CFR 438.104(b)(1)(v))

4. If the Prepaid Dental Health Plan receives permission to call or otherwise contact a potential enrollee, the Prepaid Dental Health Plan shall treat the permission as event-specific and shall not interpret the permission as an open-ended permission to contact the potential enrollee after the Prepaid Dental Health Plan has answered the potential enrollee's inquiry or questions.

5. The Prepaid Dental Health Plan shall not rent or purchase email lists to distribute information about its Medicaid Prepaid Dental Health Plan to enrollees or potential enrollees.

D. Marketing of Multiple Lines of Business

1. The Prepaid Dental Health Plan shall not influence enrollment in conjunction with the sale or offering of any private insurance. (42 CFR 438.104(b)(1)(iv))

2. The Prepaid Dental Health Plan shall provide instructions in its marketing materials to potential enrollees or enrollees on how to opt out of receiving communications describing other health-related lines of business. The Prepaid Dental Health Plan shall not send such communications to potential enrollees or enrollees who have asked to opt out of receiving future marketing communications.

3. If the Prepaid Dental Health Plan advertises multiple lines of business within the same marketing material, it shall keep the Prepaid Dental Health Plan's other lines of business clearly and understandably distinct from the Medicaid Prepaid Dental Health Plan.

4. The Prepaid Dental Health Plan shall not include enrollment applications for other health-related lines of business in Medicaid Prepaid Dental Health marketing materials.

E. Marketing Agents

1. The Prepaid Dental Health Plan shall only use insurance agents licensed to conduct face-to-face and telephonic marketing in the State of Florida, to market to potential enrollees, including pre-enrollment marketing activities. The Prepaid Dental Health Plan shall ensure

all such marketing agents or representatives comply with s. 626.112, F.S.

2. The Prepaid Dental Health Plan shall report new marketing agents to the Agency within fifteen (15) days after the marketing agent's appointment to the Prepaid Dental Health Plan, as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide, and in the manner and format determined by the Agency

3. The Prepaid Dental Health Plan shall ensure that all marketing agents (including employed agents) are trained annually on State and federal requirements and on details specific to the Prepaid Dental Health Plan. The Prepaid Dental Health Plan shall ensure that its training programs are made available to the Agency upon request.

4. The Prepaid Dental Health Plan shall report to the Agency any marketing agent who violates any requirements of this Contract, within fifteen (15) days of knowledge of such violation. The Prepaid Dental Health Plan shall submit reports to the Agency as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide, and in the manner and format determined by the Agency.

5. The Prepaid Dental Health Plan shall report the termination of any marketing agents and the reasons for the termination to the Agency, as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide, and in the manner and format determined by the Agency.

6. The Prepaid Dental Health Plan shall ensure that all marketing agents display, during marketing events, a Prepaid Dental Health Plan nametag that includes the Prepaid Dental Health Plan's name, logo, and agent's name. The marketing agent shall have business cards available to attendees of events.

F. Telephonic Activities and Scripts

1. The Prepaid Dental Health Plan may do the following activities:

   a. Call potential enrollees who have expressly given permission for the Prepaid Dental Health Plan to contact them.

   b. Return phone calls or messages from potential enrollees, as these are not unsolicited.

   c. Include information about other lines of business in scripts.

   d. Transfer calls to a marketing agent only at the proactive request of the potential enrollee.

   e. Clearly inform the potential enrollee of any change in the nature of a call from informational to marketing. This shall be done with the full and active concurrence of the potential enrollee with a yes/no question.

2. The Prepaid Dental Health Plan shall not engage in the following activities:

   a. Unsolicited calls about other business as a means of generating leads for the Prepaid Dental Health Plan.

b. Calls based on referrals. If an enrollee would like to refer a friend or relative to the Prepaid Dental Health Plan, the Prepaid Dental Health Plan may provide contact information such as a business card that the enrollee may give to the friend or family member. In all cases, a referred individual needs to contact the Prepaid Dental Health Plan directly.

c. Calls to former enrollees or to enrollees who are in the process of voluntarily disenrolling, for the purpose of marketing the Prepaid Dental Health Plan or other products.

d. Calls to potential enrollees to confirm receipt of marketing material.

e. Use language in scripts that imply the Prepaid Dental Health Plan is endorsed by the Agency, calling on behalf of the Agency, or that the Agency asked the Prepaid Dental Health Plan to call the recipient.

3. Any marketing scripts must be prior approved by the Agency. The Prepaid Dental Health Plan shall submit all marketing scripts verbatim (bullets or talking points are unacceptable).

G. Standards for Written Marketing Materials

The Prepaid Dental Health Plan shall submit Medicaid marketing material or changes in marketing materials to the Agency for review and approval prior to use.

1. The Prepaid Dental Health Plan shall submit marketing material to the Agency at least forty-five (45) days before the proposed use of the enrollee material or revised material.

2. The Prepaid Dental Health Plan shall submit all materials in publication-ready form, including a sample of each version if the Prepaid Dental Health Plan intends to use several versions.

3. The Prepaid Dental Health Plan shall conduct a quality check and ensure that all materials are consistent with this Contract and State and federal requirements prior to submitting materials for review to the Agency. Generally, the Agency will not review materials for typographical or grammatical errors, unless such errors render the material inaccurate or misleading.

4. The Prepaid Dental Health Plan shall ensure that all marketing materials comply with the standards for written materials specified in Section IV.A., General Provisions The Prepaid Dental Health Plan shall submit readability scores with its marketing material and denote any redacted wording. The Prepaid Dental Health Plan may exclude the following from the readability score: addresses, phone numbers, PDP, department names, required disclaimers, medical terminology, medical conditions, proper names, legal terms, and words that cannot be easily substituted.

5. The Prepaid Dental Health Plan shall include the following statements and disclaimers verbatim in any marketing materials that include information on benefits:

a. "[insert Prepaid Dental Health Plan's legal or marketing name] is a Prepaid Dental Health Plan with a Florida Medicaid Contract."

b. "The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the Prepaid Dental Health Plan."

c. "[Limitations, copayments, and/or restrictions] may apply."

d. "[Benefits, formulary, pharmacy network, premium and/or co-payments/co- insurance] may change."

6. The Prepaid Dental Health Plan shall include a written statement on all marketing materials promoting drawings, prizes or any promise of a free gift that there is no obligation to enroll in the Prepaid Dental Health Plan. For example, "Eligible for a free drawing and prizes with no obligation." or "Free drawing without obligation."

7. The Prepaid Dental Health Plan shall ensure that advertisements and invitations to formal marketing events include the following two statements on marketing materials:

a. "A health plan representative will be present with information."

b. "For accommodation of persons with special needs at marketing events call <insert phone and TTY number>."

8. The Prepaid Dental Health Plan shall include a Teletypewriter Telephone (TTY) number in conjunction with the Prepaid Dental Health Plan's toll-free enrollee help line number. This requirement does not apply to outdoor advertising, banner/banner-like ads, radio ads, or marketing scripts.

H. Use of Superlatives in Marketing Materials

1. The Prepaid Dental Health Plan may use statements in its logos and in its product taglines (e.g., "Your health is our major concern," "Quality care is our pledge to you," "). The Prepaid Dental Health Plan shall not use superlatives in logos/product taglines (e.g., "XYZ plan means the first in quality care" or "XYZ plan means the best in managed care").

2. The Prepaid Dental Health Plan may not use absolute superlatives (e.g., "the best," "highest ranked," "rated number 1"), unless they are substantiated with supporting data provided to the Agency as a part of the marketing review process.

I. Nominal Gifts

1. The Prepaid Dental Health Plan may distribute nominal gifts as long as the gifts are provided regardless of enrollment. The Prepaid Dental Health Plan shall obtain Agency approval before distributing any nominal gifts. Nominal gifts shall be submitted in "camera ready" form.

2. The Prepaid Dental Health Plan shall ensure the following for nominal gifts offered by the Prepaid Dental Health Plan:

a. If a nominal gift is one large gift that is available for all in attendance, the total retail

cost must be fifteen dollars (**$15**) or less per person when it is divided by the estimated attendance. For planning purposes, anticipated attendance may be used, but must be based on venue size, response rate, or advertisement circulation.

b. Nominal gifts may not be in the form of cash, gift card/certificates, or other monetary rebates.

3. The Prepaid Dental Health Plan shall track distribution of gifts given to enrollees to ensure enrollees gift levels do not exceed nominal value.

4. The Prepaid Dental Health Plan shall not provide meals (or have meals subsidized) at marketing or educational events.

J. References to Studies

1. The Prepaid Dental Health Plan may only compare itself to another Prepaid Dental Health Plan by referencing an independent study. If the Prepaid Dental Health Plan references a study in any marketing material, it must provide the following information, either in the text or as a footnote, on the marketing material:

   a. Reference information (e.g., publication, date, page number).

   b. Information about the Prepaid Dental Health Plan's relationship with the entity that conducted the study including funding source.

   c. The study sample size and number of Prepaid Dental Health Plans surveyed (unless the study that is referenced is a CMS or Agency study).

2. The Prepaid Dental Health Plan shall not compare itself to another Prepaid Dental Health Plan by name unless it has written permission from all Prepaid Dental Health Plans being compared and include this documentation with the Prepaid Dental Health Plan's marketing submission.

K. Product Endorsements/Testimonials

1. The Prepaid Dental Health Plan shall ensure that all product endorsements and testimonials adhere to the following:

   a. The speaker must identify the Prepaid Dental Health Plan by name.

   b. If an individual is paid to portray a real or fictitious situation, the ad must clearly state it is a "Paid endorsement."

2. An enrollee may offer endorsement of the Prepaid Dental Health Plan, provided the enrollee is a current enrollee and voluntarily chooses to endorse the Prepaid Dental Health Plan.

3. Any endorsement or testimonial by an individual shall not use any quotes by dentists or other dental health care providers.

4. The endorsement or testimonial shall not use negative testimonials about other Prepaid

Dental Health Plans.

5. The Prepaid Dental Health Plan shall not pay or compensate potential enrollees in any way to endorse or promote the Prepaid Dental Health Plan.

6. Re-publication of an individual user's content or comment(s) that promote a Prepaid Dental Health Plan from social/electronic media sites is considered a product endorsement/testimonial and must adhere to the requirements of this Section.

L. Marketing Events

1. The Prepaid Dental Health Plan shall obtain Agency approval prior to conducting any marketing events.

2. At a marketing event, the Prepaid Dental Health Plan shall not:

   a. Conduct health screening or other like activities that could give the impression of "biased selection."

   b. Require potential enrollees to provide any contact information as a prerequisite for attending the event. The Prepaid Dental Health Plan shall clearly indicate on any sign-in sheets that completion of any contact information is optional.

3. The Prepaid Dental Health Plan may use personal contact information to notify potential enrollees of raffle or drawing winnings.

4. The Prepaid Dental Health Plan shall notify the Agency of any change of plan attendance in advance of the scheduled event, including event cancellation and instances where the event is not cancelled but the Prepaid Dental Health Plan has decided not to attend.

5. If a marketing event is cancelled or the Prepaid Dental Health Plan has decided not to attend less than forty-eight (48) hours before its originally scheduled date and time, the Prepaid Dental Health Plan shall:

   a. Ensure a Prepaid Dental Health Plan marketing agent is present at the site of the event, at the time that the event was scheduled to occur, to inform potential enrollees of the cancellation or decision not to attend, and distribute information about the Prepaid Dental Health Plan.

   b. Ensure a Prepaid Dental Health Plan marketing agent remains onsite at least fifteen (15) minutes after the scheduled start of the event. If the event was cancelled due to inclement weather, a Prepaid Dental Health Plan marketing agent is not required to be present at the site.

6. If a marketing event is cancelled or the Prepaid Dental Health Plan decides not to attend more than forty-eight (48) hours before the originally scheduled date and time, the Prepaid Dental Health Plan shall notify potential enrollees of the cancellation or decision by the Prepaid Dental Health Plan not to attend through the same means the Prepaid Dental Health Plan used to advertise the event. A Prepaid Dental Health Plan marketing agent is not required to be present at the site.

7. All marketing events shall be reported to the Agency, as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide.

M. Individual Marketing Appointments

1. All individual marketing appointments with potential enrollees are considered marketing events.

2. The Prepaid Dental Health Plan shall only discuss those products that have been agreed upon by the potential enrollee for that appointment ("scope of appointment"). If other products need to be discussed at the request of the potential enrollee, the Prepaid Dental Health Plan shall document a second scope of appointment for the new product type and then the marketing appointment may be continued.

3. Each scope of appointment for an individual marketing event must be documented either in writing, in the form of a signed, dated agreement by the potential enrollee.

4. A potential enrollee may set a scope of appointment at a marketing event for a future individual marketing appointment.

5. The Prepaid Dental Health Plan shall submit all business reply cards for documenting potential enrollee scope of appointment or agreement to be contacted to the Agency. The Prepaid Dental Health Plan shall include a statement on the business reply card informing the potential enrollee that a marketing agent may call as a result of the potential enrollee returning a business reply card.

6. If the Prepaid Dental Health Plan has a pre-scheduled appointment that becomes a "no-show," the Prepaid Dental Health Plan may leave information at the no-show potential enrollee's residence.

7. The Prepaid Dental Health Plan shall not:

   a. Market non-health care related products (such as annuities or life insurance).

   b. Ask a potential enrollee for referrals.

8. The Prepaid Dental Health Plan shall report all individual marketing appointments to the Agency, as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide.

N. Marketing in the Health Care Setting

1. The Prepaid Dental Health Plan shall not conduct marketing activities in health care settings, except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing facility cafeterias, community or recreational rooms, and conference rooms. If a pharmacy counter area were located within a retail store, common areas would include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.

2. The Prepaid Dental Health Plan shall not conduct marketing in areas where patients primarily intend to receive dental services, health care services, or are waiting to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas (where patients interact with their clinical team and receive treatment), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications). The prohibition against conducting marketing activities in health care settings extends to activities planned in health care settings outside of normal business hours.

O. Provider-Based Activities

1. If the Prepaid Dental Health Plan chooses to utilize its provider network to distribute marketing materials, the Prepaid Dental Health Plan shall ensure through its provider agreements that providers shall remain neutral.

2. The Prepaid Dental Health Plan may permit providers to make available and/or distribute Prepaid Dental Health Plan marketing materials as long as the provider does so for all Prepaid Dental Health Plans with which the provider participates.

3. The Prepaid Dental Health Plan may permit providers to display posters or other materials in common areas, such as the provider's waiting room.

4. The Prepaid Dental Health Plan may not permit providers to:

    a. Offer marketing/appointment forms.

    b. Make phone calls or direct, urge, or attempt to persuade potential enrollees to enroll in the Prepaid Dental Health Plan based on financial or any other interests of the provider.

    c. Mail marketing materials on behalf of the Prepaid Dental Health Plan.

    d. Offer anything of value to persuade potential enrollees to select them as their provider or to enroll in a particular Prepaid Dental Health Plan.

    e. Accept compensation directly or indirectly from the Prepaid Dental Health Plan for marketing activities.

5. Provider Affiliation Information

    a. Providers may announce new or continuing affiliations with the Prepaid Dental Health Plan through general advertising (e.g., radio, television, websites).

    b. Providers may make new affiliation announcements within the first thirty (30) days of the new provider agreement.

    c. Providers may make one (1) announcement to patients of a new affiliation that names only the Prepaid Dental Health Plan when such announcement is conveyed through direct mail, email, or phone.

    d. Additional direct mail and/or email communications from providers to their patients

regarding affiliations must include a list of all Prepaid Dental Health Plans with which the provider has agreements.

6. Materials that indicate the provider has an affiliation with certain Prepaid Dental Health Plans and that only list Prepaid Dental Health Plan names, logos, product taglines, telephone contact numbers, and/or websites do not require Agency approval.

P. Public Events

1. The Prepaid Dental Health Plan may conduct, participate in, or sponsor public events. Such events must be held in a public venue. At such events, the Prepaid Dental Health Plan may distribute public event materials. Such materials do not require Agency review or approval.

2. The Prepaid Dental Health Plan may conduct the following permissible activities at public events:

   a. Distribute public event material with the Prepaid Dental Health Plan name, logo, product tagline, telephone contact number and/or website;

   b. Distribute nominal gifts that may display the Prepaid Dental Health Plan name, logo, product tagline, telephone contact number and/or the Prepaid Dental Health Plan's website. The Prepaid Dental Health Plan shall ensure that nominal gifts are free of benefit information and consistent with the requirements of nominal gift specified in this Section of this Contract; and

   c. Display promotional material such as banners, posters, or other displays with the Prepaid Dental Health Plan name, logo, product tagline, telephone contact number, and/or website.

3. The Prepaid Dental Health Plan shall ensure that any public events attended by the Prepaid Dental Health Plan:

   a. Are offered to all individuals regardless of enrollment and without discrimination.

   b. Are not items that are considered a health benefit (e.g., a free checkup).

   c. Do not consist of lowering or waiving co-payments.

   d. Are not used or included with the enrollee handbook.

   e. Do not inappropriately influence the enrollee's selection of a provider, practitioner, or supplier of any item or service.

   f. Are not tied directly or indirectly to the provision of any other covered item or service.

4. The Prepaid Dental Health Plan may not do the following with regard to public events:

   a. Hold a public event at the home of an individual.

b. Conduct one-on-one appointments.

c. Conduct marketing, including the distribution of marketing material.

d. Discuss Prepaid Dental Health Plan-specific benefits.

e. Distribute Prepaid Dental Health Plan-specific materials.

5. Participation in public events shall be reported to the Agency, as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide.

Q. Enrollee Educational Events

1. Enrollee educational events may be hosted by the Prepaid Dental Health Plan or an outside entity and must be held in a public venue. The Prepaid Dental Health Plan shall ensure that events are not held at the home of an individual or as a one-on-one appointment.

2. The Prepaid Dental Health Plan may conduct the following permissible activities at enrollee educational events:

   a. Distribute public event material with the Prepaid Dental Health Plan name, logo, product tagline, telephone contact number, and/or website.

   b. Distribute nominal gifts which may display the Prepaid Dental Health Plan name, logo, product tagline, telephone contact number, and/or website. The Prepaid Dental Health Plan shall ensure that nominal gifts are free of benefit information and consistent with the requirements of nominal gifts specified in Section IV.I., Nominal Gifts, of this Contract.

   c. Display promotional material such as banners, posters or other displays with the Prepaid Dental Health Plan name, logo, product tagline, telephone contact number, and/or website.

3. The Prepaid Dental Health Plan shall submit enrollee material for educational events to the Agency but prior Agency approval is not required. All enrollee educational events shall be reported to the Agency, as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide.

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Section V. Enrollee Services

A. General Provisions

1. The Prepaid Dental Health Plan shall establish and maintain an enrollee services function with the capability to answer enrollee inquiries and ensure that enrollees are notified of their rights and responsibilities, as described in 42 CFR 438.100, through written materials, telephone, electronic and face-to-face communication.

2. The Prepaid Dental Health Plan shall have the capability to answer enrollee inquiries through written materials, telephone, electronic transmission, and face-to-face communication.

3. The Prepaid Dental Health Plan shall provide written notice of changes affecting enrollees to those enrollees at least thirty (30) days before the effective date of change, unless otherwise specified in this Contract.

4. The Prepaid Dental Health Plan shall develop and maintain processes, compliant with applicable federal and State laws (including but not limited to 42 CFR Part 435, and Chapters 709, 744, and 765 of the F.S.), which shall ensure that the Prepaid Dental Health Plan possesses accurate and current information indicating who has legal authority to make health care decisions on behalf of an enrollee.

5. The Prepaid Dental Health Plan may send notices to the enrollee's guardian or legally authorized responsible person as applicable.

6. In accordance with Title VI of the Civil Rights Act of 1964, the Prepaid Dental Health Plan shall provide language assistance services, including the provision of foreign language interpreter and translation services, and auxiliary aids and services to enrollees to achieve effective communication. (42 CFR 438.10(d)(3))

B. Enrollee Material

1. General Provision

The Prepaid Dental Health Plan shall submit enrollee material or changes in enrollee material related to this Contract to the Agency for review and approval prior to use.

a. The Prepaid Dental Health Plan shall submit enrollee material to the Agency at least seventy-five (75) days before the proposed use of the enrollee material or revised material.

b. The Prepaid Dental Health Plan shall conduct a quality check and ensure that all materials are consistent with this Contract and State and federal requirements prior to submitting materials for review to the Agency. Generally, the Agency will not review materials for typographical or grammatical errors, unless such errors render the material inaccurate or misleading.

2. Requirements for Written Material

a. The Prepaid Dental Health Plan shall provide enrollee information in accordance with 42 CFR 438.10(c)(1), 42 CFR 438.10(c)(7), 42 CFR 438.10(d)(6)(ii)-(iv), 42 CFR 438.10(f)(3), and 42 CFR 438.3(i), which addresses information requirements related to written and oral information provided to enrollees

b. The Prepaid Dental Health Plan shall provide all enrollee communications, including written materials, spoken scripts, and websites in an easily understood language and format. Enrollee communications shall be at or near the fourth (4th) grade comprehension level. (42 CFR 438.10(d)(6)(i)) Readability tests to determine whether the written materials meet this requirement are:

   (1) Fry Readability Index;

   (2) PROSE The Readability Analyst (software developed by Education Activities, Inc.);

   (3) Gunning FOG Index;

   (4) McLaughlin SMOG Index;

   (5) The Flesch-Kincaid Index; and/or

   (6) Other readability tests approved by the Agency.

c. The Prepaid Dental Health Plan shall make all written material available in multiple languages, as prescribed by the Agency. The Prepaid Dental Health Plan shall notify all enrollees and, upon request, potential enrollees that information is available in alternative formats and how to access those formats. (42 CFR 438.10(d)(3))

d. If the Prepaid Dental Health Plan meets the five percent (5%) threshold for language translation, the Prepaid Dental Health Plan shall place the following alternate language disclaimer on all enrollee materials:

   "This information is available for free in other languages. Please contact our customer service number at [insert enrollee help line and TTY/TTD numbers and hours of operation]."

   The Prepaid Dental Health Plan shall include the alternate language disclaimer in both English and all non-English languages that meet the five percent (5%) threshold. The Prepaid Dental Health Plan shall place the non-English disclaimer(s) below the English version and in the same font size as the English version. Information on language use may be found at https://www.census.gov/topics/population/language-use.html#tab2.

e. The Prepaid Dental Health Plan shall include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided. Information on the top fifteen (15) non-English languages is located at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf.

3. Requirements for Mailing Materials to Enrollees

a. The Prepaid Dental Health Plan shall provide materials to enrollees by mail or consistent with the enrollee's preferred method of contact.

b. The Prepaid Dental Health Plan shall display one of the following four (4) statements verbatim on the front of the envelope or, if no envelope is being sent, the mailing itself:

(1) Advertising pieces – "This is an advertisement"

(2) Dental Health Plan information – "Important Dental Health Plan information"

(3) Health and wellness information – "Health and wellness or prevention information"

(4) Non-dental or non-Prepaid Dental Health Plan information – "Non-health or non-Prepaid Dental Health Plan related information"

The Agency does not require resubmission of envelopes based only on the envelope size.

c. The Prepaid Dental Health Plan shall ensure that its Prepaid Dental Health Plan name or logo is included in every mailing to enrollees.

d. The Prepaid Dental Health Plan shall include a request for address correction in mailing envelopes for enrollee materials.

e. The Prepaid Dental Health Plan shall not send emails unless the enrollee has agreed to receive those emails and shall provide an opt-out process for enrollees no longer to receive email communications.

4. Enrollee Procedures and Materials

a. The Prepaid Dental Health Plan shall notify, in writing, within five (5) days following the receipt of the X12-834 enrollment file from the Agency or its designee, each person who is to be newly enrolled or reinstated with the Prepaid Dental Health Plan.

b. The Prepaid Dental Health Plan shall furnish enrollee materials to the new enrollee:

(1) An enrollment notice.

(2) An enrollee identification (ID) card.

(3) A current enrollee handbook.

(4) A current provider directory.

(5) Name, telephone number and address of the enrollee's PDP assignment;

c. The Prepaid Dental Health Plan shall furnish a reinstatement notice to a reinstated enrollee.

5. Required Enrollment Notice

The Prepaid Dental Health Plan shall include in its enrollment notice:

a. The effective date of enrollment;

b. The enrollees' right to change their Prepaid Dental Health Plan selections, subject to Medicaid limitations. The notifications shall distinguish between enrollees subject to open enrollment and those who are not and shall include information about change procedures for cause, or general Prepaid Dental Health Plan change procedures through the Agency's enrollment broker website (www.flmedicaidmanagedcare.com) and toll-free enrollment broker telephone number as appropriate;

c. A notice that enrollees who lose eligibility and are disenrolled shall be automatically reinstated in the Prepaid Dental Health Plan if eligibility is regained within the temporary loss period;

d. A request to update the enrollee's name, address (home and mailing), county of residence and telephone number, and include information on how to update this information with the Prepaid Dental Health Plan and through DCF and/or the Social Security Administration; and

e. A postage-paid, pre-addressed return envelope.

6. Reinstatement Notice

The Prepaid Dental Health Plan shall include in its reinstatement notice:

a. The effective date of the reinstatement;

b. Instructions on how the enrollee can contact the Prepaid Dental Health Plan if a new enrollee card, new enrollee handbook, and/or a new provider directory are needed;

c. A request to update the enrollee's name, address (home and mailing), county of residence and telephone number, and include information on how to update this information with the Prepaid Dental Health Plan and through DCF and/or the Social Security Administration; and

d. A postage-paid, pre-addressed return envelope.

7. Enrollee ID Card Requirements

a. The Prepaid Dental Health Plan shall include on its enrollee ID card:

   (1) The enrollee's name and Medicaid ID number;

   (2) The Prepaid Dental Health Plan's name, address, and enrollee help line number; and

   (3) A telephone number that a non-participating provider may call for billing information.

b. The Prepaid Dental Health Plan shall provide replacement ID cards at the enrollee's request.

8. Enrollee Handbook Requirements

a. The Prepaid Dental Health Plan shall furnish each new enrollee an enrollee handbook using the model enrollee handbook template provided by the Agency. The model enrollee handbook shall comply with the provisions of 42 CFR 438.3(j), 42 CFR 438.102(b)(2), 42 CFR 438.10(c)(4)(ii), 42 CFR 438.10(g). 42 CFR 438.62(b)(3), 42 CFR 489.102(a), and 45 CFR 147.200(a).

b. The Prepaid Dental Health Plan shall provide the enrollee handbook through one of the following methods:

(1) Mailing a printed copy of the information to the enrollee's address;

(2) Providing the information by email, as permitted by this Contract;

(3) Advising the enrollee in paper or electronic form that the information is available on the Prepaid Dental Health Plan's website and providing the applicable internet address; or

(4) Providing the information by any other method that can reasonably be expected to result in the enrollee receiving that information.

Prior to utilizing methods (2), (3), or (4) above, the Prepaid Dental Health Plan shall submit a written description to the Agency Contract Manager of the process ensuring enrollees have access to a printed copy upon request.

9. Printed Provider Directory

a. The Prepaid Dental Health Plan shall include in its printed provider directory the following information:

(1) Provider(s) names and group affiliations;

(2) Street address(es);

(3) Telephone number;

(4) Website URLs, if the provider has a website;

(5) Specialty credentials and other certifications, as applicable;

(6) Whether the provider will accept new enrollees;

(7) The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training;

(8) Office hours;

(9) Specific performance indicators;

(10) In accordance with s. 1932(b)(3) of the Social Security Act, a statement that some providers may choose not to perform certain services based on religious or moral beliefs; and

(11) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment. (42 CFR 438.10(h)(1))

b. The Prepaid Dental Health Plan shall arrange the provider directory by county as follows:

(1) Providers listed by name in alphabetical order, showing the provider's specialty; and

(2) Providers listed by specialty, in alphabetical order by name.

c. The Prepaid Dental Health Plan shall provide a copy of the printed provider directory through one of the following methods:

(1) Mailing a printed copy to the enrollee's address;

(2) Providing the information by email, as permitted by this Contract;

(3) Advising the enrollee in paper or electronic form that the information is available on the internet and including the applicable internet address; or

(4) Providing the information by any other method that can reasonably be expected to result in the enrollee receiving that information.

d. The Prepaid Dental Health Plan shall update the printable version of the provider directory at least monthly and include the date of revision. (42 CFR 438.10(h)(3))

e. When distributing printed provider directories, the Prepaid Dental Health Plan shall include information stating that the most current listing of providers is available by calling the Prepaid Dental Health Plan at its toll-free telephone number and at the Prepaid Dental Health Plan's website. The letter shall include the telephone number and the internet address that links directly to the online provider database.

10. Online Enrollee Materials

a. The Prepaid Dental Health Plan shall make available electronically at the Prepaid Dental Health Plan's website without requiring enrollee login, the enrollee handbook(s), the printed provider directory, and a searchable provider database.

(1) The Prepaid Dental Health Plan shall provide enrollee information electronically and meet the criteria as outlined in 42 CFR 438.10(c)(6)(i)-(v).

(2) The Prepaid Dental Health Plan may provide a link to applications (smartphone applications, or "apps") for enrollee use that will take enrollees directly to existing Agency-approved materials (such as the Prepaid Dental Health Plan's enrollee handbook and provider directory) on the Prepaid Dental Health Plan's website.

(3) The online provider directory shall be made available in a machine readable file and format in compliance with 42 CFR 438.10(h)(4).

b. The Prepaid Dental Health Plan shall maintain an accurate and complete online provider database containing all the information required in the printed provider directory and as required by s. 409.967(2)(c)1, F.S. The online provider database must be searchable by:

(1) Name

(2) Provider type

(3) Distance from the enrollee's address

(4) County

(5) Zip code

(6) Whether the provider is accepting new patients

c. The Prepaid Dental Health Plan shall update the online provider database at least weekly to match the most recent provider network file submitted to the Agency.

d. The Agency reserves the right to publish the information specified in s. 409.967(2)(c)1, F.S.

11. Procedures for Provider Network Changes

a. The Prepaid Dental Health Plan shall have procedures to inform potential enrollees and enrollees, upon request, of any changes to service delivery and/or the provider network including the following:

(1) Up-to-date information about any restrictions on access to providers, including providers who are not taking new patients;

(2) Any restrictions on counseling and referral services based on moral or religious grounds within ninety (90) days after adopting the policy with respect to any service. (42 CFR 438.102(b)(1)(i)(B); 42 CFR 438.10(g)(4))

b. The Prepaid Dental Health Plan shall have procedures to inform enrollees of adverse changes to its provider network.

C. Enrollee Services

1. General Provisions

a. The Prepaid Dental Health Plan shall establish and maintain an enrollee services function with the capability to answer enrollee inquiries and ensure that enrollees are notified of their rights and responsibilities.

b. The Prepaid Dental Health Plan shall ensure language translation quality in all enrollee materials.

2. Translation and Interpretation Services

a. The Prepaid Dental Health Plan is required to provide interpretation services at all points of contact to any potential enrollee or enrollee who speaks any non-English language regardless of whether the enrollee speaks a language that meets the threshold of a prevalent non-English language. This includes written translation, oral interpretation, and the use of auxiliary aids such as TTY/TDY and American Sign Language. (42 CFR 438.10(d)(4); and 42 CFR 438.406(a))

b. The Prepaid Dental Health Plan is required to notify its enrollees of the availability of interpretation services and to inform them of how to access such services. Interpretation services are required for all Prepaid Dental Health Plan information provided to enrollees, including notices of adverse action. There shall be no charge to the enrollee for translation services. (42 CFR 438.10(d)(5)(i)-(iii), 42 CFR 438.10(d)(4))

c. Upon request, the Prepaid Dental Health Plan shall provide, free of charge, interpreters for potential enrollees or enrollees whose primary language is not English. (42 CFR 438.10(d)(4))

3. Toll-Free Enrollee Help Line

a. The Prepaid Dental Health Plan shall operate a toll-free help line equipped with caller identification, automatic call distribution equipment capable of handling the expected volume of calls, a telecommunication device for the deaf (TTY/TDD), and access to the interpreter services for non-English speaking beneficiaries. The Prepaid Dental Health Plan shall operate its enrollee help line as part of an inbound call center or similar functional arrangement where agents or operators staff telephones to field incoming calls.

b. The Prepaid Dental Health Plan shall staff the enrollee help line twenty-four hours per day, seven days a week (24/7) to handle care related inquiries, including emergency services from enrollees and caregivers.

c. The enrollee help line agents/operators shall be trained to respond to enrollee questions in all areas.

d. The Prepaid Dental Health Plan shall develop and implement an operational manual relevant to the call center. This manual shall provide information to agents/operators on how to conduct various call center tasks and provide procedures for processing enrollee inquiries, including procedures, such as call scripts, call-handling procedures, first call resolution, and escalation protocols.

e. If the Prepaid Dental Health Plan utilizes an automated phone tree system, the Prepaid Dental Health Plan's phone tree must include the option for enrollees to bypass options in the automated phone tree system and speak with an enrollee help line representative.

f. The Prepaid Dental Health Plan may use a voice mail option in an automated phone tree system for callers to leave messages between the hours of 7:00 p.m. and 8:00 a.m., in the enrollee's time zone, Monday through Friday and at all hours on weekends and holidays. This phone tree must provide callers with clear instructions on what to do in case of an emergency and an option to speak to a Prepaid Dental Health Plan representative.

g. If the Prepaid Dental Health Plan utilizes a voice mailbox option, the Prepaid Dental Health Plan shall ensure that the voice mailbox has adequate capacity to receive all messages. A Prepaid Dental Health Plan representative shall respond to all messages on the next business day.

h. The Prepaid Dental Health Plan shall have administrative procedures that include requirements for staffing, operations, technologies and performance measurement. The administrative procedures shall address:

   (1) Personnel management such as staff development and training, scheduling and skill-based routing;

   (2) Operational management of all call center activities such as call center shrinkage and schedule adherence, workload, and call load forecasting;

   (3) Software and technologies, such as automatic call distribution (ACD), telephone phone tree/IVR technology and call recording systems; and

   (4) Call center quality control metrics and measurement for the performance of agents/operators.

i. The Prepaid Dental Health Plan shall develop performance standards and monitor enrollee help line performance by recording calls and employing other monitoring activities. Such standards shall be submitted to and approved by the Agency before use, and comply with Attachment B., Section XIV., Liquidated Damages, of this Contract. The Prepaid Dental Health Plan shall report its performance on these standards as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide. These standards shall be measured on a monthly basis and, at a minimum, require that:

   (1) The average speed of answer shall not exceed thirty (30) seconds.

   (2) The call blockage rate for direct calls to the Prepaid Dental Health Plan shall not exceed one-half of one percent (0.5%).

   (3) The average call abandonment rate for direct calls to the Prepaid Dental Health Plan shall not exceed three percent (3%). A system which places calls in queue may be used but the average wait time in the queue shall not exceed sixty (60) seconds.

j. The Prepaid Dental Health Plan shall ensure that hold time messages do not include non-health related items (e.g., life insurance, disability). The Prepaid Dental Health Plan shall submit hold time messages that promote the Prepaid Dental Health Plan or include benefit information to the Agency for prior approval.

4. Cultural Competency Plan

As required by 42 CFR 438.206(c)(2), the Prepaid Dental Health Plan shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

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Section VI. Coverage and Authorization of Services

A. Required Benefits

1. General Provisions

a. The Agency will be responsible for promulgating coverage requirements applicable to Prepaid Dental Health Plans through Florida Medicaid Coverage Policies, services listed in the associated Florida Medicaid fee schedules, and the Florida Medicaid State Plan, as well as plan communications specific to changes in federal and State law, rules, or regulations, and the federal CMS waivers applicable to this Contract.

b. The Prepaid Dental Health Plan shall ensure the provision of services defined and specified in this Contract and the applicable federal waivers in sufficient amount, duration, and scope to be reasonably expected to achieve the purpose for which the services are furnished and shall ensure the provision of the covered services defined and specified in this Contract. (42 CFR 438.210(a)(3)(i))

c. Nothing in this Contract waives the EPSDT requirements of 42 U.S.C. § 1396d(r)(5). As such, in accordance with § 1396d(r) and all binding federal precedents interpreting it, the Prepaid Dental Health Plan shall, for Medicaid eligible children under the age of twenty-one (21) years, pay for any "other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this Section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." (42 U.S.C. 1396d(r)(5)) The Prepaid Dental Health Plan shall not place any time caps (e.g., hourly limits, daily limits, or annual limits) or expenditure caps on services for children under the age of twenty-one (21) years. The Prepaid Dental Health Plan shall develop a special services process to authorize services exceeding the coverage described in each service-specific coverage policy, if medically necessary.

d. The Prepaid Dental Health Plan shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the enrollee's diagnosis, type of illness or condition. The Prepaid Dental Health Plan may place appropriate limits on a service on the basis of medical necessity, as defined by the Agency, consistent with the terms of this Contract and as required by 42 CFR 438.210(a)(4)(i)-(ii) and 438.210(a)(1), provided the services furnished can be reasonably expected to achieve their purpose.

e. The Prepaid Dental Health Plan shall provide the services identified in Attachment B in accordance with the Florida Medicaid State Plan, the applicable federal waivers, as well as the Florida Medicaid promulgated rules in Chapter 59G-4, F.A.C., that include the Florida Medicaid Coverage Policies, and services listed in the associated Florida Medicaid fee schedules, except where the provisions of this Contract or the applicable federal waivers alter the requirements set forth in the Coverage Policies and Medicaid fee schedules.

   (1) In no instance may the Prepaid Dental Health Plan impose coverage and service limitations or exclusions more stringent than those specified in the aforementioned documents. (42 CFR 438.210(a)(5)(i))

(2) The Prepaid Dental Health Plan may exceed specific coverage criteria included in the above and specific coverage exclusions specified in the aforementioned documents.

f. The Prepaid Dental Health Plan is responsible for ensuring that all coverage and service requirements specified in the Florida Medicaid Services Coverage & Limitations Handbooks, Florida Medicaid Coverage Policies are incorporated into the Prepaid Dental Health Plan's provider agreements. This includes professional licensure and certification standards for all service providers. Exceptions exist where different standards are specified elsewhere in this Contract.

g. The Agency will be responsible for accepting complaints directly from Medicaid recipients and providers, operating the SAP, conducting Medicaid Fair Hearings, as well as reviewing complaints, grievances, and plan appeals reported by Prepaid Dental Health Plans to ensure appropriate resolution and monitor for contractual compliance, the Prepaid Dental Health Plan performance, and trends that may reflect policy changes or operational changes needed.

h. This Contract shall prevail in any instance when compliance with provisions in the Medicaid State Plan, the applicable federal waivers, as well as the Florida Medicaid promulgated rules in Chapter 59G, F.A.C. conflict with the terms of this Contract.

B. Required Dental Benefits

1. Specific Dental Services to be Provided

a. The Prepaid Dental Health Plan shall provide covered dental services in accordance with Attachment B., Section VI., Coverage and Authorization of Services, the approved federal waiver for the Statewide Medicaid Prepaid Dental Health Program, and the following Medicaid dental rules and services listed on the associated fee schedules and billing codes listings:

Rule No.	Policy Name
59G-4.002	Dental General Fee Schedule Practitioner Fee Schedule* Prescribed Drugs (Not Reviewed by the Pharmaceutical and Therapeutics Committee) Fee Schedule* Prescribed Drug Fee Schedule* Federally Qualified Health Center Billing Codes* County Health Department Billing Codes*
59G-4.055	County Health Department Clinic Services*
59G-4.060	Dental Services Coverage Policy
59G-4-100	Federally Qualified Health Care Services*
59G-4.207	Oral and Maxillofacial Surgery Services Coverage Policy
59G-4.250	Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook*

**As identified by procedure codes included on the Procedure Code Mapping tab in Appendix I to the Prepaid Dental Health Plan Program Data Book.*

b. Post-stabilization Dental Care Services

(1) In accordance with 42 CFR 438.114 and s. 1932(b)(2)(A)(ii) of the Social Security Act, the Prepaid Dental Health Plan shall cover post-stabilization care services without authorization, regardless of whether the enrollee obtains a service through a participating or non-participating provider. Only those post-stabilization dental care services that are specifically dental services shall be the responsibility of the Prepaid Dental Health Plan. Those post-stabilization dental care services that a treating physician viewed as medically necessary after stabilizing an emergency dental condition are non-emergency services. The Prepaid Dental Health Plan may choose not to cover non-emergency services if they are provided by a non-participating provider, except in those circumstances detailed below.

(a) Post-stabilization dental care services that were pre-approved by the Prepaid Dental Health Plan;

(b) Post-stabilization dental care services that were not pre-approved by the Prepaid Dental Health Plan because the Prepaid Dental Health Plan did not respond to the treating provider's request for pre-approval within one (1) hour after the treating provider sent the request; or

(c) The treating provider could not contact the Prepaid Dental Health Plan for pre-approval.

(2) In addition to the requirements outlined in s. 641.513, F.S., the Prepaid Dental Health Plan shall ensure the enrollee has a follow-up appointment scheduled within seven (7) days after discharge.

C. Expanded Benefits

1. General Provisions

a. The Prepaid Dental Health Plan may offer expanded benefits in excess of the amount, duration, and scope as approved by the Agency of those services listed in this Contract for its respective enrollees.

b. The Prepaid Dental Health Plan shall offer the approved expanded benefits to eligible enrollees in the applicable managed care program, subject to any Agency-agreed service limitations set forth in this Contract.

c. The Prepaid Dental Health Plan shall administer the expanded benefits of Medicaid covered services in accordance with any applicable service standards pursuant to this Contract, the applicable federal waivers, and any Florida Medicaid Coverage Policies.

2. Changes to Expanded Benefits Offered

a. The Prepaid Dental Health Plan's expanded benefits may be changed on a Contract year basis in a manner and format approved by the Agency, if determined by the Agency to be beneficial to the enrollees.

b. The Prepaid Dental Health Plan may increase its expanded benefits upon approval by the Agency.

c. The Prepaid Dental Health Plan may exchange an expanded benefit for another, if determined to be actuarially equivalent by the Agency, upon approval by the Agency.

D. Excluded Services

1. General Provisions

a. The Prepaid Dental Health Plan is not obligated to provide any services not specified in this Contract, except as federally required under EPSDT provisions.

b. Enrollees who require services not covered by this Contract shall receive the services through other appropriate Medicaid and non-Medicaid programs. In such cases, the Prepaid Dental Health Plan's responsibility shall include coordination and referrals in compliance with42 CFR 438.208(b)(2)(iii)-(iv).

c. The Prepaid Dental Plan is not responsible for the provision of dental services provided in a hospital, emergency room, or urgent care place of service.

2. Moral or Religious Objections

a. The Prepaid Dental Health Plan shall provide or arrange for the provision of all covered services. If, during the course of this Contract period, pursuant to 42 CFR 438.102, the Prepaid Dental Health Plan elects not to provide or reimburse for counseling or referral to a covered service because of an objection on moral or religious grounds, the Prepaid Dental Health Plan shall notify:

(1) The Agency within one hundred twenty (120) days before implementing the policy with respect to any covered service; (42 CFR 438.102(b)(1)(i)(A)(2)) and

(2) Enrollees within sixty (60) days before implementing the policy with respect to any covered service.

b. In accordance with 42 CFR 438.10, if the Prepaid Dental Health Plan chooses not to cover or furnish counseling or referral service information to enrollees due to moral or religious objections, the Agency will be responsible for providing information on how and where to obtain the service. (42 CFR 438.102(b)(1)(i)(A)(1))

E. Coverage Provisions

1. Service-Specific Requirements

a. The Prepaid Dental Health Plan shall offer the enrollee a choice of PDPs. Each enrollee shall have a single or group PDP.

b. The Prepaid Dental Health Plan shall permit enrollees to request to change PDPs at any time. If the enrollee request is not received by the Prepaid Dental Health Plan's established monthly cut-off date for system processing, the PDP change will be

effective the first day of the next month.

c. The Prepaid Dental Health Plan shall assign all enrollees that are reinstated after a temporary loss of eligibility to the PDP to which they were assigned prior to loss of eligibility, unless the enrollee specifically requests another PDP, or the PDP is at capacity or no longer participates in the Prepaid Dental Health Plan.

2. Enrollee Screening and Education

a. The Prepaid Dental Health Plan shall use the enrollee's health risk assessment and/or released enrollee record to identify enrollees who have not received well-child dental screenings in accordance with the Agency-approved periodicity schedule.

b. The Prepaid Dental Health Plan shall develop and implement an education and outreach program to increase the number of eligible enrollees receiving annual dental visits and preventive dental visits. This program shall include, at a minimum, the following:

(1) A tracking system to identify enrollees for whom a visit is due or overdue;

(2) Systematic reminder notices sent to enrollees before a visit is due. The notice shall include an offer to assist with scheduling and transportation;

(3) If the Prepaid Dental Health Plan's well-child visit rate is below eighty percent (80%), contacts (which may include automated calls) to all new enrollees under the age of twenty-one (21) years to inform them of well-child visit services and offer to assist with scheduling and transportation;

(4) A process for following up with enrollees who do not get timely visits. This shall include contacting, twice if necessary, any enrollee more than two (2) months behind in the Agency-approved periodicity screening schedule to urge those enrollees, or their legal representatives, to make an appointment with the enrollee's PDP for a screening visit and offering to assist with scheduling and transportation. The Prepaid Dental Health Plan shall document all outreach education attempts. For this subsection "contact" is defined as mailing a notice to or calling an enrollee at the most recent address or telephone number available; and

(5) Provision of enrollee education and outreach in community settings.

c. The Prepaid Dental Health Plan shall develop and implement an education outreach program to encourage preventive dental visits and a dental home.

d. The Prepaid Dental Health Plan shall take immediate action to address any identified urgent dental needs.

e. The Prepaid Dental Health Plan may have program for recognizing dental homes. If the Prepaid Dental Health Plan has a dental home program, it shall submit its procedures for such program to the Agency, which shall include recognition standards developed by the Prepaid Dental Health Plan for the program.

3. New Enrollee Procedures

a. The Prepaid Dental Health Plan shall contact each new enrollee at least twice, if necessary, within ninety (90) days of the enrollee's enrollment to conduct an initial screening of the enrollee's needs and to offer to schedule the enrollee's initial appointment with the PDP, which should occur within one hundred eighty (180) days of enrollment. This appointment is to obtain an oral health evaluation and cleaning, as appropriate. For this subsection "contact" is defined as mailing a notice to or telephoning an enrollee at the most recent address or telephone number available. Contact may also include emailing as permitted by Attachment B., Section V.B.3, Requirements for Mailing Materials to Enrollees.

b. Within thirty (30) days of enrollment, the Prepaid Dental Health Plan shall ask the enrollee to authorize release of the provider's enrollee records to the new PDP or other appropriate provider and shall assist by requesting those records from the enrollee's previous provider(s).

c. The Prepaid Dental Health Plan shall honor any written documentation of prior authorization of ongoing covered services in accordance with Section IX.H.

d. For all enrollees, written documentation of prior authorization of ongoing dental services shall include the following, provided that the services were prearranged prior to enrollment with the Prepaid Dental Health Plan:

(1) Prior existing orders

(2) Provider appointments

(3) Prior Authorizations

(4) Treatment plan/plan of care

e. The Prepaid Dental Health Plan shall not delay service authorization if written documentation is not available in a timely manner. However, the Prepaid Dental Health Plan is not required to approve claims for which it has received no written documentation.

4. Telemedicine Coverage Provisions

a. The Prepaid Dental Health Plan may use telemedicine in accordance with Rule 59G-1.057, F.A.C., and as specified in this Contract.

b. When providing services through telemedicine, the Prepaid Dental Health Plan shall ensure:

(1) The telecommunication equipment and telemedicine operations meet the technical safeguards required by 45 CFR 164.312, where applicable;

(2) The Prepaid Dental Health Plan's providers using telemedicine comply with Health Insurance Portability and Accountability Act and other State and federal

laws pertaining to patient privacy;

(3) The Prepaid Dental Health Plan's telemedicine procedures comply with the requirements in this Contract; and

(4) The Prepaid Dental Health Plan provides training to providers regarding the telemedicine requirements in this Contract.

c. The Prepaid Dental Health Plan shall ensure the enrollee has a choice of whether to access services through a face-to-face or telemedicine encounter. The Prepaid Dental Health Plan shall ensure that the enrollee record includes documentation, as applicable, when telemedicine services are provided.

F. Care Coordination/Case Management

1. General Provisions

a. The Prepaid Dental Health Plan shall be responsible for care coordination/case management of oral health benefits for enrollees as specified in this Contract.

b. The Prepaid Dental Health Plan shall have protocols in place to identify enrollees who require care coordination/case management services, and maintain written procedures for identifying, assessing, and implementing interventions for enrollees.

c. The Prepaid Dental Health Plan shall ensure case managers meet the appropriate experience and educational requirements.

2. Additional Care Coordination/Case Management Requirements

a. The Prepaid Dental Health Plan's shall maintain written care coordination and continuity of care procedures that include the following minimum functions:

(1) Appropriate referral and scheduling assistance for enrollees needing specialty dental care;

(2) A mechanism for access to specialists, without the need for a referral, for enrollees identified as having special health care needs, as appropriate for their conditions and identified needs;

(3) Coordination with the enrollee's Managed Medical Assistance plan for oral health issues exceeding the coverage of this Contract (e.g., oral cancer; services required in an hospital, emergency room or urgent care place of service);

(4) Coordination with the enrollee's Managed Medical Assistance plan for transportation to and from covered oral health services.

(5) Coordination with the enrollee's Managed Medical Assistance plan, Comprehensive Long-term Care plan, or Long-term Care Plus plan regarding expanded dental benefits offered by the enrollee's plan.

b. The Prepaid Dental Health Plan shall maintain written procedures for identifying,

assessing, and implementing interventions for enrollees with complex medical or behavioral health issues, IDD, high service utilization, intensive health care needs, or who consistently access services at the highest level of care. This shall include, at a minimum, the following:

(1) Identifying eligible enrollees and stratifying enrollees by severity and risk level including developing an algorithm to identify and stratify eligible enrollees, including identifying enrollees with co-morbid medical conditions and addressing the co-morbid medical conditions;

(2) Developing different types of interventions and specifying minimum touch frequency for each severity and/or risk level;

(3) Determining maximum caseloads for each case manager and support staff and managing and monitoring caseloads;

(4) Specifying experience and educational requirements for case managers and case management support staff;

(5) Providing training and continuing education for case management staff;

(6) Using evidence-based guidelines to enhance enrollee engagement;

(7) Ensure the development of treatment plans that address all of the following:

(a) Incorporate the health risk issues identified during the oral assessment;

(b) Incorporate the treatment preferences of the enrollee;

(c) Contain goals that are outcomes based and measurable;

(d) Include the interventions and services to be provided to obtain goals;

(e) Include community service linkage, improving support services, and lifestyle management as appropriate based on the enrollee's identified issues.

(f) Assessing enrollees for literacy levels and other hearing, vision, or cognitive functions that may impact an enrollee's ability to participate in his/her care and implementing interventions to address the limitations; and

(g) Assessing enrollees for community, environmental, or other supportive services needs and referring enrollees to get needed assistance.

The Prepaid Dental Health Plan shall ensure treatment plans are updated at least every six (6) months when there are significant changes in enrollee's condition; and

(8) Interfacing with the enrollee's PDP and/or specialists; and

3. Care Coordination/Case Management Contact

The Prepaid Dental Health Plan shall maintain contact with enrollees receiving care coordination/case management as specified in this section and as frequently as the enrollee's health condition requires.

4. Transition of Care

a. The Prepaid Dental Health Plan shall develop and maintain transition of care procedures that address all transitional care coordination/case management requirements and submit these procedures for review and approval to the Agency. (42 CFR 438.62(b)(1)-(2)) Transition of care procedures shall include the following minimum functions:

(1) Appropriate support to case managers, and to enrollees and caregivers as needed, for referral and scheduling assistance for enrollees needing specialty health care, transportation, or other service supports; (42 CFR 438.208(b)(1))

(2) Determination of the need for non-covered services and referral of the enrollee for assessment and referral to the appropriate service setting with assistance, as needed, by the Agency. (42 CFR 438.208(b)(6); 42 CFR 438.224; 45 CFR 160; 45 CFR 164) Transfer of enrollee records in compliance with HIPAA privacy and security rules;

(3) Documentation of referral services in enrollee records, including follow up resulting from the referral;

(4) Monitoring of enrollees with co-morbidities and complex medical conditions and coordination of services for high utilizers to identify gaps in services and evaluate progress of case management.

b. The Prepaid Dental Health Plan shall be responsible for coordination of care for new enrollees transitioning into the Prepaid Dental Health Plan.

c. The Prepaid Dental Health Plan shall be responsible for coordination of care for enrollees transitioning to another Prepaid Dental Health Plan or delivery system and ensure information for active services is shared with the new Prepaid Dental Health Plan or delivery system within thirty (30) days following an enrollee's enrollment date into the new plan.

d. In addition to the provisions of Attachment B., Section VI.E.2., Case Management Program Description, the Prepaid Dental Health Plan's transition of care procedures shall include the following minimum functions:

(1) Collaborating with the enrollee's Managed Medical Assistance plan to assure the provision of post-stabilization dental care services;

(2) Facilitating communication with community service providers; and

(3) Coordination of care after emergency department visits. (42 CFR 438.208(b)(2)(i))

5. Healthy Behaviors Program

a. The Prepaid Dental Health Plan may establish and maintain programs to encourage and reward healthy behaviors.

b. The Prepaid Dental Health Plan shall receive written approval of its healthy behavior programs from the Agency before implementing the programs. The Prepaid Dental Health Plan's program shall include a detailed description of the program, including the goals of the program, how targeted enrollees will be identified, the interventions the Prepaid Dental Health Plan intends to use, rewards for or incentives to participate, research to support the effectiveness of the program, and evidence that the program is medically approved or directed, as applicable. Programs administered by the Prepaid Dental Health Plan shall comply with all applicable laws, including fraud and abuse laws that fall within the purview of the United States DHHS OIG. The Prepaid Dental Health Plan is encouraged to seek an advisory opinion from OIG once the specifics of its Healthy Behaviors programs are determined.

c. The Prepaid Dental Health Plan may, through its healthy behavior programs, deploy a number of interventions as part of the overall therapeutic process.

d. The Prepaid Dental Health Plan shall make all programs, including incentives and rewards, available to all enrollees and shall not use incentives or rewards to direct individuals to select a particular provider.

e. The Prepaid Dental Health Plan shall inform new participants about the healthy behaviors program and actively engage in outreach and communication about the health benefits of its healthy behavior programs, including incentives and rewards.

f. The Prepaid Dental Health Plan shall collaborate with other agencies such as State and local public health entities, provider organizations, local community groups, or other entities to educate enrollees about the program or to help administer it.

g. The Prepaid Dental Health Plan shall annually inform PDP providers of the availability of healthy behavior programs and incentives to support enrollee engagement.

h. The Prepaid Dental Health Plan shall not include the provision of gambling, alcohol, tobacco or drugs (except for over-the-counter drugs) in any of its incentives or rewards and shall state on the incentive or reward that it may not be used for such purposes.

i. The Prepaid Dental Health Plan's healthy behavior program shall include a detailed description of the rewards and incentives offered to enrollees. Incentives by themselves do not constitute an effective program. Incentives or rewards may have some health- or child development-related function (e.g., clothing, food, books, safety devices, infant care items, subscriptions to publications that include health-related subjects, membership in clubs advocating educational advancement and healthy lifestyles, etc.). Incentive or reward dollar values shall be in proportion to the importance of the healthy behavior being encouraged or rewarded.

j. Both incentives and rewards offered to enrollees shall be reasonable, simple, and provided on a timely basis. Incentives or rewards may include any of the following:

(1) Money through debit cards;

(2) Gift cards;

(3) Flexible spending accounts that may be used for health and wellness items;

(4) Vouchers for health and wellness related items; and

(5) Points or credits that are redeemable for goods or services.

k. Incentives and rewards shall be limited to a value of twenty dollars (**$20**). The exceptions to this monetary limit are as follows:

(1) Programs that require the enrollee to complete a series of activities (e.g.; completion of a series of health education classes). In these instances, the incentive or reward shall be limited to a value of fifty dollars (**$50**).

(2) Items that are offered as incentives to engage in a healthy behavior program or rewards for completion of an action or a series of activities may have a special exception to the dollar value, with Agency approval.

(3) Participation in multiple healthy behavior programs. In these instances, the incentive or reward shall be limited to a value of no more than fifty dollars (**$50**) for each healthy behavior program.

l. The Prepaid Dental Health Plan shall not include in the dollar limits on incentives or rewards any money spent on childcare provided during the delivery of services, or the healthy behavior program or associated interventions.

m. Healthy Behavior incentives/rewards are non-transferable from one Prepaid Dental Health Plan to another.

n. The Prepaid Dental Health Plan shall report on its healthy behavior programs in accordance with Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide. This shall include submitting data related to each healthy behavior program, caseloads (new and ongoing) for each healthy behavior program, and the amount and type of rewards/incentives provided for each healthy behavior program.

o. The Prepaid Dental Health Plan shall annually evaluate enrollee engagement, program completion, and health benefit outcomes in all healthy behaviors programs for effectiveness.

G. Quality Enhancements

1. General Provisions

a. In addition to the covered services specified in this Section, the Prepaid Dental Health Plan shall offer and coordinate access to quality enhancements (QEs). Prepaid Dental Health Plans are not reimbursed separately by the Agency for these services.

b. The Prepaid Dental Health Plan shall develop and maintain written procedures to implement QEs.

c. The Prepaid Dental Health Plan shall provide information in the enrollee and provider handbooks on the QEs and how to access related services.

d. The Prepaid Dental Health Plan shall offer QEs in community settings accessible to enrollees.

e. The Prepaid Dental Health Plan is encouraged to collaborate actively with community agencies and organizations and social support providers.

f. If the Prepaid Dental Health Plan involves the enrollee in an existing community program for purposes of meeting the QE requirements, the Prepaid Dental Health Plan shall ensure documentation in the enrollee record of referrals to the community program and follow up on the enrollee's receipt of services from the community program.

2. Children's Wellness Programs

The Prepaid Dental Health Plan shall provider regular general dental wellness programs targeted specifically toward enrollees under the age of twenty-one (21) or the Prepaid Dental Health Plan shall make a good faith effort to involve enrollees in existing community oral health programs.

H. Authorization of Services

1. General Provisions

a. The Prepaid Dental Health Plan shall establish and maintain a UM system to monitor utilization of services, including an automated service authorization system for denials, service limitations, and reductions of authorization. The Prepaid Dental Health Plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required service because of the enrollee's diagnosis, type of illness, or condition (42 CFR 438.210(a)(3)(ii)).

b. The Prepaid Dental Health Plan shall ensure that applicable evidence-based guidelines are utilized with consideration given to characteristics of the local delivery systems available for specific enrollees as well as enrollee-specific factors, such as enrollee's age, co-morbidities, complications, progress in treatment, psychosocial situation, and home environment.

c. The Prepaid Dental Health Plan shall provide that compensation to individuals or entities (including subcontractors) that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee, in accordance with 42 CFR 438.210(e).

d. The Prepaid Dental Health Plan shall develop a process for authorization of any medically necessary service to enrollees under the age of twenty-one (21) years, in accordance with Section 1905(a) of the Social Security Act, when

(1) The service is not listed in the service-specific Florida Medicaid Coverage Policy or the associated Florida Medicaid fee schedule, or is not a covered dental-related service of the plan; or

(2) The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific Handbook or Coverage Policy, or the corresponding fee schedule.

e. Prepaid Dental Health Plans may utilize a national standardized set of criteria or other evidence-based guidelines approved by the Agency to approve services. Such criteria and guidelines shall not solely be used to deny, reduce, suspend, or terminate a good or service, but may be used as evidence of generally accepted medical practices that support the basis of a medical necessity determination.

2. Utilization Management Program Description

The UM program shall comply with 42 CFR Parts 438 and 456 (as applicable), reflected in a written Utilization Management Program Description, and include, but not be limited to:

a. Procedures for identifying patterns of over-utilization and under-utilization of services and for addressing potential problems identified as a result of these analyses;

b. Procedures for reporting fraud and abuse information identified through the UM program to the Agency's MPI as described in Section X., Administration and Management, and referenced in 42 CFR 455.1(a)(1);

c. Procedures for enrollees to obtain a second medical opinion at no expense to the enrollee and for the Prepaid Dental Health Plan to authorize claims for such services in accordance with 42 CFR 438.206(b)(3) and s. 641.51, F.S.; and

d. Protocols for prior authorization and denial of services;

e. The process used to evaluate initial and continuing authorization;

f. Objective evidence-based criteria to support authorization decisions;

g. Mechanisms to ensure consistent application of review criteria for authorization decisions, including consultation with the requesting provider when appropriate;

h. Practitioner profiling;

i. Retrospective review, meeting the predefined criteria below. The Prepaid Dental Health Plan shall be responsible for ensuring the consistent application of review criteria for authorization decisions and consulting with the requesting provider when appropriate. (42 CFR 438.210(b)(1)-(2)(i)-(ii))

j. Timely approval or denial of authorization of out-of-network use of non-emergency services through the assignment of a prior authorization number, which refers to and documents the approval. Written follow-up documentation of the approval must be provided to the non-participating provider within one (1) business day after the

approval; and

k. For enrollees with special health care needs determined through an assessment by appropriate qualified individuals (42 CFR 438.208(c)(2)) to need a course of treatment or regular care monitoring, a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

3. Service Authorization System

a. The Prepaid Dental Health Plan shall not require authorization for payment of primary and preventive dental care services furnished by a contracted provider. The Prepaid Dental Health Plan may require authorization for primary and preventive dental services in accordance with the Florida Medicaid Dental General Fee Schedule.

b. The Prepaid Dental Health Plan shall have automated authorization systems, as required in s. 409.967(2)(c)3., F.S. and may not require paper authorization in addition as a condition for providing treatment.

c. The Prepaid Dental Health Plan’s service authorization systems shall provide written notice of all denials, service limitations, and reductions of authorization to providers and enrollees. (42 CFR 438.210(c).)

d. The Prepaid Dental Health Plan’s service authorization systems shall provide the authorization number and effective dates for authorization to providers and non-participating providers.

e. The Prepaid Dental Health Plan shall not delay service authorization if written documentation is not available in a timely manner. However, the Prepaid Dental Health Plan is not required to approve claims for which it has received no written documentation.

f. The Prepaid Dental Health Plan shall comply with the following standards, measured on a monthly basis, for processing authorization requests in a timely manner:

(1) The Prepaid Dental Health Plan shall process ninety-five percent (95%) of all standard authorizations within fourteen (14) days.

(2) The Prepaid Dental Health Plan’s average turnaround time for standard authorization requests shall not exceed seven (7) days.

(3) The Prepaid Dental Health Plan shall process ninety-five percent (95%) of all expedited authorization requests within three (3) business days.

(4) The Prepaid Dental Health Plan’s average turnaround time for expedited authorization requests shall not exceed two (2) business days.

g. The Prepaid Dental Health Plan shall submit a monthly report of the authorization timeliness standards to the Agency as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide.

4. Practice Guidelines/Evidence-based Criteria

a. The Prepaid Dental Health Plan shall adopt practice guidelines that meet the following requirements (42 CFR 438.236(b)(1)):

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field; (42 CFR 438.263(b)(1))

(2) Consider the needs of the enrollees; (42 CFR 438.236(b)(2))

(3) Are adopted in consultation with providers; (42 CFR 438.236(b)(3)) and

(4) Are reviewed and updated periodically, as appropriate. (42 CFR 438.236(b)(4))

b. The Prepaid Dental Health Plan shall disseminate any revised practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees. (42 CFR 438.236(c))

c. The Prepaid Dental Health Plan shall ensure consistency with regard to all decisions relating to UM, enrollee education, covered services, and other areas to which the practice guidelines apply. (42 CFR 438.236(d))

d. If the Prepaid Dental Health Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Prepaid Dental Health Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C.

5. Clinical Decision-Making

The Prepaid Dental Health Plan shall ensure that all decisions to deny a service authorization request, or limit a service in amount, duration or scope that is less than requested, must be:

a. Made by a licensed physician, psychiatrist, or dentist, as appropriate, or other professional as approved by the Agency, who has the appropriate clinical expertise in treating the enrollee’s condition or disease (42 CFR 438.210(b)(3)); and

b. Determined using the acceptable standards of care, state and federal laws, the Agency’s medical necessity definition, and clinical judgment of a licensed physician, psychiatrist, or dentist, as appropriate, or other professional as approved by the Agency.

6. Service Authorization Standards for Decisions

a. The Prepaid Dental Health Plan shall notify the provider and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 CFR 438.210(c); 42 CFR 438.404)

b. The Prepaid Dental Health Plan shall comply with the following standards, measured on a monthly basis, for notifying providers and enrollees in a timely manner:

(1) The Prepaid Dental Health Plan shall provide standard authorization decisions within no more than seven (7) days following receipt of the request for service. (42 CFR 438.210(d)(1))

(2) The Prepaid Dental Health Plan may extend the timeframe for standard authorization decisions up to seven (7) additional days, if the enrollee or the provider requests extension, or the Prepaid Dental Health Plan justifies the need for additional information and how the extension is in the enrollee's interest.

(3) The Prepaid Dental Health Plan shall provide expedited authorization decisions no later than forty-eight (48) hours after receipt of the request for service. (42 CFR 438.210(d)(2))

(4) The Prepaid Dental Health Plan may extend the timeframe for expedited authorization decisions by up to two (2) additional business days if the enrollee or the provider requests an extension or if the Prepaid Dental Health Plan justifies the need for additional information and how the extension is in the enrollee's interest.

c. If the Prepaid Dental Health Plan extends the timeframe for a service authorization decision, in which case it shall:

(1) Notify the enrollee of the reason for extending the timeframe and advising of the right to file a grievance if the enrollee disagrees with the extension of time;

(2) Issue and carry out its determination as expeditiously as possible but no later than the date the extension expires; and

(3) Send notice of the extension to the enrollee within five (5) business days of determining the need for an extension.

7. Changes to Utilization Management Components

a. The Prepaid Dental Health Plan shall obtain written approval from the Agency for its service authorization protocols and any changes.

b. The Prepaid Dental Health Plan shall provide no less than sixty (60) days' written notice to the Agency before making any changes to the administration and/or management procedures and/or authorization, denial or review procedures, including any delegations, as described in this Section.

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Section VII. Grievance and Appeal System

A. General Provisions

1. The Prepaid Dental Health Plan shall establish and maintain a grievance and appeal system for reviewing and resolving enrollee complaints, grievances, and appeals. Components must include a complaint process, a grievance process, a plan appeal process, access to an applicable review outside of the Prepaid Dental Health Plan, and access to a Medicaid Fair Hearing. (s. 641.511, F.S.; 42 CFR 431, Subpart E; 42 CFR 438, Subpart F; and Rule 59G-1.100, F.A.C.)

2. The Prepaid Dental Health Plan shall ensure that all decisions on grievances and appeals are made by health care professionals in accordance with 42 CFR 438.406(b).

3. The Prepaid Dental Health Plan shall refer all enrollees who are dissatisfied with the Prepaid Dental Health Plan or its activities to the Prepaid Dental Health Plan's grievance and appeal system.

4. In accordance with Section V., Enrollee Services, the Prepaid Dental Health Plan shall assist the enrollee in completing forms and following the procedures for filing a grievance or plan appeal or requesting a Medicaid Fair Hearing.

5. Upon request, the Prepaid Dental Health Plan shall provide the enrollee and his or her authorized representative the enrollee record, including all medical records and any other documents and records considered or relied upon by the Prepaid Dental Health Plan regarding a plan appeal, Medicaid fair hearing, or SAP hearing, including the opportunity before and during the plan appeal or hearing process for the enrollee or an authorized representative to examine the record. The Prepaid Dental Health Plan shall provide such records free of charge, within seven (7) calendar days of request. (42 CFR 438.406(b)(5))

6. The Prepaid Dental Health Plan shall maintain a complete and accurate record of all complaints, grievances, and plan appeals. The Prepaid Dental Health Plan shall maintain and make complaint, grievance, and plan appeal records available upon request of the Agency and CMS. (42 CFR 438.416(c))

   a. The Prepaid Dental Health Plan shall address, log, track, and trend all complaints, regardless of the degree of seriousness or whether the enrollee or provider expressly requests filing the concern.

   b. The record of each grievance and appeal must contain, at a minimum, the information specified in 42 CFR 438.416(b)(1)-(6) and additional information as specified in the Statewide Medicaid Prepaid Dental Health Plan Report Guide.

7. The Prepaid Dental Health Plan shall report on complaints, grievances, and plan appeals to the Agency as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide, and in the manner and format determined by the Agency. (42 CFR 438.416(a))

B. Use of Independent Review Organization

1. The Prepaid Dental Health Plan may elect to have all of its unresolved grievances and plan appeals subject to external review processes by an independent review organization. (Section 641.185(1)(j), F.S.)

2. The Prepaid Dental Health Plan shall notify the Agency in writing if it elects to have all its plan appeals subject to such external review.

C. Process for Complaints

1. The Prepaid Dental Health Plan shall resolve complaints by close of business on the business day following receipt.

2. If a complaint is not resolved within one business day following receipt, the Prepaid Dental Health Plan shall enter the complaint as a grievance.

D. Process for Grievances

1. An enrollee may file a grievance with the Prepaid Dental Health Plan, orally or in writing at any time. (42 CFR 438.402(c)(2)(i); 42 CFR 438.402(c)(3)(i))

2. The Prepaid Dental Health Plan's process for handling enrollee grievances must include acknowledgement in writing within five (5) business days of receipt of each grievance. (42 CFR 438.406(b)(1); 42 CFR 438.406(a))

3. The Prepaid Dental Health Plan shall review the grievance and provide written notice of results to the enrollee, as expeditiously as the enrollee's health condition requires, no later than ninety (90) calendar days from the date the Prepaid Dental Health Plan receives the grievance. (42 CFR 438.408(a) and (b)(1))

4. The Prepaid Dental Health Plan shall extend the timeframe for a grievance resolution up to fourteen (14) calendar days if:

   a. The enrollee asks for an extension, or the Prepaid Dental Health Plan documents that additional information is needed and the delay is in the enrollee's interest.

   b. If the timeframe is extended other than at the enrollee's request, the Prepaid Dental Health Plan shall provide oral notice of the reason for the delay to the enrollee by close of business on the day of the determination, and written notice of the reason for the delay to the enrollee within two (2) calendar days of the determination. (42 CFR 438.408(c)(1)(i)-(ii); 438.408(b)(1))

   c. If notified by the Agency of an enrollee's request for a good cause plan change pursuant to Rule 59G-8.600, F.A.C., the Prepaid Dental Health Plan shall complete the grievance process within a timeframe prescribed by the Agency in accordance with 42 CFR 438.56(e). If the Prepaid Dental Health Plan fails to provide the Agency with the outcome of the grievance process within the Agency-prescribed timeframes, the enrollee's request for good cause plan change is considered approved.

   d. Title XXI MediKids enrollees are entitled to file an appeal with the SAP. Title XXI MediKids enrollees are not eligible to participate in the Medicaid Fair Hearing process.

E. Notice of Adverse Benefit Determination

1. The Prepaid Dental Health Plan shall give the enrollee written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The Prepaid Dental Health Plan shall provide the enrollee with a written notice of adverse benefit determination for any service authorization decisions, using the template provided by the Agency (42 CFR 438.10(c)(4)(ii); 42 CFR 438.404(b); 42 CFR 438.402(b)-(c)).

2. The Prepaid Dental Health Plan shall include an identifying number on each notice of adverse benefit determination in a manner prescribed by the Agency.

3. The Prepaid Dental Health Plan shall mail the notice of adverse benefit determination as follows:

   a. For termination, suspension or reduction of previously authorized Medicaid covered services no later than ten (10) days before the adverse benefit determination is to take effect. (42 CFR 438.404(c)(1); 42 CFR 431.211) Certain exceptions apply under 42 CFR 431.213 and 214;

   b. By the date of the action when any of the following occur:

      (1) The enrollee has died.

      (2) The enrollee submits a signed, dated, written statement requesting service termination that includes information that requires service termination or reduction and indicates that he or she understands that the service termination or reduction will result.

      (3) The enrollee has been admitted to an institution where he or she is ineligible under the Prepaid Dental Health Plan for further services.

      (4) The enrollee's whereabouts is determined unknown based on returned mail with no forwarding address.

      (5) The enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

      (6) The enrollee's dentist or specialty dental provider prescribes a change in the level of dental care.

      (7) The notice involves an adverse benefit determination with regard to PASSR under s. 1919(e)(7) of the Social Security Act.

      (8) The enrollee's nursing facility has made a determination to transfer or discharge the enrollee.

      (42 CFR 438.404(c)(1); 42 CFR 431.213; 42 CFR 431.231(d); s. 1919(e)(7) of the Social Security Act)

c. For denial of payment, at the time of any adverse benefit determination affecting the clean claim; (42 CFR 438.404(c)(2))

d. For service authorization decisions not reached within required timeframes, on the date the timeframes expire. Such failures constitute a denial and are, therefore, an adverse benefit determination.

F. Standard Resolution of Plan Appeals

1. The Prepaid Dental Health Plan shall adhere to the following timeframes for processing plan appeals:

a. An enrollee, authorized representative, or legal representative of the estate may file a plan appeal orally or in writing within sixty (60) calendar days from the date on the notice of adverse benefit determination. (42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii))

b. An enrollee, authorized representative, or legal representative of the estate may follow an oral appeal with a signed, dated, written appeal within ten (10) calendar days of the oral filing, unless the enrollee requests an expedited resolution. However, oral inquiries seeking to appeal an adverse benefit determination are treated as appeals and shall be confirmed in writing by the Prepaid Dental Health Plan unless the enrollee or his or her authorized representative requests expedited resolution. (42 CFR 438.402(c)(3)(ii); 42 CFR 438.406(b)(3))

(1) The date of oral filing shall constitute the date of receipt.

(2) The Prepaid Dental Health Plan shall acknowledge each plan appeal in writing within five (5) business days of receipt of each plan appeal unless the enrollee requests an expedited resolution. (42 CFR 438.406(b)(1); 42 CFR 438.406(a))

(3) The Prepaid Dental Health Plan shall ensure that enrollees who are disenrolled and wish to file an appeal have the opportunity to do so. All enrollees shall be afforded the right to file an appeal on disenrollment except for the following reasons:

(a) Moving out of the region;

(b) Loss of Medicaid eligibility;

(c) Determination that an enrollee is in an excluded population, as defined in this Contract; or

(d) Enrollee death.

c. The Prepaid Dental Health Plan shall continue and pay for the enrollee's benefits during the plan appeal if all of the following occur:

(1) The enrollee or the enrollee's authorized representative files the request for a plan appeal timely in accordance with 42 CFR 438.402(c)(2)(ii).

(2) The plan 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 period covered by the original authorization has not expired at the time the plan appeal was filed; and

(5) The enrollee timely files for continuation of benefits.

d. If, at the enrollee's request, the Prepaid Dental Health Plan continues or reinstates the benefits while the plan appeal is pending, the benefits must continue until one (1) of the following occurs:

(1) The enrollee withdraws the plan appeal; or

(2) The enrollee fails to request a fair hearing and continuation of benefits within ten (10) calendar days after the Prepaid Dental Health Plan sends the notice of plan appeal resolution that is not wholly in the enrollee's favor.

e. The Prepaid Dental Health Plan shall provide the enrollee a reasonable opportunity to present evidence and testimony and make allegations of fact or law in person as well as in writing. (42 CFR 438.406(b)(4))

f. If the final resolution of the plan appeal is adverse to the enrollee, the Prepaid Dental Health Plan may recover the cost of services furnished to the enrollee while the plan appeal was pending to the extent they were furnished solely because of the requirements for continuation of benefits.

g. For resolution, a plan appeal shall be heard and notice of plan appeal resolution shall be sent to the enrollee no later than thirty (30) calendar days from the date the Prepaid Dental Health Plan receives the plan appeal.

h. If the Prepaid Dental Health Plan fails to adhere to the notice and timing requirements for resolution of the plan appeal, the Prepaid Dental Health Plan shall give notice on the date that the timeframes expire. In such cases, the enrollee is deemed to have completed the Prepaid Dental Health Plan's appeals process, and the enrollee may initiate a Medicaid fair hearing. (42 CFR 438.408; 42 CFR 402(c)(1)(i)(A))

i. The Prepaid Dental Health Plan shall consider as parties to the plan appeal the enrollee or an authorized representative or, if the enrollee is deceased, the legal representative of the estate. (42 CFR 438.406(b)(6))

G. Extension of Plan Appeal

1. The timeframe for a plan appeal may be extended up to fourteen (14) calendar days if the enrollee asks for an extension, or the Prepaid Dental Health Plan documents that additional information is needed and the delay is in the enrollee's interest. (42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2))

2. If the timeframe is extended other than at the enrollee's request, the Prepaid Dental Health Plan shall provide oral notice of the reason for the delay to the enrollee by close of business on the day of the determination, and written notice of the reason for the delay to the enrollee within two (2) calendar days of the determination. (42 CFR 438.408(c)(2)(i)-(iii); 42 CFR 438.408(b)(2))

H. Expedited Resolution of Plan Appeals

1. The Prepaid Dental Health Plan shall have an expedited review process for plan appeals for use when taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain or regain maximum function. (42 CFR 438.410(a))

2. The Prepaid Dental Health Plan shall resolve each expedited plan appeal and provide notice to the enrollee, as quickly as the enrollee's health condition requires, within State established timeframes not to exceed seventy-two (72) hours after the Prepaid Dental Health Plan receives the plan appeal request, whether the plan appeal was made orally or in writing. (42 CFR 438.210(d)(2))

3. The Prepaid Dental Health Plan shall inform the enrollee of the limited time available to present evidence and allegations of fact or law, in the case of expedited plan appeal resolution, and ensure that the enrollee understands any time limits that may apply.

4. If the Prepaid Dental Health Plan denies the request for expedited plan appeal, it shall immediately transfer the plan appeal to the timeframes for standard resolution and so notify the enrollee. (42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2); 42 CFR 438.410(c))

5. If an enrollee asks for an extension, the Prepaid Dental Health Plan shall treat the request as a denial for expedited plan appeal, immediately transfer the plan appeal to the timeframe for standard resolution, and so notify the enrollee. Nothing in this Section relieves the plan of its obligation to resolve the enrollee's appeal as expeditiously as the enrollee's health condition requires, in accordance with 42 CFR 438.408(b)(2).

6. In the case of an expedited plan appeal denial, the Prepaid Dental Health Plan shall also provide oral notice to the enrollee by close of business on the day of resolution, and written notice to the enrollee within two (2) calendar days of the disposition.

I. Notice of Plan Appeal Resolution

1. The Prepaid Dental Health Plan shall provide the enrollee with a written notice using the notice of plan appeal resolution template provided by the Agency (42 CFR 438.10(c)(4)(ii)).

2. The Prepaid Dental Health Plan shall include on the notice a unique identifying number, corresponding to the number on the notice of adverse benefit determination that gave rise to the plan appeal.

J. Process for Medicaid Fair Hearings

1. The Prepaid Dental Health Plan shall comply with Rule 59G-1.100, F.A.C., and all terms and conditions set forth in any orders and instructions issued by the Office of Fair Hearing or a hearing officer.

2. An enrollee may request a Medicaid Fair Hearing after completing the Prepaid Dental Health Plan's appeal process. An enrollee has completed the plan appeal process after receiving a notice of plan appeal resolution indicating that the Prepaid Dental Health Plan is upholding, in whole or in part, the adverse benefit determination or after the Prepaid Dental Health Plan fails to adhere to the notice and timing requirements applicable to plan appeals. (42 CFR 438.402(c)(1); 42 CFR 438.408)

3. An enrollee, or his or her authorized representative, who has completed the Prepaid Dental Health Plan's appeal process may file for a Medicaid Fair Hearing in accordance with Rule 59G-1.100, F.A.C.

4. Parties to the Medicaid Fair Hearing include the Prepaid Dental Health Plan as well as the enrollee, or the enrollee's authorized representative.

5. The Prepaid Dental Health Plan shall attend fair hearings as scheduled. The Prepaid Dental Health Plan shall attend hearings with the necessary witnesses and evidentiary materials.

6. The Prepaid Dental Health Plan shall submit an evidence packet to the Agency and to the enrollee, free of charge, within ten (10) business days from the time the Prepaid Dental Health Plan receives notification of the hearing and must be submitted to the Agency in accordance with any prehearing instructions. The evidence packet must include all necessary documents including the statement of matters (or, alternatively, the denial letter) and any medical records or other documents/records considered or relied upon by the Prepaid Dental Health Plan, supporting the Prepaid Dental Health Plan's adverse benefit determination and plan appeal resolution.

7. Within two (2) business days of notification of the fair hearing request, the Prepaid Dental Health Plan shall provide the corresponding Notice of Adverse Benefit Determination and the Notice of Plan Appeal Resolution that relate to the fair hearing request to the Agency. (42 CFR 438.228(b))

8. The Prepaid Dental Health Plan shall designate an email address with the Agency for Health Care Administration Office of Fair Hearings for all fair hearing-related communications from the Office and any party to the fair hearing.

9. The Prepaid Dental Health Plan shall continue the enrollee's benefits while the fair hearing is pending if the enrollee timely files for continuation of benefits within ten (10) calendar days after the Prepaid Dental Health Plan sends the notice of plan appeal resolution that is not wholly in the enrollee's favor.

10. If, at the enrollee's request, the Prepaid Dental Health Plan continues or reinstates the benefits while fair hearing is pending, the benefits must continue until one (1) of the following occurs:

    a. The enrollee withdraws the fair hearing request;

b. The enrollee fails to request a fair hearing and continuation of benefits within ten (10) calendar days after the Prepaid Dental Health Plan sends the notice of plan appeal resolution that is not wholly in the enrollee's favor; or

c. The fair hearing office issues a hearing decision adverse to the enrollee.

11. If the Prepaid Dental Health Plan's action is sustained by the hearing decision, the Prepaid Dental Health Plan may recover the cost of services furnished to the enrollee while the plan appeal and fair hearing were pending, to the extent they were furnished solely because of the requirements for continuation of benefits.

12. If the Prepaid Dental Health Plan's action is reversed by the hearing decision and services were not furnished while the plan appeal was pending, the Prepaid Dental Health Plan shall authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours from the date the Prepaid Dental Health Plan receives the notice reversing the determination.

K. Appellate Responsibilities

1. Should an enrollee appeal a Medicaid Fair Hearing final order to the appropriate DCA, the Prepaid Dental Health Plan shall fully participate as a party in the appellate process and shall be responsible for defending both its actions and the Hearing Officer's final order, to the extent that position on appeal is consistent with the rules governing The Florida Bar and Florida law. The Agency may choose whether or not to participate in the appellate proceeding as a party and/or whether to participate in briefing.

2. The Prepaid Dental Health Plan shall file all appropriate document(s) with the DCA to participate in the appeal as a party and defend both its actions and the Hearing Officer's final order to the extent that position on appeal is consistent with the rules governing The Florida Bar and Florida law.

3. The Prepaid Dental Health Plan shall bear all costs associated with completing the record and transmitting it to the DCA, including transcribing the audio recording of the Medicaid Fair Hearing proceedings. The Prepaid Dental Health Plan shall ensure that a copy of the record is provided to all of the following:

   a. The enrollee, or enrollee's authorized representative;

   b. The enrollee's attorney, if applicable; and

   c. The Agency's Appellate Section.

4. The Prepaid Dental Health Plan shall contact the Agency's Appellate Section to coordinate the appeal within five (5) business days after receipt of notification that an appeal of a Medicaid Fair Hearing has been filed with the DCA.

5. The Prepaid Dental Health Plan shall provide the Agency's Appellate Section with a copy of its draft brief(s) for review no later than ten (10) business days in advance of the filing deadline(s) set by the DCA.

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Section VIII. Provider Services

A. Network Adequacy Standards

1. General Provisions

a. The Prepaid Dental Health Plan shall develop and maintain a provider network that meets the needs of enrollees in accordance with the requirements in Section VIII., Provider Services of this Contract. The Prepaid Dental Health Plan shall submit model provider agreement templates to the Agency for review as specified in Section VIII., Provider Services.

b. Pursuant to s. 42 CFR 438.68(b)(1)(i)-(viii), the Prepaid Dental Health Plan shall maintain a statewide network of providers in sufficient numbers to meet the network capacity and geographic access standards for each region for services with respect to the applicable PDHP program.

c. The Agency will be responsible for establishing standards and requirements for provider networks, reviewing Prepaid Dental Health Plan's provider networks and monitoring such Prepaid Dental Health Plans to ensure provider networks are capable of meeting the needs of their enrollees and are sufficient to serve the number of enrollees in the Prepaid Dental Health Plan in accordance with this Contract.

d. The Prepaid Dental Health Plan shall enter into provider agreements with a sufficient number of providers to provide all covered services to enrollees and ensure that each medically necessary covered service is accessible and provided to the enrollee with reasonable promptness (within the meaning of that term as set forth in 42 U.S.C. §1396a(a)(8)). (42 CFR 438.3(q)(1) and(3)) The Prepaid Dental Health Plan shall take any and all necessary action to ensure that all medically necessary covered services are provided to enrollees with reasonable promptness, including but not limited to the following:

   (1) Utilizing out-of-network providers (42 CFR 438.206(b)(4)); and

   (2) Using financial incentives to induce network or out-of-network providers to accept an enrollee as a patient/client and provide all medically necessary covered services with reasonable promptness.

e. The Prepaid Dental Health Plan shall develop and maintain a provider network as required by this Contract and in accordance with 42 CFR 438.68(c).

f. The Agency reserves the right to change Provider Qualifications and Minimum Network Adequacy Requirements.

g. The Prepaid Dental Health Plan shall perform ongoing monitoring activities, including Agency-prescribed secret shopper activities.

h. The Prepaid Dental Health Plan shall allow each enrollee to choose among participating providers in accordance with 42 CFR 431.51.

i. The Prepaid Dental Health Plan shall require non-participating providers to coordinate with respect to payment and must ensure that cost to the enrollee is no greater than it would be if the covered services were furnished within the network. (42 CFR 438.206(b)(5))

j. Prepaid Dental Health Plans must maintain sufficient Indian Health Care Providers (IHCPs) in the network to ensure timely access to services available under the Contract for Indian enrollees who are eligible to receive services from such providers, in accordance with the American Recovery and Reinvestment Act of 2009 and 42 CFR 438.14(b), and must permit out-of-network or out-of-state IHCPs to provide covered services and make referrals to network providers for Indian enrollees.

2. Network Capacity and Geographic Access Standards

a. The Prepaid Dental Health Plan shall have sufficient service locations and dental practitioners to provide the covered services as required by this Contract.

b. The Prepaid Dental Health Plan shall have the dental provider capacity to provide covered services to all enrollees, by region, as indicated in this Contract.

c. The Prepaid Dental Health Plan shall provide access in each region for urgent care to a dentist(s) that offers extended office hours (before 8:00 a.m., after 4:30 p.m., and/or on Saturdays).

d. Pursuant to 42 CFR 438.68(b)(1)(i)-(viii), Prepaid Dental Health Plans must maintain a region-wide network of dental providers in sufficient numbers to meet the access standards for specific dental services for all plan enrollees. At a minimum, Prepaid Dental Health Plans shall contract with the providers specified in the Prepaid Dental Health Plan Provider Network Standards Table (table) below. Prepaid Dental Health Plans shall ensure regional provider ratios and provider-specific geographic access standards for enrollees in urban or rural counties are met and maintained throughout the life of this Contract, as specified in the table. The regional provider ratios shall be based upon one hundred twenty percent (120%) of the Prepaid Dental Health Plan's actual monthly enrollment measured at the first of each month, by region.

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Prepaid Dental Health Plan Provider Network Standards Table					
	Urban County		Rural County		Regional Provider Ratios
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Enrollee*
Primary Dental Providers					
General Dentist	50	35	75	60	1:1,500
Specialists					
Pediatric Dentist	50	35	75	60	1:3,000
Endodontist	80	60	90	75	1:5,000
Orthodontist	100	75	110	90	1:38,500
Oral Surgeon	100	75	110	90	1:20,600

3. Primary Dental Providers

a. The Prepaid Dental Health Plan shall enter into provider contracts with a sufficient number of Primary Dental Providers (PDPs) providing dental services to ensure adequate accessibility for enrollees of all ages. The Prepaid Dental Health Plan shall ensure that PDPs provide services in accordance with this Contract and the Medicaid Dental Services Coverage Policies.

b. The Prepaid Dental Health Plan shall enter into provider contracts with at least one (1) dentist per 1,500 enrollees. The Prepaid Dental Health Plan may increase this dentist ratio by 500 enrollees for each licensed dental hygienist affiliated with a PDP providing dental services. However, this increase is limited to two (2) licensed dental hygienists per dentist.

4. Specialists and Other Providers

a. The Prepaid Dental Health Plan shall enter into provider agreements with at least one (1) pediatric dentist per 3,000 enrollees. The Prepaid Dental Health Plan shall enter into provider agreements with at least one (1) endodontics specialist per 5,000 enrollees. The Prepaid Dental Health Plan shall use participating dental practitioners with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (for example a dentist permitted to use pediatric conscious sedation).

b. The Prepaid Dental Health Plan shall ensure the availability of specialists, including periodontics and prosthodontics on at least a referral basis. The Prepaid Dental Health Plan shall determine when exceptional referrals to non-participating specialty-qualified providers are needed to address any unique dental needs of an enrollee. Financial arrangements for the provision of such services shall be agreed to prior to the provision of services. The Prepaid Dental Health Plan shall develop and maintain policies and procedures for such referrals.

c. The Prepaid Dental Health Plan shall enter into a sufficient number of provider agreements to ensure the availability providers offering conscious sedation, general/deep sedation, and pediatric conscious sedation, as medically necessary.

5. Public Health Providers

a. The Prepaid Dental Health Plan shall enter into provider agreements, as specified in this Sub-Section, with public health providers, including:

(1) CHDs qualified pursuant to rule 59G-4.055, F.A.C.; and

(2) FQHCs qualified pursuant to rule 59G-4.100, F.A.C.

b. The Prepaid Dental Health Plan shall pay without authorization at the rate negotiated between the Prepaid Dental Health Plan and the CHD or the Medicaid FFS rate for all authorized claims for dental services provided by the CHD. The Medicaid FFS rate is the standard Medicaid fee schedule rate or the CHD encounter rate as specified by the County Health Department Clinic Rule and the associated Florida Medicaid fee schedule for applicable rates.

c. The Prepaid Dental Health Plan shall not deny claims for services delivered by CHD providers solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred sixty-five (365) days.

d. The Prepaid Dental Health Plan shall not deny reimbursement for failure to prior authorize services rendered pursuant to s. 392.62 F.S.

e. The Prepaid Dental Health Plan shall reimburse FQHCs at rates comparable to those rates paid for similar services in the FQHC's community.

f. The Prepaid Dental Health Plan shall make a good faith effort to execute memoranda of agreement with private schools, charter schools, and school districts participating in the certified match program regarding the coordinated provision of school-based dental services pursuant to ss. 1011.70, 409.9071, F.S., 409.908(22), F.S., and 409.9072, F.S.

g. The Prepaid Dental Health Plan may reimburse health access settings for dental hygiene services provided in accordance with s. 409.906(6), F.S.

6. Demonstration of Network Adequacy

The Prepaid Dental Health Plan shall submit a provider network file of all participating providers to the Agency or its agent(s) on a weekly basis and at any time upon request of the Agency with sufficient evidence that the Prepaid Dental Health Plan has the capacity to provide covered services to all enrollees up to the maximum enrollment level, including evidence that the Prepaid Dental Health Plan, as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide. (42 CFR 438.207(b)(1))

a. Maintains a region-wide network of providers offering an appropriate range of services in sufficient numbers to meet the access standards established by the Agency; and

b. Maintains a sufficient number, mix and geographic distribution of providers, including providers who are accepting new Medicaid patients as specified in s. 1932(b)(5) of the Social Security Act, as enacted by s. 4704(a) of the Balanced Budget Act of 1997.

7. Timely Access Standards

a. The Prepaid Dental Health Plan shall contract with and maintain a provider network sufficient to comply with timely access standards as specified in this Contract.

b. In accordance with 42 CFR 438.206(c)(1), the Prepaid Dental Health Plan shall establish mechanisms to ensure network providers comply with timely access requirements, monitor regularly to determine compliance, and take corrective action if there is a failure to comply.

c. The Prepaid Dental Health Plan shall ensure that PDP services and referrals to participating specialists are available on a timely basis, as follows:

   (1) Urgent care services – within twenty-four (24) hours of a request for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization;

   (2) Routine Sick Patient Care – within seven (7) days;

   (3) Primary Dental Care – within thirty (30) days; and

   (4) Follow-up Dental Services – within thirty (30) days after assessment.

d. Quarterly, the Prepaid Dental Health Plan shall review a statistically valid sample of average appointment wait times to ensure services are in compliance with this subsection (a) above, and report the results to the Agency as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide. (42 CFR 438.206(c)(1)(iv),(v), and (vi))

8. Network Adequacy Measures

a. The Prepaid Dental Health Plan shall collect regional data on the following measures in order to evaluate its provider network and to ensure that covered services are reasonably accessible.

b. The Prepaid Dental Health Plan shall comply with the regional standards for each measure as specified in the Provider Network Adequacy Standards Table below.

c. The Prepaid Dental Health Plan shall submit the results of the network adequacy standards specified in the table below to the Agency quarterly as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide.

d. The Agency reserves the right to require Statewide Medicaid Prepaid Dental Health Plans to collect data and report results on additional network adequacy standards.

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Provider Network Adequacy Measures Table												
Measure		**Region**										
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
The Prepaid Dental Health Plan agrees that at least ___ percent of required participating PDPs (as required by the Prepaid Dental Health Plan Provider Network Standards Table), by region, are accepting new Medicaid enrollees.	Standard	90	85	90	85	85	90	85	90	85	85	85
The Prepaid Dental Health Plan agrees that at least ___ percent of required participating specialist providers, (as required by the Prepaid Dental Health Plan Provider Network Standards Table), by region, are accepting new Medicaid enrollees.		90	90	85	90	90	90	90	90	90	90	90
The Prepaid Dental Health Plan agrees that at least ___ percent of required participating PDPs (as required by the Prepaid Dental Health Plan Provider Network Standards Table), by region, offer after hours appointment availability to Medicaid enrollees.		30	40	35	40	35	35	40	30	40	40	40
The Prepaid Dental Health Plan agrees that no more than ___ percent of enrollee specialty care (dental specialists) utilization, by region, shall occur with non-participating providers, excluding continuity of care periods, as defined in Subsection IX.G., Continuity of Care in Enrollment.		8	10	10	10	8	8	8	8	10	10	8

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9. Waiver

a. If the Prepaid Dental Health Plan is unable to demonstrate network adequacy for either timely or geographic access standards, the Prepaid Dental Health Plan may submit a waiver request for review and approval by the Agency. The Prepaid Dental Health Plan shall augment its network as such providers become available in order to meet the network adequacy requirements.

b. The Prepaid Dental Health Plan may submit a waiver request in a manner and format approved by the Agency.

c. Nothing in this Section relieves the plan of its obligation to provide adequate and timely access to medically necessary services for its enrollees with reasonable promptness.

B. Network Management

1. General Provisions

The Prepaid Dental Health Plan shall develop and maintain procedures to evaluate the Prepaid Dental Health Plan's provider network to ensure that covered services are available and accessible, at a minimum, in accordance with the access standards in this Contract. (42 CFR 438.207(b); 42 CFR 438.206)

2. Annual Network Development Plan

a. The Prepaid Dental Health Plan shall develop and maintain an annual network development plan. The Prepaid Dental Health Plan shall submit this plan by September 1 of each Contract year to the Agency.

b. The Prepaid Dental Health Plan's annual network development plan shall include:

(1) The Prepaid Dental Health Plan's processes and methods to develop, maintain, and monitor an appropriate provider network that is sufficient to provide adequate access to all services covered under this Contract.

(2) A description of network design by region and county for each population served by the Prepaid Dental Health Plan.

(3) The Prepaid Dental Health Plan shall establish processes to monitor and reduce the appointment no-show rate for PDPs. As best practices are identified, the Agency may require implementation by the Prepaid Dental Health Plan. This information shall be provided to the PDHP during the readiness review process.

c. The Prepaid Dental Health Plan's annual network development plan shall include a description or explanation of the current status of the network by each covered service at all levels, including:

(1) Immediate short-term interventions to address network gaps, including the process for enrollees to access services;

(2) Long-term interventions to resolve network gaps and an evaluation of the effectiveness of those interventions to resolve network gaps and barriers;

(3) Methods for accessing a non-participating provider to address any potential gaps, including a description of the Prepaid Dental Health Plan's provider outreach strategy;

(4) The extent to which the Prepaid Dental Health Plan utilizes telemedicine services to resolve network gaps;

(5) Ongoing activities for network development, including network management functions delegated to subcontractors.

d. The Prepaid Dental Health Plan's annual network development plan shall include an organizational flowchart that outlines relationships between internal departments, including all committees and committee membership, by department/area, where this coordination occurs.

e. The Prepaid Dental Health Plan's annual network development plan shall include the results of "secret shopper" activities, including those prescribed by the Agency, and how those results are used to monitor and maintain the provider network.

f. The Prepaid Dental Health Plan's annual network development plan shall include a description of coordination with provider associations and other outside organizations.

g. The Prepaid Dental Health Plan's annual network development plan shall include a description of the overall monitoring strategy of subcontractors delegated for network management functions, including how those monitoring results are used to ensure continuous oversight across all provider network functions between the Prepaid Dental Health Plan and its subcontractors.

h. The Prepaid Dental Health Plan's annual network development plan shall include a description of the evaluation of the prior year's plan including an explanation of the method used to evaluate the network and reference to the success of proposed interventions and/or the need for re-evaluation.

i. The Prepaid Dental Health Plan's annual network development plan shall include a description or explanation of the current status of the network by each covered service at all levels, including:

(1) The assistance and communication tools provided to PDPs when they refer enrollees to specialists and the methods used to communicate the availability of this assistance to the providers;

(2) Providers having a sedation permit; and

(3) Specialty Providers.

3. Regional Network Changes

a. The Prepaid Dental Health Plan shall have procedures to address changes in the

Prepaid Dental Health Plan network that negatively affect the ability of enrollees to access services, including access to a culturally diverse provider network.

b. The Prepaid Dental Health Plan shall provide the Agency with documentation of compliance with access requirements at any time there has been a significant change in the Prepaid Dental Health Plan's regional network that would affect adequate capacity and services.

c. The Prepaid Dental Health Plan shall notify the Agency within seven (7) business days of any adverse changes to its regional provider network, as follows:

(1) Any change that would cause more than five percent (5%) of enrollees in the region to change the location where services are received or rendered; or

(2) As defined in the Exhibits.

d. In addition to the requirements of Attachment B., Section VIII.B., Network Management, the Prepaid Dental Health Plan shall notify the Agency within seven (7) business days of a decrease in the total number of PDPs by more than five percent (5%).

C. Provider Credentialing and Contracting

1. General Provisions

a. The Prepaid Dental Health Plan shall be responsible for the credentialing and recredentialing of its provider network.

b. If the Prepaid Dental Health Plan has delegated credentialing and/or recredentialing to a subcontractor, the agreement must ensure that all providers are credentialed in accordance with the Prepaid Dental Health Plan's and the Agency's credentialing requirements as found in Section VIII.C., Provider Credentialing and Contracting.

c. The Prepaid Dental Health Plan may be required to contract with a single credentialing vendor, managed by the Agency.

2. Credentialing and Recredentialing

a. The Prepaid Dental Health Plan shall ensure that all providers are eligible for participation in the Medicaid program, consistent with provider disclosure, screening, and enrollment requirements. (42 CFR 455.100-106; 42 CFR 455.400-470)

b. The Prepaid Dental Health Plan shall ensure all providers have a current provider agreement with Agency, as prescribed by the Agency.

c. The Prepaid Dental Health Plan shall require each provider to have a NPI in accordance with s. 1173(b) of the Social Security Act, as enacted by s. 4707(a) of the Balanced Budget Act of 1997. The provider agreement shall require providers to submit all NPI numbers to the Prepaid Dental Health Plan. The Prepaid Dental Health Plan shall file the providers' NPI numbers as part of its provider network file to the Agency or its agent, as set forth in Section XVI., Reporting Requirements, and the

Statewide Medicaid Prepaid Dental Health Plan Report Guide. The Prepaid Dental Health Plan need not obtain an NPI from an entity that does not meet the definition of "health care provider" found at 45 CFR 160.103.

d. The Prepaid Dental Health Plan shall deem providers with a valid Limited Enrolled or Fully Enrolled agreement with the Agency as having met all requirements described below:

(1) Proof of each provider's current license or authority to do business, including documentation of provider qualifications, as specified in the service-specific policy; if the provider is located in Georgia or Alabama, the provider's license and permit must be current and applicable to the respective state in which the provider is located;

(2) No revocation, moratorium, or suspension of the provider's license by the licensing authority in this or any state, if applicable;

(3) No sanctions imposed on the provider by Medicare or Medicaid, without proof of reinstatement or other documentation that all obligations under the sanction have been met;

(4) Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106); and

(5) A level II background check pursuant to s. 409.907, F.S.

e. In order to receive payment for covered services, non-participating providers must have a Medicaid provider identification number in the FMMIS.

f. The Prepaid Dental Health Plan may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to one hundred twenty (120) days but must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of the one hundred twenty (120)- day period without enrollment of the provider, and notify affected enrollees. [42 CFR 438.602(b)(2)]

g. The Prepaid Dental Health Plan is authorized to recoup any payments made under this Contract if the provider does not successfully complete the credentialing process within one hundred twenty (120) days and the delay is not caused by the Prepaid Dental Health Plan.

h. The Prepaid Dental Health Plan's credentialing and recredentialing procedures shall be in writing and include the following:

(1) Formal delegations and approvals of the credentialing process;

(2) A designated credentialing committee;

(3) Identification of providers who fall under its scope of authority;

(4) A process that provides for the verification of the credentialing and recredentialing criteria required under this Contract;

(5) Approval of new providers and imposition of sanctions, termination, suspension, and restrictions on existing providers;

(6) Identification of quality deficiencies that result in the Prepaid Dental Health Plan's restriction, suspension, termination, or sanctioning of a provider.

i. The Prepaid Dental Health Plan shall establish and verify additional provider credentialing and recredentialing.

j. If a provider is currently suspended or terminated from the Florida Medicaid program whether by contract or sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider. Suspension and termination are described further in Rule 59G-9.070, F.A.C.

k. The Prepaid Dental Health Plan shall submit provider disclosures and notifications to the federal DHHS OIG and to MPI in accordance with s. 1128, s. 1156, and s. 1892, of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1, as described in Section X.E.6., Reporting and Disclosure Requirements.

l. The Prepaid Dental Health Plan's credentialing and recredentialing processes must include verification of the following additional requirements for PDPs:

(1) Valid Drug Enforcement Administration certificates, where applicable.

(2) A good standing report on a site visit survey. For each provider, documentation in the Prepaid Dental Health Plan's credentialing files regarding the site survey shall include the following:

(a) Evidence that the Prepaid Dental Health Plan has evaluated the provider's facilities using the Prepaid Dental Health Plan's organizational standards;

(b) Evidence that the provider's office meets criteria for access for persons with disabilities and that adequate space, supplies, proper sanitation, smoke-free facilities, and proper fire and safety procedures are in place; and

(c) Evidence that the Prepaid Dental Health Plan has evaluated the provider's enrollee record keeping practices at each site to ensure conformity with the Prepaid Dental Health Plan's organizational standards.

(3) An attestation by the provider as to the correctness/completeness of the provider's application.

(4) Statement regarding any history of loss or limitation of privileges or disciplinary activity as described in s. 456.039, F.S.

(5) A statement from each provider applicant regarding the following:

(a) Any physical or behavioral health problems that may affect the provider's ability to provide health care; and

(b) Any history of chemical dependency/substance abuse.

(6) Current curriculum vitae or completed credentialing application, which includes at least five (5) years of work history.

(7) Proof of the provider's medical school graduation, completion of residency or other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency, and other postgraduate training, if applicable.

(8) Evidence of specialty board certification, if applicable.

m. The Prepaid Dental Health Plan shall recredential its providers at least every three (3) years using information from ongoing provider monitoring.

3. Minority Recruitment and Retention Plan

The Prepaid Dental Health Plan shall implement and maintain a minority recruitment and retention plan in accordance with s. 641.217, F.S. The Prepaid Dental Health Plan shall have procedures for the implementation and maintenance of such a plan. The minority recruitment and retention plan may be company-wide for all product lines.

4. Prohibition Against Discriminatory Practices

a. The Prepaid Dental Health Plan shall not discriminate with respect to participation, reimbursement, or indemnification as to any participating or nonparticipating provider who is acting within the scope of the provider’s license or certification under applicable State law. (42 CFR 438.12(a)(1))

b. The Prepaid Dental Health Plan shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments. (42 CFR 438.12(a)(2); 42 CFR 438.214(c))

c. The Prepaid Dental Health Plan shall not discriminate or take punitive action against a provider that requests an expedited resolution or supports an enrollee’s plan appeal.

5. **Provider Agreement Requirements**

a. The Prepaid Dental Health Plan shall submit all provider agreement templates for Agency review to determine compliance with Contract requirements. The Prepaid Dental Health Plan shall submit to the Agency, upon request, individual provider agreements as required by the Agency. If the Agency determines, at any time, that a provider agreement is not in compliance with a Contract requirement, the Prepaid Dental Health Plan shall promptly revise the provider agreement to bring it into compliance. In addition, the Prepaid Dental Health Plan may be subject to sanctions pursuant to Section XIII., Sanctions, and/or liquidated damages pursuant to Section XIV., Liquidated Damages.

b. The Prepaid Dental Health Plan shall ensure all provider agreements comply with Chapter 641.315, F.S., 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106.

c. All provider agreements and amendments executed by the Prepaid Dental Health Plan shall be in writing, signed, and dated by the Prepaid Dental Health Plan and the provider, and shall meet the following requirements:

(1) Not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient regarding:

(a) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

(b) Any information the enrollee needs to decide among all relevant treatment options.

(c) The risks, benefits, and consequences of treatment or non-treatment.

(d) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. (42 CFR 438.102(a)(1));

(2) Not prohibit a provider from advocating on behalf of the enrollee in any part of the grievance and appeal system or UM process, or individual authorization process to obtain necessary services; (42 CFR 438.402(c)(1)(i)-(ii); 42 CFR 438.408)

(3) Require providers to offer hours of operation that are no less than the hours of operation offered to commercial Prepaid Dental Health Plan members or comparable Medicaid FFS recipients if the provider serves only Medicaid recipients (42 CFR 438.206(c)(1));

(4) Require providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with special health care needs, including physical or intellectual and developmental disabilities (42 CFR 438.206(c)(3));

(5) Specify covered services, including applicable prior authorization requirements, acceptable billing codes, and populations to be served under the provider agreement;

(6) Require providers to meet timely access standards pursuant to this Contract;

(7) Require all direct service providers to complete abuse, neglect, and exploitation training, including training to identify victims of human trafficking;

(8) Include provisions for the provider to ensure immediate transfer to another

provider if the enrollee's health or safety is in jeopardy;

(9) Require providers of transitioning enrollees to cooperate in all respects with providers of other Prepaid Dental Health Plans to assure maximum health outcomes for enrollees;

(10) Provide for continuity of care for the course of treatment in the event a provider agreement terminates during the course of an enrollee's treatment;

(11) Require the provider to look solely to the Prepaid Dental Health Plan for compensation for services rendered, with the exception of cost sharing and patient responsibility (if applicable);

(12) Require the provider to participate with the Prepaid Dental Health Plan's peer review, grievance, QI and UM activities, as directed by the Prepaid Dental Health Plan;

(13) Include the monitoring and oversight activities the Plan shall follow, including monitoring of services rendered to enrollees, by the Prepaid Dental Health Plan;

(14) Identify the measures, metrics, and frequency of measurement that shall be used by the Prepaid Dental Health Plan to monitor the quality and performance of the provider;

(15) Require that any marketing materials related to this Contract that are displayed by the provider be submitted to the Agency for written approval before use;

(16) Require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to the Prepaid Dental Health Plan's enrollees;

(17) Require that records be maintained for a period not less than ten (10) years from the close of this Contract, and retained further if the records are under review or audit until the review or audit is complete. (42 CFR 438.3(u)) Prior approval for the disposition of records must be requested and approved by the Prepaid Dental Health Plan if the provider agreement is continuous;

(18) Require providers to cooperate fully with the Agency (or its designee), CMS, the OIG, the Comptroller General, and Attorney General's Office for the inspection, evaluation, and auditing of any records or documents (medical or financial) of the Prepaid Dental Health Plan or its subcontractors at any time, related to this Contract (42 CFR 438.3(h));

(19) Require providers to cooperate fully in any investigation by the Agency, MPI, MFCU or other State or federal entity and in any subsequent legal action that may result from such an investigation involving this Contract;

(20) Include the specific reports and clinical information required by the Prepaid Dental Health Plan for QI or other administrative purposes out of claims processing;

(21) Require providers to submit timely, complete, and accurate claims to the Prepaid Dental Health Plan in accordance with the requirements of Section X.D., Information Management and Systems, at a minimum;

(22) Require compliance with the background screening requirements of this Contract;

(23) Require compliance with HIPAA privacy and security provisions (42 CFR 438.224);

(24) Require providers to submit notice of withdrawal from the network at least ninety (90) days before the effective date of such withdrawal;

(25) Specify that any provider whose participation is terminated pursuant to the provider agreement for any reason shall utilize the applicable appeals procedures outlined in the provider agreement. No additional or separate right of appeal to the Agency or the Prepaid Dental Health Plan is created as a result of the Prepaid Dental Health Plan's act of terminating, or decision to terminate, any provider under this Contract.

(26) Require an exculpatory clause, which survives provider agreement termination, including breach of provider agreement due to insolvency, which assures that neither Medicaid enrollees nor the Agency will be held liable for any debts of the provider;

(27) Require that the provider secure and maintain during the life of the provider agreement workers' compensation insurance (complying with the Florida workers' compensation law) for all of its employees connected with the work under this Contract unless such employees are covered by the protection afforded by the Prepaid Dental Health Plan;

(28) Require all providers to notify the Prepaid Dental Health Plan in the event of a lapse in general liability or medical malpractice insurance, or if assets fall below the amount necessary for licensure under Florida Statutes;

(29) Contain a clause indemnifying, defending, and holding the Agency and the Prepaid Dental Health Plan's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the provider agreement. This clause must survive the termination of the provider agreement, including breach due to insolvency. The Agency may waive this requirement for itself, but not Prepaid Dental Health Plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the provider is a State agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers shall be approved in writing by the Agency;

(30) Specify the process for a network provider to report to the Prepaid Dental Health Plan when the network provider has received an overpayment, to return the overpayment to the Prepaid Dental Health Plan within sixty (60) days after the date on which the overpayment was identified, and to notify the Prepaid Dental

Health Plan in writing of the reason for the overpayment; (42 CFR 438.608(d)(2));

(31) Specify that any contracts or agreements entered into by the provider for purposes of carrying out any aspect of this Contract shall include assurances that the individuals who are signing this Contract or agreement are so authorized and that it includes all the requirements of this Contract; and

(32) If copayments are waived as an expanded benefit, the provider must not charge enrollees copayments for covered services; and if copayments are not waived as an expanded benefit, the amount paid to providers shall be the contracted amount, less any applicable copayments.

d. No provider agreement that the Prepaid Dental Health Plan enters into with respect to performance under this Contract shall in any way relieve the Prepaid Dental Health Plan of any responsibility for the provision of services or duties under this Contract. The Prepaid Dental Health Plan shall assure that all services and tasks related to the provider agreement are performed in accordance with the terms of this Contract. The Prepaid Dental Health Plan shall identify in its provider agreement any aspect of service that may be delegated by the provider.

e. The Prepaid Dental Health Plan may execute provider agreements pending the outcome of the provider enrollment process. The Prepaid Dental Health Plan shall terminate a network provider immediately upon notification from the Agency that the network provider cannot be enrolled, or upon expiration of the one hundred twenty (120) day period without enrollment of the provider, and notify affected enrollees in accordance with 42 CFR 438.602(b)(2).

f. The Prepaid Dental Health Plan shall include the following additional provisions in its Prepaid Dental Health Plan provider agreements:

(1) For a Prepaid Dental Health Plan dental provider incentive plan, include a statement that the Prepaid Dental Health Plan shall make no specific payment directly or indirectly under a dental provider incentive plan to a provider as an inducement to reduce or limit, medically necessary services to an enrollee, and that incentive plans shall not contain provisions that provide incentives, monetary or otherwise, for withholding medically necessary care;

(2) Require that all providers agreeing to participate in the network as PDPs fully accept and agree to responsibilities and duties associated with the PDP designation;

(3) If the provider has been approved by the Prepaid Dental Health Plan to provide services through telemedicine, specify that the provider be required to have protocols to prevent fraud and abuse. The provider must implement telemedicine fraud and abuse protocols that address:

(a) Authentication and authorization of users;

(b) Authentication of the origin of the information;

(c) The prevention of unauthorized access to the system or information;

(d) System security, including the integrity of information that is collected, program integrity and system integrity; and

(e) Maintenance of documentation about system and information usage; and

(4) For contracts with public health providers, require such providers to contact the Prepaid Dental Health Plan before providing dental care services to enrollees and provide the Prepaid Dental Health Plan with the results of the office visit, including test results.

6. Network Performance Management

a. The Prepaid Dental Health Plan shall monitor the quality and performance of each participating provider.

b. The Prepaid Dental Health Plan shall monitor participating providers on performance measures specified and collected by the Agency, as well as additional measures agreed upon by the provider and the Prepaid Dental Health Plan as documented in the provider agreement.

c. Except as otherwise provided in this Contract, the Prepaid Dental Health Plan may limit the providers in its network based on credentials, quality indicators, and price.

d. The Prepaid Dental Health Plan shall have procedures for imposing provider sanctions, restrictions, suspensions and/or terminations.

e. The Prepaid Dental Health Plan shall develop and implement an appeal procedure for providers against whom the Prepaid Dental Health Plan has imposed sanctions, restrictions, suspensions and/or terminations.

7. Provider Termination and Continuity of Care

a. The Prepaid Dental Health Plan shall comply with all State and federal laws regarding provider termination.

b. The Prepaid Dental Health Plan shall not pay, employ, or contract with individuals on the State or federal exclusions lists.

c. The Prepaid Dental Health Plan shall notify the provider and enrollees that received services from the provider within the past six months, at least sixty (60) days before the effective date of the suspension or termination of a provider from the network. If the termination was for "cause," the Prepaid Dental Health Plan shall provide to the Agency the reasons for termination.

d. If an enrollee is receiving care from any provider who becomes unavailable to continue to provide services, the Prepaid Dental Health Plan shall notify the enrollee in writing within ten (10) days from the date the Prepaid Dental Health Plan becomes aware of such unavailability. The requirements to provide notice prior to the effective dates of termination shall be waived in instances where a provider becomes physically unable

to care for enrollees due to illness, death, or leaving the enrollee's region of residence and fails to notify the Prepaid Dental Health Plan, or when a provider fails credentialing. Under these circumstances, notice shall be issued immediately upon the Prepaid Dental Health Plan's becoming aware of the circumstances.

e. The Prepaid Dental Health Plan shall provide immediate notice to the provider, the enrollee, and the Agency in a case in which an enrollee's health is subject to imminent danger or a provider's ability to practice medicine or otherwise provide services is effectively impaired by an action by the Board of Medicine or other governmental agency. The Prepaid Dental Health Plan shall develop and implement a plan for transitioning enrollees to another provider.

f. The Prepaid Dental Health Plan shall allow enrollees to continue receiving medically necessary services from a not-for-cause terminated provider and shall process provider claims for services rendered to such enrollees until the enrollees select another provider, for a minimum of sixty (60) days after the termination of the provider's Contract. Notwithstanding the provisions in this Section, a terminated provider may refuse to continue to provide care to an enrollee who is abusive or noncompliant.

g. For continuity of care under this Section, the Prepaid Dental Health Plan and the terminated provider shall continue to abide by the same terms and conditions as existed in the terminated Contract.

h. The Prepaid Dental Health Plan shall report provider terminations, suspensions, and denials, including documentation of enrollee notification and additions as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide.

i. The Prepaid Dental Health Plan shall notify enrollees in accordance with the provisions of this Contract and State and federal law regarding provider termination. (42 CFR 438.10(f)(1))

D. Provider Services

1. General Provisions

a. The Prepaid Dental Health Plan shall establish and maintain a formal provider relations function to respond timely and adequately to inquiries, questions, and concerns from participating providers.

b. The Prepaid Dental Health Plan shall provide sufficient information and procedural guidelines to all providers in order to operate in full compliance with this Contract and all applicable federal and State laws and regulations.

c. The Prepaid Dental Health Plan shall monitor provider compliance with Contract requirements and take Contract action when needed to ensure compliance.

2. Provider Handbook and Bulletin Requirements

a. The Prepaid Dental Health Plan shall issue a provider handbook to all providers at the time provider credentialing is complete.

b. The Prepaid Dental Health Plan may choose to distribute the provider handbook from the Prepaid Dental Health Plan's website. This notification shall detail how to obtain the handbook from the Prepaid Dental Health Plan's website and how the provider can request a hard copy from the Prepaid Dental Health Plan at no charge.

c. The Prepaid Dental Health Plan shall keep all provider handbooks and bulletins up to date and in compliance with State and federal laws. The provider handbook shall serve as a source of information regarding Prepaid Dental Health Plan covered services, procedures, statutes, regulations, telephone access, and special requirements, to ensure all Contract requirements are met.

d. The Prepaid Dental Health Plan's provider handbook shall include, at a minimum, the following information:

(1) Description of the Medicaid program and the PDHP program;

(2) Emergency service responsibilities;

(3) Provider responsibilities;

(4) Requirements regarding background screening;

(5) Requirements regarding the recredentialing process;

(6) Description of where to obtain service-specific coverage requirements and medical necessity criteria;

(7) Description of how to obtain prior authorization and referral procedures, including required forms;

(8) Information on the Prepaid Dental Health Plan's QE programs;

(9) Enrollee record standards for providers;

(10) Description of where to obtain claims submission protocols and standards, including instructions and all information required for a clean or complete claim;

(11) Protocols for submitting claims data;

(12) Requirements regarding marketing activities and marketing prohibitions;

(13) Procedures that address the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the Prepaid Dental Health Plan to file a provider complaint, including complaints about claims issues, and the complaint review process;

(14) Information on identifying and reporting abuse, neglect, and exploitation of enrollees, including information on identifying victims of human trafficking;

(15) Enrollee rights and responsibilities (42 CFR 438.100); and

(16) Required procedural steps in the Prepaid Dental Health Plan's enrollee grievance process, including the address, telephone number, and office hours of the grievance staff; the enrollee's right to request continuation of benefits while utilizing the grievance and appeal system in accordance with 42 CFR 438.414; and information about the SAP. The Prepaid Dental Health Plan shall specify telephone numbers to call to present a complaint, grievance, or appeal on behalf of an enrollee. Each telephone number shall be toll-free within the caller's geographic area and provide reasonable access to the Prepaid Dental Health Plan without undue delays.

(17) Procedures to obtain authorization of any medically necessary service to enrollees under the age of twenty-one (21) years when the service is not listed in the service-specific Florida Medicaid Coverage Policy or the associated Florida Medicaid fee schedule, or is not a covered service of the plan; or the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

(18) The Prepaid Dental Health Plan's responsibilities; and

(19) Whether the Prepaid Dental Health Plan allows the use of telemedicine, telemedicine requirements for providers.

e. The Prepaid Dental Health Plan shall disseminate bulletins as needed to incorporate any needed changes to the provider handbook.

3. Provider Education and Training

a. The Prepaid Dental Health Plan shall make available training to all providers and their staff regarding the requirements of this Contract, including any Contract amendments and special needs of enrollees.

b. The Prepaid Dental Health Plan shall conduct initial training within thirty (30) days of placing a newly contracted provider, or provider group, on active status. The Prepaid Dental Health Plan also shall conduct ongoing training, as deemed necessary by the Prepaid Dental Health Plan or the Agency, in order to ensure compliance with this Contract.

c. For a period of at least twelve (12) months following the implementation of this Contract, the Prepaid Dental Health Plan shall conduct monthly education and training for the top five (5) specific provider types identified by the Prepaid Dental Health Plan through its monitoring and QI processes, and claims submission and payment processes, which shall include, but not be limited to, an explanation of common claims submission errors and how to avoid those errors. Such a period may be extended as determined necessary by the Agency.

d. The Prepaid Dental Health Plan shall ensure all participating and direct service providers required to report abuse, neglect, or exploitation of vulnerable adults under s. 415.1034, F.S., obtain training on these subjects.

e. The Prepaid Dental Health Plan shall conduct outreach, education, and training with

PDPs and specialists on best practices for serving individuals with IDD.

4. Toll-Free Provider Help Line

a. The Prepaid Dental Health Plan shall operate a toll-free telephone help line to respond to provider questions, comments, and inquiries.

b. The Prepaid Dental Health Plan shall develop provider help line procedures that address personnel hiring and training, staffing ratios, hours of operation, response standards, monitoring of calls via recording or other means, and compliance with additional Prepaid Dental Health Plan standards.

c. The provider help line must be staffed twenty-four hours per day, seven days a week (24/7) to respond to prior authorization requests.

d. This provider help line shall have staff to respond to provider questions in all other areas, including but not limited to the provider complaint system and provider responsibilities, between the hours of 8 a.m. and 7 p.m. in the provider's time zone, Monday through Friday, excluding State holidays. The Prepaid Dental Health Plan shall ensure that, after regular business hours, the provider help line (not the prior authorization line) is answered by an automated system with the capability to provide callers with information about operating hours and instructions about how to verify enrollment for an enrollee with an emergency or urgent medical condition. This requirement shall not be construed to mean that the provider must obtain verification before providing emergency services and care.

e. The Prepaid Dental Health Plan's (or its subcontractor's) call center systems shall have the capability to track call management metrics and shall ensure that the following metrics comply with the corresponding performance metric, including:

(1) The average speed of answer shall not exceed thirty (30) seconds.

(2) The call blockage rate for direct calls to the Prepaid Dental Health Plan shall not exceed one-half of one percent (0.5%).

(3) The average call abandonment rate for direct calls to the Prepaid Dental Health Plan shall not exceed three percent (3%). A system, which places calls in queue, may be used but the average wait time in the queue shall not exceed sixty (60) seconds.

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5. Provider Complaint System

The Prepaid Dental Health Plan shall establish and maintain a provider complaint system that permits a provider to dispute the Prepaid Dental Health Plan's policies, procedures, or any aspect of a Prepaid Dental Health Plan's administrative functions, including proposed actions, claims/billing disputes, and service authorizations.

a. As a part of the provider complaint system, the Prepaid Dental Health Plan shall:

(1) Have dedicated staff for providers to contact via telephone, electronic mail, regular mail, or in person, to ask questions, file a provider complaint and resolve

problems;

(2) Identify staff specifically designated to receive and process provider complaints;

(3) Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider agreement provisions, collecting all pertinent facts from all parties and applying the Prepaid Dental Health Plan's written procedures; and

(4) Ensure that Prepaid Dental Health Plan executives with the authority to require corrective action are involved in the provider complaint process.

b. The Prepaid Dental Health Plan's process for provider complaints concerning claims issues shall be in accordance with s. 641.3155, F.S. The Prepaid Dental Health Plan shall comply with all terms and conditions set forth in any orders and instructions issued by the Agency as a result of the claim dispute resolution process.

c. For provider complaints concerning non-claims issues, the Prepaid Dental Health Plan shall:

(1) Allow providers forty-five (45) days from the date the issue occurred to file a written complaint for issues that are not about claims;

(2) Within three (3) business days of receipt of a complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution;

(3) Document why a complaint is unresolved after fifteen (15) days of receipt and provide written notice of the status to the provider every fifteen (15) days thereafter; and

(4) Resolve all complaints within ninety (90) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

d. For provider complaints concerning claims issues, the Prepaid Dental Health Plan shall:

(1) Allow providers ninety (90) days from the date of final determination of the primary payer to file a written complaint for claims issues;

(2) Within three (3) business days of receipt of a claim complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution;

(3) Notify the provider in writing within three (3) business days of the receipt of the complaint, and every fifteen (15) days thereafter.

(4) Provide written notice of the status of a complaint to the Agency within fifteen (15) days of receipt of an Agency-submitted claim complaint. If the Agency-submitted claim issue will require additional time to research, the Managed Care

Plan shall submit a written request to the Agency within three (3) business days of receipt of the complaint and shall include:

- An explanation for the need of an extension; and
- The expected time needed beyond the fifteen (15) days for research and response.

Approval of an extension is contingent upon Agency review.

(5) Resolve all claims complaints in accordance with s. 641.3155, F.S., within sixty (60) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

(6) Resolve all other claim-related complaints within ninety (90) days from the date of receipt and provide written notice of the disposition, including the basis of the resolution to the provider, within three (3) business days of resolution.

e. The Prepaid Dental Health Plan shall utilize with the Agency's contracted dispute resolution vendor, as described in s. 408.7057, F.S., for managing, addressing, and resolving provider complaints related to claims issues. The process shall comply with s. 641.3155, F.S.

f. The Prepaid Dental Health Plan shall also distribute the provider complaint system procedures, including claims issues, to non-participating providers upon request. The Prepaid Dental Health Plan may distribute a summary of these procedures, if the summary includes information about how the provider may access the full procedures on the Prepaid Dental Health Plan's website. This summary shall also detail how the provider can request a hard copy from the Prepaid Dental Health Plan at no charge.

g. The Prepaid Dental Health Plan shall maintain a complete and accurate record of all complaints and shall make such records available upon request of the Agency.

h. The Prepaid Dental Health Plan is prohibited from discriminating or taking punitive action against a provider for making a complaint to the Agency in good faith.

i. The Prepaid Dental Health Plan shall report provider complaints as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide.

E. Claims and Provider Payment

1. General Provisions

a. The Prepaid Dental Health Plan shall process claims and pay providers in compliance with the federal and State requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., whichever is more stringent.

b. The Prepaid Dental Health Plan shall have claims payment performance metrics, including those for quality, accuracy, and timeliness. The Prepaid Dental Health Plan

shall also include a process for measurement and monitoring, and for the development and implementation of interventions for improvement in regards to claims processing and claims payment. The Prepaid Dental Health Plan shall make documentation of such metrics available for Agency review upon request.

c. The Prepaid Dental Health Plan shall use electronic transmission of claims, transactions, notices, documents, forms, and payments to the greatest extent possible by the Prepaid Dental Health Plan.

d. The Prepaid Dental Health Plan shall provide an itemized accounting of the individual claims included in the payment to a provider, including the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement, and the identification of the Prepaid Dental Health Plan.

e. The Prepaid Dental Health Plan shall pay Medicare co-insurance and deductibles for covered services in accordance with Rule 59G-1.052, F.A.C.

f. The Prepaid Dental Health Plan shall not deny Medicare crossover claims solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three (3) years.

g. The Prepaid Dental Health Plan shall not pay for the following:

(1) Items or services furnished by an individual or entity during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend payments; (42 CFR 438.608(a)(8); 42 CFR 455.23);

(2) Any expenditures related to items or services for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (Section 1903(i) of the Social Security Act) and

(3) Items or services furnished by a provider during a period where the Agency has determined there is reliable evidence of circumstances giving rise to the need for a withholding of payments, which involves, fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients. (s. 409.913(25)(a), F.S.)

h. The Prepaid Dental Health Plan shall incorporate into its claim processing and claims payment system the NCCI editing programs for the HCPCS/CPT codes to promote correct coding and control coding errors, except for allowable NCCI edits exclusions in accordance with the claims processing requirements of 42 CFR 433.116 and 45 CFR 95, subpart F.

i. The Prepaid Dental Health Plan shall submit an aging claims summary as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide, and in the manner and format determined by the Agency.

j. The Agency will ensure that no payment is made to a provider other than by the Prepaid Dental Health Plan for services available under this Contract, except when these payments are specifically provided for in Title XIX of the Social Security Act, in

42 CFR Chapter IV, or when the Agency has adjusted the capitation rates paid under this Contract to make payments for graduate medical education. (42 CFR 438.60)

k. In the event the Agency establishes systems and processes to collect submitted claims data, including denied claims, from the providers directly, the Prepaid Dental Health Plan shall be capable of sending and receiving any claims information directly to the Agency in standards and timeframes specified by the Agency within sixty (60) days' notice. The Prepaid Dental Health Plan shall also work cooperatively with the Agency during any transition period for network providers to move to submitting claims through the State instead of directly to the Prepaid Dental Health Plan.

l. The Prepaid Dental Health Plan shall not deny claims for the provision of emergency services and care submitted by a non-participating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred sixty-five (365) days.

m. Notwithstanding the requirements set forth for coverage of emergency services and care, the Prepaid Dental Health Plan shall approve all claims for emergency services and care by non-participating providers pursuant to the requirements set forth in s. 641.3155, F.S., and 42 CFR 438.114.

n. The Prepaid Dental Health Plan shall reimburse IHCPs, whether participating in the network or not, for covered managed care services provided to Indian enrollees who are eligible to receive services from the IHCP either at a negotiated rate between the Prepaid Dental Health Plan and the IHCP or, if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made to a participating provider which is not an IHCP, in accordance with the American Recovery and Reinvestment Act of 2009 and 42 CFR 438.14(b).

2. Timely Claims Payment

For claims for services:

a. For all electronically submitted claims for services, the Prepaid Dental Health Plan shall:

(1) Within twenty-four (24) hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim.

(2) Within fifteen (15) days after receipt of a non-nursing facility/non-hospice claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of denial reasons or codes and additional information or documents necessary to process the claim.

(3) Pay or deny the claim within ninety (90) days after receipt of the non-nursing-facility/non-hospice claim. Failure to pay or deny the claim within one hundred twenty (120) days after receipt of the claim creates an uncontestable obligation for the Prepaid Dental Health Plan to pay the claim. (s. 641.3155(3)(e), F.S.)

b. For all non-electronically submitted claims for services, the Prepaid Dental Health Plan shall:

(1) Within fifteen (15) days after receipt of the claim, provide acknowledgment of receipt of the claim to the provider or designee or provide the provider or designee with electronic access to the status of a submitted claim.

(2) Within twenty (20) days after receipt of the claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.

(3) Pay or deny the claim within one hundred twenty (120) days after receipt of the claim. Failure to pay or deny the claim within one hundred forty (140) days after receipt of the claim creates an uncontestable obligation for the Prepaid Dental Health Plan to pay the claim.

c. The Prepaid Dental Health Plan shall comply with the following standards regarding timely claims processing for all providers:

(1) The Prepaid Dental Health Plan shall pay fifty percent (50%) of all clean claims submitted within seven (7) days.

(2) The Prepaid Dental Health Plan shall pay seventy percent (70%) of all clean claims submitted within ten (10) days.

(3) The Prepaid Dental Health Plan shall pay ninety percent (90%) of all clean claims submitted within twenty (20) days.

d. The Prepaid Dental Health Plan shall reimburse providers for the delivery of authorized services as described in s. 641.3155, F.S., including but not limited to:

(1) The provider must mail or electronically transfer (submit) the claim to the Prepaid Dental Health Plan within six (6) months after:

(a) The date of service or discharge from an inpatient setting; or

(b) The date that the non-participating provider was furnished with the correct name and address of the Prepaid Dental Health Plan, if applicable.

(2) When the Prepaid Dental Health Plan is the secondary payer and the primary payer is an entity other than Medicare, the Prepaid Dental Health Plan shall require the provider to submit the claim to the Prepaid Dental Health Plan within ninety (90) days after the final determination of the primary payer, in accordance with the Medicaid Provider General Handbook. When the Prepaid Dental Health Plan is the secondary payer and the primary payer is Medicare, the Prepaid Dental Health Plan shall require the provider to submit the claim to the Prepaid Dental Health Plan in accordance with timelines established in the Medicaid Provider General Handbook.

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Section IX. Quality

A. Quality Improvement

1. General Provisions

a. The Prepaid Dental Health Plan shall have a QI program that ensures enhancement of quality of care and emphasizes improving the quality of patient outcomes, including establishing metrics for monitoring the quality and performance of each participating provider. The Prepaid Dental Health Plan shall evaluate the provider's performance and determine continued participation in the network as specified in Section IX., Quality.

b. The Agency will be responsible for establishing standards and requirements for QI, including performance measures, targets, improvement plans, satisfaction surveys and enrollee record reviews, and providing instructions to Dental Plans through the Statewide Medicaid Prepaid Dental Health Plan Report Guide referenced in Section XVI., Reporting Requirements and Performance Measures Specifications Manual. The Agency may change these targets and/or change the timelines associated with meeting the targets. The Agency will make these changes with sixty (60) days' advance notice to the Prepaid Dental Health Plan.

c. The Agency will be responsible for contracting with an EQRO and conducting other QI activities, including but not limited to audits of: enrollee records, enrollee plans of care, provider credentialing records, service provider reimbursement records, contractor personnel records, and other documents and files as required under this Contract and its Exhibits.

d. The Agency will be responsible for establishing incentives to high-performing Prepaid Dental Health Plan and take appropriate action in accordance with the terms of this Contract if the Dental Plans do not meet acceptable QI and performance indicators. (42 CFR 438.6(b))

e. The Prepaid Dental Health Plan shall identify and track adverse incidents and shall review and analyze adverse incidents to identify and address/eliminate potential and actual quality of care and/or health and safety issues. The Prepaid Dental Health Plan shall make such tracking available to the Agency upon request.

f. The Prepaid Dental Health Plan and its QI plan shall demonstrate specific interventions in its care coordination/case management to better manage and promote positive enrollee outcomes for enrollees with complex needs, in long-term care settings, with disabilities, and/or those needing specialized services (e.g. conscious sedation). The dental plan's written procedures shall address components of effective coordination/case management including but not limited to: anticipation, identification, monitoring, measurement, evaluation of needs, and effective action to promote quality of care; and the provision of enhanced care coordination and management for high-risk populations.

g. The Prepaid Dental Health Plan and its QI plan shall demonstrate a health outcome improvement strategy to include coordination of care between the dental plan and the

Statewide Medicaid Managed Care plans to ensure positive performance on dental quality performance scores (HEDIS, Child Core Set , and CMS-416). This Plan shall also reflect a focus on reducing utilization of preventable emergency department services for the treatment of dental conditions.

2. Oral Health Promotion and Disease Prevention

The Prepaid Dental Health Plan shall demonstrate a plan:

a. To assess enrollee health risks and social determinants to conduct health promotion and disease prevention outreach which must include targeted interventions to address populations that lack proficiency in the English language.

b. To pursue engagement of enrollees through broad and targeted outreach to positively impact oral health education and awareness of benefits and services. This shall include innovative communication methods and technologically advanced resources, including, but not limited to the use of social media, texting and smartphone application platforms.

c. To track missed and cancelled appointments in order to target outreach to members with repeated occurrences.

d. To monitor network use and assist members in finding dental providers

e. To facilitate collaborative outreach with community-based organizations.

f. To ensure enrollees have access to evidenced-based/best practice educational programs with a specific focus on improving rates of preventive dental utilization and providing early disease intervention.

3. Individuals with Special Health Care Needs

Pursuant to 42 CFR Section 438.208(c) the Prepaid Dental Health Plan shall implement mechanisms for identifying, assessing, and ensuring the existence of a treatment plan for individuals with special health care needs.

a. Mechanisms to comprehensively assess each Medicaid enrollee identified by the State as having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.

b. A treatment or service plan for enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan shall be:

   (1) In accordance with any applicable State quality assurance and utilization review standards; and

   (2) Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee per §441.301(c)(3) of this chapter

c. Pursuant to 42 CFR Section 438.208(c)(4), for enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with 42 CFR Section 438.208(c)(2)) to need a course of treatment or regular care monitoring, each PDHP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

4. Accreditation

a. The Prepaid Dental Health Plan shall be accredited by a nationally recognized accrediting body, or have initiated the accreditation process within one (1) year after this Contract was executed.

(1) If the Prepaid Dental Health Plan is not accredited or has not initiated the accreditation process within one (1) year, all enrollee auto-assignments to the Prepaid Dental Health Plan shall be suspended until the Prepaid Dental Health Plan is accredited by a nationally recognized body. (42 CFR 438.332(a))

(2) If the Prepaid Dental Health Plan is not accredited within eighteen (18) months after executing this Contract, the Agency may terminate this Contract for the Prepaid Dental Health Plan's failure to comply with this Contract.

b. In accordance with 42 CFR 438.332, the Prepaid Dental Health Plan shall authorize its accrediting body to provide the Agency a copy of its most recent accreditation review, including: its accreditation status, survey type, and level (as applicable); recommended actions or improvements, CAPs, and summaries of findings; and the expiration date of accreditation.

5. Quality Improvement Program

a. The Prepaid Dental Health Plan shall have an ongoing QI program that objectively and systematically monitors, evaluates, and improves the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to enrollees, thereby promoting quality of care and quality patient outcomes in service performance to its enrollees. (42 CFR 438.330(a)(1) and (3); 42 CFR 438.330(b)(4); 42 CFR 438.340)

b. The Prepaid Dental Health Plan's governing body shall oversee and evaluate the impact and effectiveness of its QI program. (42 CFR 438.330(e)(2); 42 CFR 438.310(c)(2)) The role of the Prepaid Dental Health Plan's governing body shall include providing strategic direction to the QI program, as well as ensuring the QI plan is incorporated into processes throughout the Prepaid Dental Health Plan.

c. The Prepaid Dental Health Plan shall cooperate with the Agency and the EQRO. The Prepaid Dental Health Plan shall use the methodology and standards for QI set by the Agency.

6. Quality Improvement Program Committee

a. The Prepaid Dental Health Plan shall have a QI program committee, which includes:

(1) The Dental Director, as chair or co-chair;

(2) Provider representation (either through providers serving on the committee or through a provider liaison position, such as a representative from the network management department); and

(3) Other committee representatives shall be selected to meet the needs of the Prepaid Dental Health Plan.

b. Individual staff members may serve in multiple roles on the committee if they also serve in multiple positions within the Prepaid Dental Health Plan.

c. At a minimum, the committee must meet quarterly. The Prepaid Dental Health Plan shall maintain minutes of all QI program committee and sub-committee meetings and make the minutes available for Agency review on request.

d. The Prepaid Dental Health Plan's QI program committee shall be responsible for development and implementation of a written QI plan, which incorporates the strategic direction provided by the Prepaid Dental Health Plan's governing body.

7. Quality Improvement Plan

a. The Prepaid Dental Health Plan shall develop and maintain a written QI plan and submit its QI plan to the Agency initially prior to implementation and annually by November 1.

b. The QI plan shall include a description of:

(1) The Prepaid Dental Health Plan positions assigned to the QI program committee, including a description of why each position was chosen to serve on the committee and the roles each position is expected to fulfill. The resumes of QI program committee members shall be made available upon the Agency's request;

(2) The QI program committee structure, including development of subcommittees and task forces, and the committee's role in monitoring and evaluating of quality and appropriateness of care provided to enrollees;

(3) The mechanism within the Prepaid Dental Health Plan for the governing body to provide strategic direction for the QI program and for the QI program committee to communicate with the governing body;

(4) Specific training about quality that shall be provided by the Prepaid Dental Health Plan to staff serving in the QI program committee. At a minimum, the training shall include protocols developed by CMS regarding quality. CMS protocols may be obtained from:

https://www.medicaid.gov/medicaid/quality-of-care/index.html.

(5) The Prepaid Dental Health Plan's guiding philosophy for quality management,

including any nationally recognized, standardized approach that is used (e.g., PDCA, Rapid Cycle Improvement, FOCUS-PDCA, Six Sigma). Selection of performance indicators and sources for benchmarking also shall be included in addressing the following specific components of the QI plan:

(a) Methods for assessment of the quality and appropriateness of care provided to enrollees with timely resolution of problems and new or continued improvement activities, including but not limited to:

(i) Service availability and accessibility;

(ii) Quality of services in accordance with acceptable professional practice standards;

(iii) Network quality;

(iv) Care planning and care coordination;

(v) Enrollee safety;

(vi) Utilization review processes;

(vii) Grievance and appeals; and

(viii) Adverse/critical incident reporting

(b) The process to direct and analyze periodic review of enrollee service utilization patterns (including detection of underutilization and overutilization of services); (42 CFR 438.330(b)(3))

(c) Monitoring and evaluation of provider network quality, including but not limited to:

(i) Credentialing and recredentialing processes;

(ii) Provider performance measurement;

(iii) Metrics for monitoring the quality and performance of participating providers related to their continued participation in the network.

(6) The process for selecting evaluation and study design procedures; and

(7) A standard describing the process the QI program shall use to review and suggest new and/or improved QI activities.

(8) The Prepaid Dental Health Plan's QI plan shall describe the process for annual QI activities evaluation, the evaluation results of the prior year's QI activities, and any subsequent revisions to the QI plan.

c. The Prepaid Dental Health Plan shall submit its updated QI plan, including the findings from its annual QI program evaluation, to the Agency by November 1 of each Contract

year.

6. EQRO Coordination Requirements

The Prepaid Dental Health Plan shall cooperate with and provide all information requested by the EQRO. (42 CFR 438.350)

B. Performance Measures

1. General Provisions

a. The Prepaid Dental Health Plan shall meet Agency-specified performance targets for all PMs as specified in this Contract and the applicable Exhibit(s).

b. The Agency may add or remove PM requirements, including performance targets and timelines associated with meeting the targets, with sixty (60) days' advance notice.

2. Required Performance Measures

a. The Prepaid Dental Health Plan shall collect statewide data on enrollee PMs, as defined by the Agency and as specified in the Performance Measure Table below, the Statewide Medicaid Prepaid Dental Health Plan Report Guide and Performance Measures Specifications Manual.

b. The Prepaid Dental Health Plan shall report results of PMs to the Agency as specified in Section XVI., Reporting Requirements, the Statewide Medicaid Prepaid Dental Health Plan Report Guide, and Performance Measures Specifications Manual.

c. The Prepaid Dental Health Plan shall collect and report the following performance measures, certified via a National Committee for Quality Assurance (NCQA) certified HEDIS auditor.

Healthcare Effectiveness Data and Information Set (HEDIS)	
1.	Annual Dental Visits - (ADV)
Child Core Set	
2.	Preventive Dental Services
3.	Sealants for 6-9 Year-Old Children at Elevated Caries Risk (National Quality Forum #2508)
Dental Quality Alliance	
4.	Oral Evaluation (National Quality Forum #2517)
5.	Topical Fluoride for Children at Elevated Caries Risk (National Quality Forum #2528)
6.	Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children (National Quality Forum #2689)
7.	Follow-up after Emergency Department Visits for Dental Caries in Children (National Quality Forum #2695)

Agency-Defined – based on CMS-416	
8.	Dental Treatment Services
Agency-Defined (based on Dental Quality Alliance specifications for children's measure)	
9.	Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Adults (ages 21 years and up)

d. The Prepaid Dental Health Plan shall submit the first Performance Measure Report to the Agency no later than July 1, 2020, covering the measurement period of calendar year 2019. Measures should be collected based on the technical specifications for the measure.

e. For the Annual Dental Visit performance measure, the Prepaid Dental Health Plan shall achieve or exceed the following rates by year:

- CY 2019: 48%
- CY 2020: 49%
- CY 2021: 50%
- CY 2022: 51%
- CY 2023: 52%

Failure to meet these rates may result in a corrective action plan as described in Attachment II, Section VII.B.4.b. in addition to the liquidated damages and sanctions provided in this Exhibit.

f. The Agency will calculate each Prepaid Dental Health Plan's Preventive Dental Services (PDENT) and Dental Treatment Services (TDENT) measures using encounter data and/or data that the plans report on their CMS-416 reports. Prepaid Dental Health Plans do not need to calculate and report on these measures as part of their annual performance measure submission.

3. **Well-Child Visit Performance Measures**

a. The Prepaid Dental Health Plan shall achieve a preventive dental services rate corresponding to the following schedule for those enrollees who are continuously eligible for EPSDT for ninety (90) continuous days. This rate shall be based on the dental visit data reported by the Prepaid Dental Health Plan in its CMS-416 audited report and/or supporting encounter data and shall be calculated by dividing line 12b by line 1b from the CMS-416 report, excluding children under the age of one (1). Beginning with the report for federal fiscal year 2018-19, failure to meet or exceed the following preventive dental services rates may result in a corrective action plan in addition to the liquidated damages and sanctions provided in this Exhibit.

- FFY 2018-19: 41%
- FFY 2019-20: 44%
- FFY 2020-21: 46%
- FFY 2021-22: 48%
- FFY 2022-23: 50%

b. The Prepaid Dental Health Plan shall achieve a dental treatment services rate corresponding to the following schedule for those enrollees who are continuously eligible for EPSDT for ninety (90) continuous days. This rate shall be based on the dental visit data reported by the Prepaid Dental Health Plan in its CMS-416 audited report and/or supporting encounter data and shall be calculated by dividing line 12c by line 1b from the CMS-416 report, excluding children under the age of one (1). Beginning with the report for federal fiscal year 2018-19, failure to meet or exceed the following dental treatment services rates may result in a corrective action plan in addition to the liquidated damages and sanctions provided in this Exhibit.

- FFY 2018-19: 21%
- FFY 2019-20: 23%
- FFY 2020-21: 24%
- FFY 2021-22: 24%
- FFY 2022-23: 24%

4. **Annual Report of Performance**

a. By July 1 of each Contract year, the Prepaid Dental Health Plan shall deliver to the Agency a report on performance measure data and a certification by a NCQA certified HEDIS auditor that the performance measure data reported for the previous year are fairly and accurately presented. The HEDIS auditor shall certify the report, and the auditor must certify the actual file submitted to the Agency.

b. The Prepaid Dental Health Plan shall submit performance measure data as specified by the Agency and in a manner and format prescribed by the Agency.

c. The Agency may grant extensions to the due date for up to thirty (30) days and require a signed, dated, written request by the Prepaid Dental Health Plan CEO or designee. The Agency must receive the request before the report due date and the delay must be due to unforeseen and unforeseeable factors beyond the Prepaid Dental Health Plan's control. Extensions shall not be granted on oral requests.

d. The Prepaid Dental Health Plan shall use a software vendor who has achieved full HEDIS Measure Certification Status from NCQA for the current reporting year to calculate its PM rates each year.

e. The Agency will consider deficient a report that contains a "not reportable" (NR) designation due to bias for any or all measures by the HEDIS auditor or that contains a "false" designation.

5. **Publication of Performance Measures**

The Prepaid Dental Health Plan shall publish its results for HEDIS and other measures on the Prepaid Dental Health Plan's website in a manner that allows recipients to compare reliably the performance of Prepaid Dental Health Plans. The Prepaid Dental Health Plans may meet this requirement by including information about the comparison of performance measures conducted by the Agency and providing a link to the Agency's applicable website page.

C. Performance Improvement Projects

1. General Provisions

a. The Prepaid Dental Health Plan shall develop, implement, and monitor PIPs. The Prepaid Dental Health Plan shall achieve significant improvement to the quality of care and service delivery, through ongoing measurement of performance using objective quality indicators and ongoing interventions, sustained over time.

b. By January 1 of each Contract year, the Agency will determine and notify the Prepaid Dental Health Plan if there are changes in the number and types of PIPs the Prepaid Dental Health Plan shall perform for the coming Contract year.

c. The Prepaid Dental Health Plan's PIP methodology must comply with the most recent protocol set forth by CMS, Implementation of PIPs. CMS protocols may be obtained at:

http://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

(1) The Prepaid Dental Health Plan shall include a statistically valid sample size for each PIP.

(2) Populations selected for study under the PIP shall be specific to this Contract and shall not include Medicaid recipients from other states, or enrollees from other lines of business.

(3) If the Prepaid Dental Health Plan contracts with a separate entity for management of particular services, PIPs conducted by the separate entity shall not include enrollees for other Prepaid Dental Health Plans served by that entity.

d. Improvement must be measured through comparison of a baseline measurement and an initial re-measurement following application of an intervention. Change must be statistically significant at the ninety-five percent (95%) confidence level and must be sustained for two (2) additional re-measurement periods.

e. The Agency will consider PIPs that have successfully achieved sustained improvement, as approved by the Agency, to be complete, and such PIPs shall not meet the requirement for one (1) of the number of PIPs required by the Agency, although the Prepaid Dental Health Plan may wish to continue to monitor the performance target as part of its overall QI program. In this event, the Prepaid Dental Health Plan shall select a new PIP and submit it to the Agency for approval. (42 CFR 438.330(d)(2); 42 CFR 438.330(d)(2)(iv))

2. Performance Improvement Projects

The Prepaid Dental Health Plan shall perform two (2) Agency-approved statewide performance improvement projects (PIPs) as specified below:

a. One (1) of the PIPs shall focus on increasing the rate of enrollees accessing preventive dental services; and

b. One (1) of the PIPs shall be an administrative PIP focusing on a topic prior approved by the Agency.

c. One or more of the PIPs may be a collaborative PIP coordinated by the Agency and the EQRO. The EQRO will put together proposed methodologies for the collaborative PIPs, which will be sent to the Prepaid Dental Health Plans for review. Once the proposed methodologies for the collaborative PIPs have been sent to the Prepaid Dental Health Plans, the Prepaid Dental Health Plan has two (2) weeks to submit feedback to the Agency and the EQRO on the methodologies.

2. PIP Proposals

a. The Prepaid Dental Health Plan shall submit its measurement periods and methodologies to the Agency for approval before initiation of the PIP. Within thirty (30) days of Contract execution, the Prepaid Dental Health Plan shall submit to the Agency, in writing:

(1) The initial proposed PIP topics and their indicators;

(2) A brief summary of the baseline data and time period that the Prepaid Dental Health Plan shall use for each indicator for each of the proposed PIPs.

(3) An estimate of how many plan members will be in the eligible/affected population for each PIP.

(4) A brief rationale for why the Prepaid Dental Health Plan has selected each proposed PIP topic.

b. On or before October 1, 2018, the Prepaid Dental Health Plan shall submit to the Agency in writing, a final proposal for each planned PIP.

c. Each initial PIP proposal shall be submitted using the most recent version of the EQRO PIP validation form. The Prepaid Dental Health Plan may obtain instructions for using the form to submit PIP proposals and updates from the Agency.

d. Activities 1 through 6 of the EQRO PIP validation form must be addressed in the PIP proposal. These activities are listed at http://www.myfloridaeqro.com/pips.aspx.

e. In the event the Prepaid Dental Health Plan elects to modify a portion of the PIP proposal after initial Agency approval, the Prepaid Dental Health Plan shall submit a written request to the Agency for approval.

3. Annual PIP Submission

a. The Prepaid Dental Health Plan shall submit ongoing PIPs by October 1 of each Contract year to the Agency for review and approval. (42 CFR 438.330(c)(1) and (2)) The Agency will provide the PIPs to the EQRO for validation.

b. The Prepaid Dental Health Plan shall update the EQRO PIP validation form in its annual submission to reflect the Prepaid Dental Health Plan's progress. The Prepaid Dental Health Plan is not required to transfer ongoing PIPs to a new, updated EQRO form.

4. EQRO Validation

The Prepaid Dental Health Plan's PIPs shall be subject to review and validation by the EQRO. The Prepaid Dental Health Plan shall comply with any recommendations for improvement requested by the EQRO, subject to approval by the Agency.

D. Satisfaction and Experience Surveys

1. Enrollee Satisfaction Survey

a. The Prepaid Dental Health Plan shall conduct an annual survey of enrollees using an adapted version of the Consumer Assessment of Health Care Providers and Systems (CAHPS) Dental Plan Survey.

b. The Prepaid Dental Health Plan shall follow the Survey Administration Guidelines below:

(1) The Prepaid Dental Health Plan shall contract with a qualified, Agency-approved, NCQA-certified survey vendor to administer the surveys. The minimum sample size is 1,650, with a target of 411 completed surveys. The survey should be administered according to the NCQA mixed methodology (two-wave mail protocol with telephone follow-up of at least three (3) but no more than six (6) attempts).

(2) To be included in the survey sample, enrollees must have been enrolled in the Prepaid Dental Health Plan for at least six (6) months with no more than a one (1)-month gap in enrollment.

(3) The Prepaid Dental Health Plan shall have its sample validated by an NCQA-certified HEDIS Auditor.

(4) If the Prepaid Dental Health Plan would like to add questions to the survey, those questions may be added to the end of the CAHPS Dental Plan Survey. Additional questions must be submitted to the Agency contract manager for review and approval prior to being included in the survey.

c. The Prepaid Dental Health Plan shall submit a written proposal for survey administration and reporting to the Agency by December 1 of each Contract year. The proposal shall include the following:

(1) Identification of survey administrator and evidence of the survey administrator's NCQA certification as a CAHPS survey vendor

(2) Sampling methodology

(3) Administration protocol

(4) Analysis plan

(5) Reporting description

(6) Copy of the survey tool

(7) Cover letters and/or postcards

d. The Prepaid Dental Health Plan shall provide the survey results to the Agency, in accordance with the survey results reporting templates and instructions from the Agency, along with an action plan.

e. The Agency will specify the survey requirements including survey specifications, applicable supplemental item sets and Agency-defined survey items. Annually, by October 15 of each Contract year, the Agency will determine and notify the Prepaid Dental Health Plan if there are changes in survey requirements.

f. The Prepaid Dental Health Plans shall report CAHPS dental survey results to the Agency by July 1 of each year.

g. By October 1 of each Contract year, the Prepaid Dental Health Plan shall submit its CAHPS dental survey vendor's final report to the Agency, along with the plan's action plan to address the results of the CAHPS survey.

h. The Prepaid Dental Health Plan shall submit a CAP, as required by the Agency, within thirty (30) days of the request from the Agency to address any deficiencies identified in the annual CAHPS survey.

i. The Prepaid Dental Health Plan shall use the results of the annual CAHPS dental survey to develop and implement plan-wide activities designed to improve enrollee satisfaction. Activities conducted by the Prepaid Dental Health Plan pertaining to improving enrollee satisfaction resulting from the annual enrollee satisfaction survey must be reported to the Agency on a quarterly basis.

j. In addition to the core survey, the Prepaid Dental Health Plan shall include the following item in its CAHPS survey.

(1) How would you rate the number of dentists you had to choose from?

Response options: Excellent, Very Good, Good, Fair, Poor, No Experience

2. Provider Satisfaction Survey

a. The Prepaid Dental Health Plan shall conduct an annual Provider Satisfaction survey. The Prepaid Dental Health Plan shall submit a written provider satisfaction survey plan to the Agency for written approval within ninety (90) days after initial Contract execution and by January 1 of each Contract year, thereafter. (42 CFR 438.66(c)(5))

b. The proposal shall include the following:

(1) Copy of the survey tool, using a four-point Likert scale and including the following domains:

(a) Provider relations and communication

(b) Authorization processes, including denials and appeals

(c) Timeliness of claims payment and assistance with claims processing

(d) Complaint resolution process

(e) Care coordination/case management support.

(2) Sampling methodology

c. The Agency reserves the right to require a specific survey tool, survey questions and/or survey methodology and to provide for minimum qualifications for survey vendors.

d. The Prepaid Dental Health Plan shall conduct the survey, compile, and analyze its survey results, and provide the survey results to the Agency with an action plan to address the results of the Provider Satisfaction survey by July 1 of each Contract year.

e. The Prepaid Dental Health Plan shall submit a CAP, as required by the Agency, within 30 days of the request from the Agency to address any deficiencies identified in the annual Provider Satisfaction survey.

E. Enrollee Record Requirements

1. General Provisions

The Prepaid Dental Health Plan shall ensure maintenance of an enrollee record for each enrollee in accordance with this Section and with 42 CFR 431 and 42 CFR 456. Enrollee records shall include documents related to the quality, quantity, appropriateness, and timeliness of services performed under this Contract.

a. In addition to the requirements of Attachment B., Section IX.E., Enrollee Record Requirements, the Prepaid Dental Health Plan shall ensure the following documentation is included in the enrollee record:

(1) A copy of the completed screening instrument in the enrollee record and provides a copy to the enrollee.

(2) Documentation in the enrollee record of referral services, including reports resulting from the referral.

(3) Documentation in the enrollee record of post-stabilization dental care services provided in response to emergency care encounters.

2. Enrollee Record Review Strategy

a. By June 1 of each Contract year, the Prepaid Dental Health Plan shall submit a written strategy for conducting enrollee record reviews for Agency approval. The strategy shall include, at a minimum:

(1) Designated staff to perform this duty;

(2) Process for establishing inter-rater reliability with internal and external enrollee record reviews;

(3) Method for identifying enrollee records;

(4) Anticipated number of reviews for a statistically significant sample of enrollee records maintained by the Prepaid Dental Health Plan, its subcontractors, and providers;

(5) The tool that the Prepaid Dental Health Plan shall use to review each record;

(6) Record review deficiencies and how results will be utilized in process improvement(s); and

(7) How the Prepaid Dental Health Plan shall link the information compiled during the review to other Prepaid Dental Health Plan functions (e.g., QI, recredentialing, peer review).

b. The Prepaid Dental Health Plan shall conduct enrollee record reviews of all providers with a pattern of complaints regarding poor quality of service and providers with poor quality outcomes.

c. The Prepaid Dental Health Plan shall distribute the standards, which must include all enrollee record documentation requirements addressed in this Contract, to all providers.

3. Standards for Prepaid Dental Health Plan Enrollee Records

a. The Prepaid Dental Health Plan shall develop and maintain enrollee records meeting the documentation standards set forth in Rule 59G-1.054, F.A.C., below:

(1) Include the enrollee's identifying information, including name, enrollee identification number, date of birth, gender, and legal guardianship (if any);

(2) Include information relating to the enrollee's use of tobacco, alcohol, and drugs/substances;

(3) Reflect the primary language spoken by the enrollee and any translation needs of the enrollee;

(4) Identify enrollees needing communication assistance in the delivery of health care services;

(5) Include copies of any completed consent or attestation form(s) used by the

Prepaid Dental Health Plan;

b. The Prepaid Dental Health Plan shall maintain written procedures for enrollee advance directives that address how the Prepaid Dental Health Plan shall access copies of any advance directives executed by the enrollee. The Prepaid Dental Health Plan's procedure shall be updated to reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change. (42 CFR 438.3(j)(4))

(1) All enrollee records shall contain documentation that the enrollee was provided with written information concerning the enrollee's rights regarding advance directives (written instructions for living will or power of attorney), including information on Chapter 765, F.S., and whether or not the enrollee has executed an advance directive. (42 CFR 438.3(j)(3))

(2) Neither the Prepaid Dental Health Plan, nor any of its providers shall require the enrollee to execute or waive an advance directive as a condition of treatment. (42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5))

c. If the Prepaid Dental Health Plan is not yet fully accredited by a nationally recognized accrediting body, the Prepaid Dental Health Plan shall establish processes for enrollee record review that meet or exceed nationally recognized accrediting body enrollee record review standards.

4. Standards for Provider-Specific Enrollee Records

The Prepaid Dental Health Plan shall ensure that its network of providers follow the enrollee record standards set forth in Rule 59G-1.054, F.A.C.

F. Provider-Specific Performance Monitoring

1. General Provision

The Prepaid Dental Health Plan shall monitor the quality and performance of each participating provider. At the beginning of this Contract period, the Prepaid Dental Health Plan shall notify all its participating providers of the metrics used by the Prepaid Dental Health Plan for evaluating the provider's performance and determining continued participation in the network.

2. Peer Review

a. The Prepaid Dental Health Plan shall have a peer review process that results in:

(1) Review of a provider's practice methods and patterns, morbidity/mortality rates, and all complaints and grievances filed against the provider;

(2) Evaluation of the appropriateness of care rendered by providers;

(3) Implementation of corrective action(s) when the Prepaid Dental Health Plan deems it necessary to do so;

(4) Development of policy recommendations to maintain or enhance the quality of care provided to enrollees;

(5) Reviews that include the appropriateness of diagnosis and subsequent treatment, maintenance of a provider's enrollee records, adherence to standards generally accepted by a provider's peers and the process and outcome of a provider's care;

(6) Education of enrollees and Prepaid Dental Health Plan staff about the peer review process, so that enrollees and the Prepaid Dental Health Plan staff can notify the peer review authority of situations or problems relating to providers.

3. Monitoring Activities

The Prepaid Dental Health Plan shall comply with monitoring activities requirements as specified in the Contract.

G. Additional Quality Management Requirements

1. Incident Reporting Requirements

a. As part of the Prepaid Dental Health Plan's quality management requirements, the Prepaid Dental Health Plan shall implement and maintain a risk management program.

b. The Prepaid Dental Health Plan shall develop and implement an incident reporting and management system for adverse incidents.

c. The Prepaid Dental Health Plan shall require participating service providers and direct service providers to report adverse incidents to the Prepaid Dental Health Plan.

d. The Prepaid Dental Health Plan shall provide appropriate training and take corrective action as needed to ensure its staff, participating providers, and direct service providers comply with critical incident requirements.

e. The Prepaid Dental Health Plan shall immediately report to DCF's Central Abuse Hotline any suspected cases of abuse, neglect or exploitation of enrollees, in accordance with s. 39.201 and Chapter 415, F.S. The Prepaid Dental Health Plan shall maintain documentation related to the reporting of such events in a confidential file, separate from the enrollee record. Such file shall be made available to the Agency upon request.

f. The Prepaid Dental Health Plan shall report a summary of adverse incidents to the Agency, as specified in Section XVI., Reporting Requirements, and in the Statewide Medicaid Prepaid Dental Health Plan Report Guide, and in the manner and format determined by the Agency.

g. The Prepaid Dental Health Plan shall require providers to report adverse incidents to the Prepaid Dental Health Plan within forty-eight (48) hours of the incident.

h. The Prepaid Dental Health Plan shall not require provider submission of adverse

incident reports from health maintenance organizations and health care clinics reporting in accordance with s. 641.55, F.S.

2. Agency Monitoring

The Prepaid Dental Health Plan shall furnish specific data requested by the Agency in order to conduct monitoring of the Prepaid Dental Health Plan's compliance with this Contract.

H. Continuity of Care in Enrollment

The Prepaid Dental Health Plan shall be responsible for continuity of care for new enrollees transitioning into the Prepaid Dental Health Plan.

1. In the event a new enrollee is receiving prior authorized ongoing course of treatment with any dental provider, the Prepaid Dental Health Plan shall be responsible for the costs of continuation of such course of treatment without any form of authorization and regardless of provider network affiliation, for up to sixty (60) days after the effective date of enrollment. The Prepaid Dental Health Plan shall reimburse non-participating providers at the rate they received for dental services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of thirty (30) days, unless said provider agrees to an alternative rate.

2. The Prepaid Dental Health Plan will ensure, in conjunction with Medicaid eligibility, continuity of care for active orthodontia until completion of care and reimbursement to providers, regardless of provider network affiliation.

3. The Prepaid Dental Health Plan shall maintain written case management continuity of care protocol(s) that include the following minimum functions:

   a. Appropriate referral of and scheduling assistance for members needing specialty dental care.

   b. Documentation of referral services in members' dental records, including results.

   c. Monitoring members with ongoing dental conditions and coordination of services for high users such that the following functions are addressed as appropriate: acting as a liaison between the enrollee and providers, ensuring the enrollee is receiving routine dental care, ensuring that the enrollee has adequate support at home, and assisting members who are unable to access necessary care due to their medical or emotional conditions or who do not have adequate community resources to comply with their care.

   d. Documentation in dental records of appropriate follow-up to enrollee emergency encounters, when indicated.

4. The Prepaid Dental Health Plan shall provide continuation of services until the enrollee's PDP reviews the enrollee's treatment plan, in accordance with Attachment B., Section IX.H., Continuity of Care in Enrollment.

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Section X. Administration and Management

A. General Provisions

1. The Agency is responsible for administering the Medicaid program. The Agency will administer contracts, monitor Prepaid Dental Health Plan performance, and provide oversight in all aspects of Prepaid Dental Health Plan processes.

2. The Agency will be responsible for the administration of the FMMIS and contracting with the State's fiscal agent to exchange data with Prepaid Dental Health Plans and enroll Medicaid providers. The Agency is responsible also for the administration of programs for Florida's Medicaid Electronic Health Record Incentive Program, the Florida Health Information Network and other efforts to provide information and resources relating to HIT and HIE, as well as collecting data and statistics for the purpose of developing public policy and promoting the transparency of consumer health care information through http://www.floridahealthfinder.gov/index.html.

3. The Agency will be responsible for establishing standards and requirements to ensure receipt of complete and accurate data for program administration as required to determine compliance with Title XIX of the Social Security Act, the Balanced Budget Act of 1997, 42 CFR 438, and Chapters 409 and 641, F.S. The Agency will be responsible for establishing systems, processes, standards and requirements, including but not limited to encounter data collection and submission, and providing instructions to Prepaid Dental Health Plans through the Medicaid Companion Guides and Pharmacy Payer Specifications. The Agency will be responsible for validating and reporting encounter data in accordance with 42 CFR 438.818.

4. The Agency will be responsible for coordinating Medicaid overpayment and abuse prevention, detection and recovery efforts. The Attorney General's office is responsible for investigating and prosecuting Medicaid fraud. The Agency will operate the MPI program, which includes but is not limited to such monitoring as may be done by desk reviews or on site as determined by the Agency. Various Agency bureaus may conduct these reviews and the Agency will provide appropriate notice for requesting documents as needed and for conducting on-site reviews, as well as providing Prepaid Dental Health Plans with the result of such reviews. The Agency, Bureau of MPI, audits and investigates providers suspected of overbilling or defrauding the Florida Medicaid Program, recovers overpayments, issues administrative sanctions and refers cases of suspected fraud for criminal investigation to the MFCU. The Agency will conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate.

5. The Prepaid Dental Health Plan shall be responsible for the administration and management of all aspects of this Contract, including but not limited to delivery of services, provider network, provider education, claims resolution and assistance, and all subcontracts, employees, agents and services performed by anyone acting for or on behalf of the Prepaid Dental Health Plan.

6. The Prepaid Dental Health Plan shall have a centralized executive administration, and must ensure adequate staffing and information systems capability to ensure the Prepaid Dental Health Plan may appropriately manage financial transactions, record keeping, data collection, and other administrative functions, including the ability to submit any financial, programmatic, encounter data, or other information required by this Contract.

B. Organizational Governance and Staffing

1. General Provisions

a. The Prepaid Dental Health Plan shall be responsible for the administration and management of all aspects of this Contract, including all subcontracts, employees, agents, and services performed by anyone acting for or on behalf of the Prepaid Dental Health Plan.

b. The Prepaid Dental Health Plan shall have a centralized executive administration, which shall serve as the contact point for the Agency, except as otherwise specified in this Contract.

c. The Prepaid Dental Health Plan shall ensure adequate staffing and information systems capability to ensure the Prepaid Dental Health Plan may appropriately manage financial transactions, record keeping, data collection, and other administrative functions, including the ability to submit any financial, programmatic, and encounter data, or other information required by the Agency, and to comply with the HIPAA and the HITECH Act.

d. The Prepaid Dental Health Plan shall be located in the U.S. (42 CFR 438.602(i))

e. The Prepaid Dental Health Plan shall meet all requirements for doing business in the State of Florida.

f. The Prepaid Dental Health Plan shall submit any changes to its approved organizational chart to the Agency for prior approval. If any member of the minimum staffing is terminated or becomes unavailable for any reason, the Prepaid Dental Health Plan shall submit to the Agency the resume of the proposed replacement(s) and offer the Agency to review the qualifications of the proposed applicant(s).

g. The Agency reserves the right to disapprove proposed applicant(s) with reason.

2. Minimum Staffing

The positions described below represent the minimum management staff required for the Prepaid Dental Health Plan. The Prepaid Dental Health Plan shall notify the Agency of changes in the staff positions indicated below, within five (5) business days of the changes in staffing. The Prepaid Dental Health Plan shall not delegate minimum staffing positions.

a. The Prepaid Dental Health Plan shall designate a full-time Contract Manager to work directly with the Agency. The Contract Manager shall be a full-time employee of the Prepaid Dental Health Plan and shall dedicate one hundred percent (100%) of their time employed with the Prepaid Dental Health Plan to this Contract. The Contract

Manager shall have the authority to administer the day-to-day business activities of this Contract, including revising processes or procedures and assigning additional resources as needed to maximize the efficiency and effectiveness of services required under this Contract. The Prepaid Dental Health Plan Contract Manager shall meet in person, or by telephone, at the request of Agency. The Contract Manager shall be located in the State of Florida.

b. The Prepaid Dental Health Plan shall designate a full-time Dental Director who is a dentist licensed in the State of Florida with experience providing services to the populations served under this Contract. The Dental Director shall be a full-time employee of the Prepaid Dental Health Plan and shall dedicate one hundred percent (100%) of their time employed with the Prepaid Dental Health Plan to this Contract. The Director shall oversee and be responsible for the proper provision of covered services to enrollees, the quality management program, and the grievance and appeal system.

c. The Prepaid Dental Health Plan shall designate a full-time Compliance Officer, qualified by knowledge, training, and experience in health care or risk management, to promote, implement, and oversee the compliance program and to oversee the Prepaid Dental Health Plan's compliance with non-discrimination requirements in this Contract. The Compliance Officer shall be a full-time employee of the Prepaid Dental Health Plan and shall dedicate one hundred percent (100%) of their time employed with the Prepaid Dental Health Plan to this Contract. The Compliance Officer shall exhibit knowledge of relevant regulations, provide expertise in compliance processes, and be qualified to design, implement, and oversee a fraud and abuse program designed to ensure program integrity through fraud and abuse prevention and detection, which identifies and addresses emerging trends of fraud, abuse, and waste pursuant to this Contract and State and federal law.

d. The Prepaid Dental Health Plan shall designate a staff for each of the following functional areas within the Agency:

(1) Medicaid Quality

(2) Medicaid Recipient/Provider Assistance

(3) Medicaid Policy

(4) Medicaid Data Analytics

(5) Medicaid Finance

(6) Claims and Encounter Data

(7) Program Integrity

(8) Subcontractor Oversight

3. Dental and Professional Support Staff

The Prepaid Dental Health Plan shall have an adequate number of dental and professional support staff, sufficient to conduct daily business in an orderly manner, including having enrollee services staff directly available during business hours for enrollee services consultation, as determined through management and medical reviews. The Prepaid Dental Health Plan shall maintain and adequate number sufficient dental and professional support staff, available twenty-four hours per day, seven days a week (24/7), to handle emergency services and care inquiries from enrollees and caregivers.

4. Care Coordination/Case Management Staff

The Prepaid Dental Health Plan shall have sufficient care coordination/case management staff, qualified by training, experience, and certification/licensure to conduct the Prepaid Dental Health Plan's care coordination/case management functions.

5. Staff Training and Education

The Prepaid Dental Health Plan shall educate its staff about its procedures and all applicable provisions of this Contract. (42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5))

6. **Non-discrimination Compliance Requirements**

a. The Prepaid Dental Health Plan shall comply with all applicable federal and State civil rights laws, regulations, rules and policies, including but not limited to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the ADA of 1990, Section 1557 of the Patient Protection and Affordable Care Act (ACA), and the Age Discrimination Act of 1975.

b. The Prepaid Dental Health Plan shall develop a non-discrimination compliance plan. The Prepaid Dental Health Plan shall be responsible for initial and ongoing training regarding the non-discrimination compliance plan to all Prepaid Dental Health Plan staff. The Prepaid Dental Health Plan shall maintain documented proof of such training and provide such proof to the Agency upon request.

c. The Prepaid Dental Health Plan's non-discrimination compliance plan shall include written procedures that demonstrate non-discrimination in the provision of services to enrollees. The policy shall also demonstrate non-discrimination in the provision of language assistance services for members with limited English proficiency and those requiring communication assistance in alternative formats. See Section V.B., Enrollee Material.

7. Emergency Management Plan

Before implementation of this Contract and by May 1st of each Contract year, the Prepaid Dental Health Plan shall submit to the Agency an emergency management plan specifying what actions the Prepaid Dental Health Plan shall conduct to ensure the ongoing provision of covered services in a disaster or man-made emergency, including but not limited to localized acts of nature, accidents, and technological and/or attack-related emergencies. The emergency management plan shall include risk assessment and emergency planning procedures, a communication plan, and training and testing. If the emergency management plan is unchanged from the previous year and was approved by the Agency,

the Prepaid Dental Health Plan shall submit an electronic certification to the Agency that the prior year's plan is still in place.

C. Subcontracts

1. General Provisions

a. The Prepaid Dental Health Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract, and may, delegate performance of work required under this Contract to a subcontractor. The Prepaid Dental Health Plan shall submit any proposed delegation to the Agency for prior written approval. The Prepaid Dental Health Plan shall submit all subcontracts for Agency review at least ninety (90) days before the proposed effective date of the subcontract or change. If the submission is for management of a covered service, the Prepaid Dental Health Plan shall include the following in its submission to the Agency in a manner prescribed by the Agency:

(1) Draft subcontract that complies with the subcontract requirements specified in this section, the Agency Standard Contract, 42 CFR 438.230(c)(1)(i), and 42 CFR 438.3(k)

(2) Test PNV file as proof of provider network adequacy

(3) Copy of applicable licensure, if appropriate

(4) Enrollee materials in publication ready formats as specified in the Contract

(5) The population covered by the subcontract

(6) Provider materials in publication ready formats as specified in the Contract

(7) Model provider agreement template as specified in Section VIII., Provider Services

(8) Approximate number of impacted enrollees

If the Agency determines, at any time, that a subcontract does not comply with a Contract requirement, the Prepaid Dental Health Plan shall promptly revise the subcontract into compliance.

b. All subcontracts must comply with 42 CFR 438.230, 42 CFR 438.3(k), 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106 and all applicable Medicaid laws and regulations, including applicable sub regulatory guidance and Contract provisions, and any other applicable State or federal law.

c. The Prepaid Dental Health Plan shall identify the service(s) and/or goods covered by the subcontract, as applicable.

d. All subcontracts must contain provisions wherein the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental

Health Plan Report Guide.

e. No subcontract that the Prepaid Dental Health Plan enters into with respect to performance under this Contract shall relieve the Prepaid Dental Health Plan in any way of any responsibility for the performance of duties under this Contract. The Prepaid Dental Health Plan shall assure that all tasks related to the subcontract are performed in accordance with the terms of this Contract and shall provide the Agency with its monitoring schedule for all Agency-approved subcontractors by December 1 of each Contract year.

f. All executed subcontracts and amendments used by the Prepaid Dental Health Plan under this Contract shall be in writing, signed, and dated by the Prepaid Dental Health Plan.

g. The Prepaid Dental Health Plan shall immediately advise the Agency of the insolvency of a subcontractor or of the filing of a petition in bankruptcy by or against a principal subcontractor.

h. The Prepaid Dental Health Plan shall have a contingency plan for each subcontract to provide for continuity of care should the subcontractor cease to provide services that are the subject of the subcontract.

i. If the Prepaid Dental Health Plan offers a dental provider incentive plan, all model and executed subcontracts and amendments used by the Prepaid Dental Health Plan under this Contract shall include a statement that the Prepaid Dental Health Plan shall make no specific payment directly or indirectly under a dental provider incentive plan to a subcontractor as an inducement to reduce or limit medically necessary services to an enrollee, and affirmatively state that all incentive plans do not provide incentives, monetary or otherwise, for the withholding of medically necessary care. (42 CFR 422.208(c)(1); 42 CFR 438.3(i)) If the dental provider incentive plan places a dental provider or dental provider group at substantial financial risk (pursuant to 42 CFR 422.208(a)(d)) for services that the dentist or dental provider group does not furnish itself, the Prepaid Dental Health Plan shall assure that all dentists and dental provider groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with 42 CFR 422.208(c)(2). The Prepaid Dental Health Plan shall provide assurances to the Secretary of DHHS that the requirements of 42 CFR 422.208 are met in accordance with 42 CFR 422.210(a).

2. Subcontractor Eligibility

a. All subcontractors must be eligible for participation in the Medicaid program; however, the subcontractor is not required to participate in the Medicaid program as a provider.

b. If a subcontractor was involuntarily terminated from the Medicaid program other than for purposes of inactivity, that entity is not considered an eligible subcontractor.

c. The Prepaid Dental Health Plan shall not delegate provider network management to a subcontractor that meets both of the following:

(1) The subcontractor is owner or has controlling interest in any provider(s) included in the network; and

(2) The subcontractor limits enrollee choice of network providers through a requirement for a referral/authorization process to access network providers.

3. Subcontract Content Requirements

a. Payment - The Prepaid Dental Health Plan agrees to make payment to all subcontractors pursuant to all State and federal laws, rules and regulations, including Part IV of 409, F.S., s. 641.3155, F.S., 42 CFR 238.230, 42 CFR 447.46, and 42 CFR 447.45(d)(2), (3), (5) and (6), in addition to sub regulatory guidance and the provisions of this Contract. All model and executed subcontracts and amendments used by the Prepaid Dental Health Plan under this Contract shall meet the following requirements:

(1) Identify conditions and method of payment;

(2) Provide for prompt submission of information needed to make payment;

(3) Provide for full disclosure of the method and amount of compensation or other consideration to be received from the Prepaid Dental Health Plan;

(4) Require any claims processing vendors to maintain accurate enrollee and provider information, including provider agreements reflecting the correct reimbursement rate and provider specialty, in order to ensure the correct adjudication of claims and proper payment to providers;

(5) Require any payment to a provider be accompanied by an itemized accounting of the individual claims included in the payment, including but not limited to the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement, and the identification of the Prepaid Dental Health Plan;

(6) Require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to the Prepaid Dental Health Plan;

(7) Specify that the Prepaid Dental Health Plan shall assume responsibility for cost avoidance measures for third party collections in accordance Section XII., Financial Requirements.

b. Monitoring and Inspections - All model and executed subcontracts and amendments used by the Prepaid Dental Health Plan under this Contract shall meet the following requirements with respect to provisions for monitoring and inspections:

(1) Provide that the Agency, CMS, the DHHS Inspector General, the Comptroller General or their designees, and DHHS have the right to audit, evaluate, or inspect the subcontractor's premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's subcontractor, pertaining to any aspect of services and activities performed, or determination of amounts payable under the Prepaid Dental Health Plan's Contract with the State. In accordance with 42 CFR 438.230(c)(3)(iii), the subcontractor shall agree that the right to audit exists

through ten (10) years from the final date of this Contract period or from the date of completion of any audit, whichever is later;

(2) Provide that the subcontractor shall make available for purposes of an audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems relating to its Medicaid enrollees pertinent to this Contract by the Agency, CMS, the DHHS Inspector General, the Comptroller General or their designees, and DHHS; (42 CFR 438.3(h); s. 1903(m)(2)(A)(iv) of the Social Security Act)

(3) Require full cooperation in any investigation by the Agency, MFCU, CMS, the DHHS Inspector General, the Comptroller General, or their designees, or other State or federal entity or any subsequent legal action that may result from such an investigation.

(4) In addition to record retention requirements for practitioner or provider licensure, require subcontractors to retain, as applicable, the following information in accordance with 42 CFR 438.3(u): enrollee grievance and appeal records in 42 CFR 438.416; base data in 42 CFR 438.5(c); MLR reports in 42 CFR 438.8(k); and the data, information, and documentation specified in 42 CFR 438.604, 42 CFR438.606, 42 CFR 438.608, and 42 CFR 438.610 for a period not less than ten (10) years from the close of this Contract and retained further if the records are under review or audit until the review or audit is complete. (Prior approval for the disposition of records must be requested and approved by the Prepaid Dental Health Plan if the subcontract is continuous.); (42 CFR 438.3(h))

(5) Provide for monitoring and oversight by the Prepaid Dental Health Plan and the subcontractor to provide assurance that all licensed dental professionals are credentialed in accordance with the Prepaid Dental Health Plan's and the Agency's credentialing requirements as found in Section VIII., Provider Services, if the Prepaid Dental Health Plan has delegated the credentialing to a subcontractor;

(6) Provide for monitoring of services rendered to Prepaid Dental Health Plan enrollees through the subcontractor.

c. Protective Clauses - All model and executed subcontracts and amendments used by the Prepaid Dental Health Plan under this Contract shall meet the following requirements with respect to protective clauses:

(1) Require safeguarding of information about enrollees according to 42 CFR Part 438.224.

(2) Require an exculpatory clause, which survives subcontract termination, including breach of subcontract due to insolvency, which assures that enrollees or the Agency will not be held liable for any debts of the subcontractor.

(3) Contain a clause indemnifying, defending and holding the Agency, its designees, and the Prepaid Dental Health Plan's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act

or other wrongful conduct arising from the subcontract agreement. This clause must survive the termination of the subcontract, including breach due to insolvency. The Agency may waive this requirement for itself, but not Prepaid Dental Health Plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the subcontractor is a State agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers must be approved in writing by the Agency.

(4) Require that the subcontractor secure and maintain, during the life of the subcontract, workers' compensation insurance for all of its employees connected with the work under this Contract unless such employees are covered by the protection afforded by the Prepaid Dental Health Plan. Such insurance shall comply with Florida's Workers' Compensation Law.

(5) Require that, if the Prepaid Dental Health Plan delegates claims processing and payment, the subcontractor shall:

(a) Report its financial status (i.e. periodic financial reporting, financial statements) to the Prepaid Dental Health Plan at a frequency determined acceptable to the Prepaid Dental Health Plan.

(b) Require, if the subcontractor is at financial risk and/or is delegated to process and pay claims, the subcontractor shall maintain a surplus account to meet its obligations.

(6) Specify that if the subcontractor delegates or subcontracts any functions of its contract with the Prepaid Dental Health Plan, that the subcontract or delegation shall include all the requirements of this Contract.

(7) Make provisions for a waiver of those terms of the subcontract, which, as they pertain to Medicaid recipients, are in conflict with the specifications of this Contract.

(8) Provide for revoking delegation, or imposing other sanctions, if the subcontractor's performance is inadequate.

(9) Provide that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. (42 CFR 438.210(e))

(10) Provide that the subcontractor shall establish, enforce, and monitor solvency requirements that provide assurance of the subcontractor's ability to meet its obligations.

(11) Require that the subcontractor timely notify the Prepaid Dental Health Plan of changes in directory information.

(12) Provide details about the following as required by Section 6032 of the federal Deficit Reduction Act of 2005:

(a) The False Claims Act;

(b) The penalties for submitted false claims and statements;

(c) Whistleblower protections; and

(d) The entity's role in preventing and detecting fraud, waste and abuse, and each person's responsibility relating to detection and prevention.

(42 CFR 438.608(a)(6); s. 1902(a)(68) of the Social Security Act)

d. Termination Procedures - In conjunction with the Standard Contract, Section III., B., Termination, all provider agreements and subcontracts shall contain termination procedures.

e. Marketing - All subcontracts specify that the subcontractor shall comply with the marketing requirements specified in Section IV., Marketing.

f. Encounter Data - All model and executed subcontracts and amendments used by the Prepaid Dental Health Plan under this Contract shall require subcontractors to submit timely, complete and accurate encounter data to the Prepaid Dental Health Plan in accordance with the requirements of Section X.D., Information Management Systems.

4. Other Contract Requirements

Subcontractors are subject to background checks. The Prepaid Dental Health Plan shall consider the nature of the work a subcontractor or agent shall perform in determining the level and scope of the background checks in accordance with s. 408.809, F.S.

5. Minority Business Enterprises

The State supports and encourages supplier diversity and the participation of small and minority business enterprises in State contracting, both as vendors and as subcontractors. The Agency supports diversity in its Procurement Program and requests that all subcontracting opportunities afforded by this Contract enthusiastically embrace diversity. The award of subcontracts should reflect the full diversity of the citizens of the State of Florida. Respondents can contact the Office of Supplier Diversity online at http://osd.dms.state.fl.us/ for information on minority vendors who may be considered for subcontracting opportunities.

D. Information Management and Systems

1. General Provisions

The Prepaid Dental Health Plan shall have information management processes and information systems of sufficient capacity that enable it to meet Agency and federal reporting requirements, other Contract requirements, and all applicable Agency policies, State and federal laws, rules and regulations, including HIPAA. The Prepaid Dental Health Plan shall be responsible for establishing connectivity to the Agency's/State's wide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable Agency and/or State policies, standards and

guidelines, as well as coordinating activities and developing cohesive systems strategies across vendors and agencies.

a. Systems Functions - The Prepaid Dental Health Plan shall have information management processes and information systems that collect, analyze, integrate, and report data, enabling the Prepaid Dental Health Plan to meet Agency and federal reporting requirements. (42 CFR 438.242(a) and (b); s. 6504(a) of the ACA)

b. Systems Capacity - The Prepaid Dental Health Plan's system(s) shall possess capacity sufficient to handle the workload projected for the begin date of implementation of this Contract and shall be scalable and flexible as to be adapted as needed, within negotiated timeframes, in response to changes in Contract requirements, increases in enrollment estimates, etc.

c. Email System - The Prepaid Dental Health Plan shall provide a continuously available electronic mail communication link (email system) with the Agency. This system shall be:

    (1) Available from the workstations of the designated Prepaid Dental Health Plan contacts; and

    (2) Capable of attaching and sending documents created using software products other than the Prepaid Dental Health Plan's systems, including the Agency's currently installed version of Microsoft Office and any subsequent upgrades as adopted. The electronic mail system shall include encryption capabilities compliant with FIPS 140-2.

d. HIPAA Compliance - The Prepaid Dental Health Plan shall ensure it meets all federal regulations regarding required standard electronic transactions and standards for privacy and individually identifiable health information as identified in the HIPAA of 1996 and the HITECH Act of 2009 and associated regulations.

e. Data Security - The Prepaid Dental Health Plan shall conduct all activities in compliance with 45 CFR 164 Subpart C to ensure data security, including, but not limited to encryption of all information that is confidential under Florida or federal law, while in transmission and while resident on portable electronic media storage devices. Encryption is required and shall be consistent with FIPS, and/or the NIST publications regarding cryptographic standards.

f. Security Rating Score - In order to enable the Agency to effectively measure and mitigate the Prepaid Dental Health Plan's security risks, the Prepaid Dental Health Plan shall annually obtain a security rating score from a vendor information security rating service (e.g., BigSight Technologies, Security Scorecard, CORL Technologies, or other comparable company that rates vendor information security). If the Prepaid Dental Health Plan does not maintain a top tier security rating score, the Prepaid Dental Health Plan may be subject to liquidated damages and/or sanctions.

g. Participation in Information Systems Work Groups/Committees - The Prepaid Dental Health Plan shall meet as requested by the Agency, to coordinate activities and develop cohesive systems strategies across vendors and agencies.

h. Connectivity to the Agency/State Network and Systems - The Prepaid Dental Health Plan shall be responsible for establishing connectivity to the Agency's/State's wide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable Agency and/or State policies, standards, and guidelines. The Prepaid Dental Health Plan shall notify the Agency of termination of any staff with access to the Agency's network within twenty-four (24) hours of the termination.

i. Security Training - Prepaid Dental Health Plan staff that have access connectivity to the Agency's data communications network shall be required to complete Agency Security Awareness Training and Agency HIPAA Training. The Prepaid Dental Health Plan shall sign an Acceptable Use Acknowledgement Form and submit the completed form to the Agency's Information Security Manager. The requirements described in this Item must be completed before access to the Agency's network is provided.

j. The Prepaid Dental Health Plan shall adhere and comply with the Agency's Division of IT standards regarding SSL Web interface(s) and TLS.

k. The Prepaid Dental Health Plan shall adhere to the Driver Privacy Protection Act rules that address a memorandum of understanding and security requirements as well as other requirements contained in Rule.

l. The Prepaid Dental Health Plan shall conform to current and updated publications of the principles, standards, and guidelines of the FIPS, the NIST publications, including but not limited to Cybersecurity-Framework and NIST.SP.800-53r4.

m. The Prepaid Dental Health Plan shall employ traffic and network monitoring software and tools on a continuous basis

  (1) To identify obstacles to optimum performance.

  (2) To identify email and Internet spam and scams and restrict or track user access to appropriate websites.

  (3) To identify obstacles to detect and prevent hacking, intrusion and other unauthorized use of the Prepaid Dental Health Plan's resources.

  (4) To prevent adware or spyware from deteriorating system performance.

  (5) To update virus blocking software daily and aggressively monitor for and protect against viruses.

  (6) To monitor bandwidth usage and identify bottlenecks that impede performance.

  (7) To provide methods to flag recipient data to exclude PHI from data exchanges as approved by the State, and to comply with recipient rights under the HIPAA privacy law for: 1) Requests for restriction of the uses and disclosures on PHI (45 CFR 164.522(a)); 2) Requests for confidential communications (45 CFR 164.522(b)); and 3) Requests for amendment of PHI (45 CFR 164.526). The Prepaid Dental Health Plan shall also enter into a BAA with the Agency. The provisions of the BAA apply to HIPAA requirements and in the event of a conflict

between the BAA and the provisions of this Sub-Section, the BAA shall control. (See **Exhibit A-8,** Standard Contract).

2. Data and Document Management Requirements

a. Adherence to Data and Document Management Standards

(1) The Prepaid Dental Health Plan's systems shall conform to the standard transaction code sets specified in this Contract.

(2) The Prepaid Dental Health Plan's systems shall conform to HIPAA and HITECH standards for data and document management.

(3) The Prepaid Dental Health Plan shall collaborate with the Agency in the management of standard transaction code sets specific to the Agency. Furthermore, the Prepaid Dental Health Plan shall collaborate with the Agency in the development and implementation planning of future standard code sets not specific to HIPAA or other federal efforts and shall conform to these standards as stipulated in the plan to implement the standards.

b. Data Model and Accessibility. Prepaid Dental Health Plan systems shall be SQL and/or ODBC compliant. Alternatively, the Prepaid Dental Health Plan's systems shall employ a relational data model in the architecture of its databases in addition to a relational database management system to operate and maintain them.

c. Data and Document Relationships. The Prepaid Dental Health Plan shall house indexed images of documents used by enrollees and providers to transact with the Prepaid Dental Health Plan in the appropriate database(s) and document management systems so as to maintain the logical relationships between certain documents and certain data.

d. Information Retention. Information in the Prepaid Dental Health Plan's systems shall be maintained in electronic form for three (3) years in live systems and for an additional seven (7) years in archival systems. Enrollee grievance and appeal records (42 CFR 438.416) base data (42 CFR 438.5(c)), MLR reports (42 CRF 438.8(k)), and the data, information, and documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608, and 42 CFR 438.610 shall be maintained for a period of no less than ten (10) years in accordance with 42 CFR 438.3(u) in live and/or archival systems, or longer for audits or litigation as specified elsewhere in this Contract.

e. Information Ownership. All information, whether data or documents, and reports that contain or make references to said Information, involving or arising out of this Contract is owned by the Agency. The Prepaid Dental Health Plan is expressly prohibited from sharing or publishing the Agency information and reports without the prior written consent of the Agency. In the event of a dispute regarding the sharing or publishing of information and reports, the Agency's decision on this matter shall be final and not subject to change.

3. System and Data Integration Requirements

a. Adherence to Standards for Data Exchange

(1) The Prepaid Dental Health Plan's systems shall be able to transmit, receive and process data in HIPAA-compliant formats.

(2) The Prepaid Dental Health Plan's systems shall be able to transmit, receive and process data in the Agency-specific formats and/or methods.

(3) The Prepaid Dental Health Plan's systems shall conform to future federal and/or Agency-specific standards for data exchange, including HIPAA-compliant data formats, within one hundred twenty (120) days of the standard's effective date or, if earlier, the date stipulated by HHS, CMS, or the Agency. The Prepaid Dental Health Plan shall partner with the Agency in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort. Furthermore, the Prepaid Dental Health Plan shall conform to these standards as stipulated in the Agency agreed-upon plan to implement such standards.

b. HIPAA Compliance Checker. All HIPAA-conforming transactions between the Agency and the Prepaid Dental Health Plan shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker application.

c. Data and Report Validity and Completeness. The Prepaid Dental Health Plan shall institute processes to ensure the validity and completeness of the data, including reports, it submits to the Agency. At the Agency's discretion, the Prepaid Dental Health Plan shall be subject to general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that shall be audited include, but are not limited to: enrollee ID, date of service, assigned Medicaid provider ID, category and subcategory (if applicable) of service, diagnosis codes, procedure codes, revenue codes, date of claim processing, and (if and when applicable) date of claim payment. Control totals shall also be reviewed and verified.

d. State/Agency Website/Portal Integration. Where deemed that the Prepaid Dental Health Plan's web presence shall be incorporated to any degree to the Agency's or the State's web presence (also known as a portal), the Prepaid Dental Health Plan shall conform to any applicable Agency or State standard for website structure, coding, and presentation.

e. Functional Redundancy with Agency Systems. The Prepaid Dental Health Plan's systems shall be able to transmit and receive transaction data to and from Agency Systems as required for the appropriate processing of claims and any other transaction that could be performed by either system.

f. Data Exchange in Support of the Agency's Program Integrity and Compliance Functions. The Prepaid Dental Health Plan's systems shall be capable of generating files in the prescribed formats for upload into Agency systems used specifically for program integrity and compliance purposes.

g. Address Standardization. The Prepaid Dental Health Plan's system(s) shall possess mailing address standardization functionality in accordance with U.S. Postal Service

conventions.

h. Eligibility and Enrollment Data Exchange Requirements

(1) The Prepaid Dental Health Plan shall receive process and update enrollment files sent daily by the Agency or its agent(s).

(2) The Prepaid Dental Health Plan shall update its eligibility/enrollment databases within twenty-four (24) hours after receipt of said files.

(3) The Prepaid Dental Health Plan shall transmit to the Agency or its agent, in a periodicity schedule, format, and data exchange method to be determined by the Agency, specific data it may garner from an enrollee including third party liability data.

(4) The Prepaid Dental Health Plan shall be capable of uniquely identifying a distinct Medicaid recipient across multiple systems within its span of control.

4. Systems Availability, Performance, and Problem Management Requirements

a. Availability of Critical Systems Functions. The Prepaid Dental Health Plan shall ensure that critical systems functions available to enrollees and providers, functions that if unavailable would have an immediate detrimental impact on enrollees and providers, are available twenty-four hours per day, seven days per week (24/7), except during periods of scheduled system unavailability agreed upon by the Agency and the Prepaid Dental Health Plan. Unavailability caused by events outside of a Prepaid Dental Health Plan's span of control should be addressed in a Business Continuity plan. The Prepaid Dental Health Plan shall make the Agency aware of the nature and availability of these functions prior to extending access to these functions to enrollees and/or providers.

b. Availability of Data Exchange Functions**.** The Prepaid Dental Health Plan shall ensure that the systems and processes within its span of control associated with its data exchanges with the Agency and/or its agent(s) are available and operational according to specifications and the data exchange schedule.

c. Availability of Other Systems Functions**.** The Prepaid Dental Health Plan shall ensure that at a minimum, all other system functions and information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m., in the time zone where the user is located, Monday through Friday.

d. Problem Notification

(1) Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of all systems functions and the availability of information in said systems, including any problems affecting scheduled exchanges of data between the Prepaid Dental Health Plan and the Agency and/or its agent(s), the Prepaid Dental Health Plan shall notify the applicable Agency staff via phone, fax, and/or electronic mail within one (1) hour of such discovery. In its notification, the Prepaid Dental Health Plan shall explain in detail the impact to critical path processes such as enrollment management

and claims submission processes.

(2) The Prepaid Dental Health Plan shall provide to appropriate Agency staff information on system unavailability events, as well as status updates on problem resolution. At a minimum, these updates shall be provided on an hourly basis and made available via electronic mail and/or telephone.

e. Recovery from Unscheduled System Unavailability. Unscheduled system unavailability caused by the failure of systems and telecommunications technologies within the Prepaid Dental Health Plan's span of control shall be resolved, and the restoration of services implemented, within forty-eight (48) hours of the official declaration of system unavailability.

f. Exceptions to System Availability Requirement. The Prepaid Dental Health Plan shall not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the Prepaid Dental Health Plan's span of control.

g. Information Systems CAP. If at any point there is a problem with a critical systems function, at the request of the Agency, the Prepaid Dental Health Plan shall provide to the Agency full written documentation that includes a CAP that describes how problems with critical systems functions shall be prevented from occurring again. The CAP shall be delivered to the Agency within five (5) business days of the problem's occurrence. Failure to submit a CAP and to show progress in implementing the CAP shall make the Prepaid Dental Health Plan subject to sanctions, in accordance with Section XIII., Sanctions.

h. Business Continuity-Disaster Recovery (BC-DR) Plan

(1) Regardless of the architecture of its systems, the Prepaid Dental Health Plan shall develop, maintain, and be continually ready to invoke a BC-DR plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed. The BC-DR plan shall limit service interruption to a period of twenty-four (24) hours and shall ensure compliance with all contractual requirements. The records backup standards and BC-DR plan shall be developed and maintained for the entire Contract period.

(2) The BC-DR plan shall include a strategy for restoring day-to-day operations, including alternative locations for the Prepaid Dental Health Plan to operate. The BC-DR plan shall maintain database backups in a manner that eliminates service disruptions or data loss due to system or program failures or destruction.

The Prepaid Dental Health Plan's BC-DR plan shall be submitted to the Agency. If the approved plan is unchanged from the previous year, the Prepaid Dental Health Plan shall submit a certification to the Agency that the prior year's plan is still in place May 1st of each Contract year. Changes in the plan are due to the Agency within ten (10) business days after the change.

(3) At a minimum, the Prepaid Dental Health Plan's BC-DR plan shall address the following scenarios:

(a) The central computer installation and resident software are destroyed or damaged;

(b) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage;

(c) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of data maintained in a live or archival system;

(d) System interruption or failure resulting from network, operating hardware, software, or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but do prevent access to the system, i.e., cause unscheduled system unavailability; and

(e) Malicious acts, including malware or manipulation.

(4) The Prepaid Dental Health Plan shall periodically, but no less than annually, by April 30 of each Contract year, perform comprehensive tests of its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to the Agency that it can restore system functions by being ISO22301 certified (Business Continuity Management) or comparable standard (contingent upon Agency approval) certified.

(5) Outbound mail gateways used by the Prepaid Dental Health Plan shall be configured to only send emails to the Agency over an encrypted connection (currently, TLS). Additionally, all incoming mail gateways must be configured to accept encrypted connections (TLS) as the Agency will only be transmitting mail across such connections.

(6) In the event that the Prepaid Dental Health Plan fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Contract, the Prepaid Dental Health Plan shall be required to submit to the Agency a CAP in accordance with Section XIII., Sanctions, that describes how the failure shall be resolved. The CAP shall be delivered within ten (10) business days of the conclusion of the test.

i. Data Security

(1) The Prepaid Dental Health Plan, its employees, subcontractors, and agents shall provide immediate notice within one hour to the Agency ISM in the event it becomes aware of any security breach and any unauthorized transmission or loss of any or all of the data collected or created for or provided by the Agency (State Data) or, to the extent the Prepaid Dental Health Plan is allowed any access to the Agency's IT resources, provide immediate notice to the ISM, of any allegation or suspected violation of security procedures of the Agency. Except as required by law and after notice to the Agency, the Prepaid Dental Health Plan shall not divulge to third parties any confidential information obtained by the Prepaid Dental Health Plan or its agents, distributors, resellers,

subcontractors, officers, or employees in the course of performing contract work according to applicable rules, including, but not limited to, Rule 74-2, F.A.C., and its successor regulation, security procedures, business operations information, or commercial proprietary information in the possession of the State or the Agency. After the conclusion of this Contract unless otherwise provided herein, the Prepaid Dental Health Plan shall not be required to keep confidential information that is publicly available through no fault of the Plan, material that the Prepaid Dental Health Plan developed independently without relying on the State's confidential information, or information that is otherwise obtainable under State law as a public record.

(2) In the event of loss of any State Data or record where such loss is due to the negligence of the Prepaid Dental Health Plan or any of its subcontractors or agents, the Prepaid Dental Health Plan shall be responsible for recreating such lost data in the manner and on the schedule set by the Agency at the Prepaid Dental Health Plan's sole expense, in addition to any other damages the Agency may be entitled to by law or this Contract. In the event lost or damaged data is suspected, the Prepaid Dental Health Plan shall perform due diligence and report findings to the Agency and perform efforts to recover the data. If it is unrecoverable, the Prepaid Dental Health Plan shall pay all the related costs associated with the remediation and correction of the problems engendered by any given specific loss. Further, failure to maintain security that results in certain data release shall subject the Prepaid Dental Health Plan to liquidated damages for failure to comply with Section 501.171, F.S., together with any costs to the Agency of such breach of security caused by the Prepaid Dental Health Plan. If State Data will reside in the Prepaid Dental Health Plan's system, the Agency may conduct, or request the Prepaid Dental Health Plan conduct at the Prepaid Dental Health Plan's expense, an annual network penetration test or information security audit of the Prepaid Dental Health Plan's system(s) on which State Data resides. State-owned Data shall be processed and stored in data centers that are located only in the forty-eight (48) contiguous U.S. All successful Prepaid Dental Health Plan personnel who will have access to State-owned Data shall undergo the background checks and screenings described in this Contract. Within the first year of this Contract term, the Prepaid Dental Health Plan shall obtain a NIST compliant information security risk assessment conducted by an independent third party unless one has been completed within the year prior to Contract execution.

5. System Testing and Change Management Requirements

a. Notification and Discussion of Potential System Changes. The Prepaid Dental Health Plan shall notify the Agency of the following changes to systems within its span of control at least ninety (90) days before the projected date of the change. If so directed by the Agency, the Prepaid Dental Health Plan shall discuss the proposed change with the applicable Agency staff. This includes: (1) software release updates of core transaction systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment, and data management; and (2) conversions of core transaction management systems.

b. Response to Agency Reports of Systems Problems not Resulting in System Unavailability

(1) The Prepaid Dental Health Plan shall respond to Agency reports of system problems not resulting in system unavailability according to the following timeframes:

(a) Within seven (7) days of receipt, the Prepaid Dental Health Plan shall respond in writing to notices of system problems; and

(b) Within twenty (20) days, the correction shall be made or a requirements analysis and specifications document shall be due.

(2) The Prepaid Dental Health Plan shall correct the deficiency by an effective date to be determined by the Agency.

c. Valid Window for Certain System Changes. Unless otherwise agreed to in advance by the Agency as part of the activities described in this Section, scheduled system unavailability to perform system maintenance, repair, and/or upgrade activities shall not take place during hours that could compromise or prevent critical business operations.

d. Testing

(1) The Prepaid Dental Health Plan shall work with the Agency pertaining to any testing initiative as required by the Agency.

(2) Upon the Agency's written request, the Prepaid Dental Health Plan shall provide details of the test regions and environments of its core production information systems, including a live demonstration, to enable the Agency to corroborate the readiness of the Prepaid Dental Health Plan's information systems.

(3) The Prepaid Dental Health Plan shall be required to complete system integration testing with the Agency for enhancements and future initiatives, when needed.

6. Information Systems Documentation Requirements

a. Types of Documentation. The Prepaid Dental Health Plan shall develop, prepare, print, maintain, produce, and distribute distinct system process and procedure manuals, user manuals, and quick-reference guides, and any updates thereafter, for the Agency and other applicable Agency staff.

b. Content of System Process and Procedure Manuals. The Prepaid Dental Health Plan shall ensure that written system process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.

c. Content of System User Manuals. The system user manuals shall contain information about, and instructions for, using applicable system functions and accessing applicable system data.

d. Changes to Manuals

(1) When a system change is subject to the Agency's written approval, the Prepaid Dental Health Plan shall draft revisions to the appropriate manuals prior to Agency approval of the change.

(2) Updates to the electronic version of these manuals shall occur in real time; updates to the printed version of these manuals shall occur within ten (10) business days of the update's taking effect.

e. Availability of/Access to Documentation. All of the aforementioned manuals and reference guides shall be available in printed form and/or online. If so prescribed, the manuals shall be published in accordance with the appropriate Agency and/or State standard.

7. Reporting Requirements

The Prepaid Dental Health Plan shall extract and upload data sets, upon request, to an Agency-hosted secure FTP site to enable authorized Agency personnel, or the Agency's agent, on a secure and read-only basis, to build and generate reports for management use. The Agency and the Prepaid Dental Health Plan shall arrange technical specifications for each data set as required for completion of the request.

8. Community Health Record/Continuity of Care Document/Electronic Enrollee Record and Related Efforts

a. At such times that the Agency requires, the Prepaid Dental Health Plan shall participate and cooperate with the Agency to implement, within a reasonable timeframe, secure, web-accessible, community health records for enrollees.

b. The design of the vehicle(s) for accessing the community health record/continuity of care document, the health record format, and design shall comply with all HIPAA and related regulations.

c. The Prepaid Dental Health Plan shall also cooperate with the Agency in the continuing development of the State's health care data site (www.FloridaHealthFinder.com).

d. The Prepaid Dental Health Plan shall provide to its staff and volunteers, initial and ongoing/periodic training on this Contract, including but not limited to HIPAA and the HITECH Act regarding the use and safeguarding of PHI.

9. Compliance with Standard Coding Schemes

a. Compliance with HIPAA-Based Code Sets. Prepaid Dental Health Plan systems that are required to or otherwise contain the applicable data type shall conform to the following HIPAA-based standard code sets; the processes through which the data are generated should conform to the same standards as needed; for example:

(1) LOINC;

(2) HCPCS;

(3) Home Infusion EDI Coalition Product Codes;

(4) NDC;

(5) NCPDP;

(6) ICD;

(7) DRG;

(8) CARC; and

(9) RARC.

b. Compliance with Other Code Sets. Prepaid Dental Health Plan systems that are required to or otherwise contain the applicable data type shall conform to the following non-HIPAA-based standard code sets:

(1) As described in all Agency Medicaid reimbursement handbooks, for all "covered entities," as defined under HIPAA, and which submit transactions in paper format (non-electronic format); and

(2) As described in all Agency Medicaid reimbursement handbooks for all "non-covered entities," as defined under HIPAA.

10. Data Exchange and Formats and Methods Applicable to Prepaid Dental Health Plans

a. HIPAA-Based Formatting Standards. Prepaid Dental Health Plan systems shall conform to the following HIPAA-compliant standards for EDI of health care data effective the first day of implementation in the applicable region(s). The Prepaid Dental Health Plan shall submit and receive transactions, ASC X12N or NCPDP (for certain pharmacy transactions), including claims and encounter information, payment and remittance advice, claims status, eligibility, enrollment and disenrollment, referrals and authorizations, coordination of benefits, and premium payment. The implementation specifications for ASC X12N standards may be obtained from the Washington Publishing Company on the Internet at http://www.wpc-edi.com/. Florida specifications may be obtained on the Florida Medicaid provider portal at: http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_CompanionGuides/tabId/62/default.aspx

Transaction types include, but are not limited to:

(1) ASC X12N 820 Payroll Deducted & Other Premium Payment

(2) ASC X12N 834 Enrollment and Audit Transaction

(3) ASC X12N 835 Claims Payment Remittance Advice Transaction

(4) ASC X12N 837I Institutional Claim/Encounter Transaction

(5) ASC X12N 837P Professional Claim/Encounter Transaction

(6) ASC X12N 270/271 Eligibility/Benefit Inquiry/Response

(7) ASC X12N 276 Claims Status Inquiry

(8) ASC X12N 277 Claims Status Response

(9) ASC X12N 278/279 Utilization Review Inquiry/Response

(10) NCPDP D.0 Pharmacy Claim/Encounter Transaction

b. Methods for Data Exchange

(1) The Prepaid Dental Health Plan and the Agency and/or its agent shall make predominant use of SFTP and EDI in their exchanges of data.

(2) The Prepaid Dental Health Plan shall encourage network providers to participate in the Agency's DSM service.

c. Agency-Based Formatting Standards and Methods. Prepaid Dental Health Plan systems shall exchange the following data with the Agency and/or its agent in formats specified by the Agency:

(1) Provider network data;

(2) Case management fees; and

(3) Payments.

11. Smartphone Applications

a. The Prepaid Dental Health Plan shall develop and maintain procedures regarding the use of social networking or smartphone applications (apps).

b. If the Prepaid Dental Health Plan uses apps to allow enrollees direct access to Agency-approved enrollee materials, the Prepaid Dental Health Plan shall comply with the following:

(1) The smartphone application shall disclaim that the app being used is not private and that no PHI or personally identifying information should be published on this application by the Prepaid Dental Health Plan or end user; and

(2) The Prepaid Dental Health Plan shall ensure that software applications obtained, purchased, leased, or developed are based on secure coding guidelines.

12. Social Networking

a. The Prepaid Dental Health Plan shall adhere to the following user requirements for procedure development, permitted uses of apps, and acceptable content for social networking applications/tools in performance of this Contract. These requirements shall apply to all interactions/communications by the Prepaid Dental Health Plan or its subcontractors with enrollees, providers, and website requirements, when conducted

through social networking applications.

b. The Prepaid Dental Health Plan is vicariously liable for any social networking violations of its employees, agents, volunteers, providers, or subcontractors.

c. User Requirements

(1) The Prepaid Dental Health Plan's presence on such social networking sites must include an avatar and/or a username that clearly indicates the Prepaid Dental Health Plan that is being represented and cannot use any Agency logo or State of Florida seal. When registering for social networking applications, the Prepaid Dental Health Plan shall use its email address. If the application/tool requires a username, the following syntax shall be used: http://twitter.com/<Prepaid Dental Health Plan_identifier><username>.

(2) The enrollee or prospective enrollee, or friend/follower, and not the Prepaid Dental Health Plan, must initiate all Social Networking interactions/communications. Any communication resulting from such a subscription shall include a link/method to opt-out of the subscription.

(3) The Prepaid Dental Health Plan shall place photographs on pages that are hosted on the site and not linked from outside Web pages. The Prepaid Dental Health Plan shall not post information, photos, links/URLs or other items online that would reflect negatively on any individual(s), its enrollees, the Agency or the State.

(4) The Prepaid Dental Health Plan shall not tag photographic or video content and must remove all tags placed by others upon discovery.

d. Functionalities

The following functionalities are prohibited:

(1) Authoring – The ability to create and update content leads to the collaborative work of many rather than just a few Web authors such as in wikis and/or blogs. In wikis, users may extend, undo and redo each other's work. In blogs, posts and the comments of individuals build up over time;

(2) Tags – Categorization of content by users adding one-word descriptions to facilitate searching, without dependence on pre-made categories;

(3) Extensions – Software that makes the Web an application platform as well as a document server; and

(4) Forums – Sites hosted by a company that allow users to create topics (threads) and post comments, questions, etc., that are available for public conversation among all members in the forum.

E. Encounter Data Requirements

1. General Provisions

a. Encounter data collection and submission is required from the Prepaid Dental Health Plan for all services, including expanded benefits, rendered to its enrollees (excluding services paid directly by the Agency through the FFS delivery system). The Prepaid Dental Health Plan shall submit encounter data that meets established Agency data quality standards as defined herein. These standards are defined by the Agency to ensure receipt of complete and accurate data for program administration and to set actuarially sound capitation rates. These standards are closely monitored and enforced. (42 CFR 438.242(b)(1); 42 CFR 438.604(a)(1); 42 CFR 438.606; 42 CFR 438.818)

b. The Prepaid Dental Health Plan shall receive amended standards with advance notice as described in this Section to ensure continuous QI. The Prepaid Dental Health Plan shall make changes or corrections to any systems, processes, or data transmission formats as needed to comply with the Agency's data quality standards. The Prepaid Dental Health Plan shall receive:

  (1) No notice for Medicaid Companion Guide updates that are informational and/or limited to clarification of existing standards, or setting an edit from deny to pay.

  (2) Thirty (30) days' notice for setting a pay edit to deny or informing the plan of new CARC and RARC combinations.

  (3) Sixty (60) days' notice for adding a new and unique plan-related edit.

  (4) Ninety (90) days' notice of a system change resulting in a process change for the Prepaid Dental Health Plan.

  The Prepaid Dental Health Plan shall be capable of sending and receiving any claims information directly to the Agency meeting the above standards and timeframes.

c. The Prepaid Dental Health Plan shall certify all data to the extent required in 42 CFR 438.606. Such certification must be submitted to the Agency concurrently with the data and must be based on the knowledge, information and belief of the CEO, CFO, Chief Medical Officer or an individual who has written delegated authority to sign for, and directly reports to the CEO or CFO that all data submitted in conjunction with the encounter data and all documents requested by the Agency are accurate, truthful, and complete. (42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c))

d. The Prepaid Dental Health Plan shall have the capacity to identify encounter data anomalies and shall provide a description of that process to the Agency for review and approval.

e. The Prepaid Dental Health Plan shall designate sufficient IT and staffing resources to perform these encounter functions as determined by generally accepted best industry practices.

f. The Prepaid Dental Health Plan shall retain submitted encounter data for a period not

less than ten (10) years as specified in the Standard Contract, Section I., Item D., Retention of Records.

g. The Prepaid Dental Health Plan shall participate in Agency-sponsored workgroups directed at continuous improvements in encounter data quality and processes.

2. Requirements for Complete and Accurate Encounters

a. The Prepaid Dental Health Plan shall have a comprehensive automated and integrated encounter data system capable of meeting the requirements below:

b. All Prepaid Dental Health Plan encounters shall be submitted to the Agency in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P — Professional; D — Dental). The Prepaid Dental Health Plan's encounters shall also follow the standards in the Agency's 5010 Companion Guides, the Florida D.0 Payer Specification – Encounters and in this Section. Encounters must include Prepaid Dental Health Plan amounts paid to the providers and shall be submitted for all providers (capitated and non-capitated).

c. The Prepaid Dental Health Plan shall convert all information that enters its claims system via hard copy paper claims or other proprietary formats to encounter data to be submitted in the appropriate HIPAA-compliant formats.

d. For any services in which a Prepaid Dental Health Plan has entered into capitation reimbursement arrangements with providers, the Prepaid Dental Health Plan shall comply with all encounter data submission requirements in this Section. The Prepaid Dental Health Plan shall require timely submissions from its providers as a condition of the capitation payment.

e. The Prepaid Dental Health Plan shall implement and maintain review procedures to validate encounter data submitted by providers.

f. The Prepaid Dental Health Plan shall submit complete, accurate and timely encounter data to the Agency as defined below.

g. For all services rendered to its enrollees (excluding services paid directly by the Agency through the FFS delivery system), the Prepaid Dental Health Plan shall submit encounter data, without alteration or omission of provider submitted data, no later than seven (7) days following the date on which the Prepaid Dental Health Plan adjudicated the claims. The Prepaid Dental Health Plan may append to the provider-submitted data the Prepaid Dental Health Plan data required by the Agency as described in the Medicaid Companion Guides.

h. The Prepaid Dental Health Plan shall provide complete and accurate encounters to the Agency. The Prepaid Dental Health Plan shall implement review procedures to validate encounter data submitted by providers.

(1) Complete: The Prepaid Dental Health Plan shall submit encounters for ninety-five percent (95%) of the covered services provided by participating and non-participating providers, as defined in D.1. of this Sub-Section.

(2) Accurate: No less than ninety-five percent (95%) of the Prepaid Dental Health Plan's encounter lines submission shall pass FMMIS system edits as specified by the Agency.

i. For encounter data acceptance purposes the Prepaid Dental Health Plan shall ensure the provider information it supplies to the Agency is sufficient to ensure providers are recognized in FMMIS.

j. The Prepaid Dental Health Plan shall ensure all encounter data submissions include the actual amount paid to providers.

3. Encounter Data Submission

a. The Prepaid Dental Health Plan shall collect and submit encounter data to the Agency's fiscal agent. The Prepaid Dental Health Plan shall be held responsible for errors or noncompliance resulting from their own actions or the actions of an agent authorized to act on its behalf.

b. The encounter data submission standards required to support encounter data collection and submission are defined by the Agency in the Medicaid Companion Guides, Pharmacy Payer Specifications and this Section. In addition, encounter data reporting requirements shall be posted on the following websites:

http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_CompanionGuides/tabId/62/Default.aspx

http://portal.flmmis.com/flpublic/Provider_ManagedCare/Provider_ManagedCare_Encounter/Provider_ManagedCare_Pharmacy/tabid/82/desktopdefault/+/Default.aspx.

c. The Prepaid Dental Health Plan shall implement and maintain review procedures to validate the successful loading of encounter files by the Agency's fiscal agent's EDI clearinghouse. The Prepaid Dental Health Plan shall use the EDI response (acknowledgement) files to determine if files were successfully loaded. Within seven (7) days of the original submission attempt, the Prepaid Dental Health Plan shall correct and resubmit files that fail to load.

d. Encounter Resubmission – Adjustments, Reversals or Corrections

(1) Within thirty (30) days after encounters fail X12 (EDI) edits or FMMIS system edits, the Prepaid Dental Health Plan shall correct and resubmit all encounters for which errors can be remedied.

(2) The Prepaid Dental Health Plan shall correct and resubmit one hundred percent (100%) of previously submitted X12 encounter data transactions to reflect the most current and accurate payment adjustments or reversals that resulted in a recoupment or additional payment within thirty (30) days of the respective action.

e. If the Prepaid Dental Health Plan fails to comply with the encounter data reporting requirements of this Contract, the Prepaid Dental Health Plan may be subject to sanctions pursuant to Section XIII., Sanctions, or liquidated damages pursuant to Section XIV., Liquidated Damages.

F. Fraud and Abuse Prevention

1. General Provisions

a. The Prepaid Dental Health Plan shall establish functions and activities governing program integrity in order to reduce the incidence of fraud and abuse and shall comply with all State and federal program integrity requirements, including but not limited to the applicable provisions of the Social Security Act, ss. 1128, 1902, 1903, and 1932; 42 CFR 431, 433, 434, 435, 438, 441, 447, 455; 45 CFR Part 75; Chapters 409, 414, 458, 459, 460, 461, 626, 641 and 932, F.S., and Rules 59A-12.0073, 59G and 69D-2, F.A.C.; 2 CFS Part 200 and 2 CFR 300.1.

b. The Prepaid Dental Health Plan shall have adequate Florida-based staffing and resources to enable the compliance officer to investigate indicia of fraud, abuse, waste and develop and implement CAPs relating to fraud, abuse, waste and overpayment.

c. The Prepaid Dental Health Plan's written fraud and abuse prevention program shall have internal controls and procedures in place that are designed to prevent, reduce, detect, investigate, correct and report known or suspected fraud, abuse, and waste activities. This shall include reporting instances of fraud and abuse pursuant to 42 CFR 438.608, ss. 409.91212, 626.989, and 641.3915, F.S.

d. In accordance with s. 6032 of the federal Deficit Reduction Act of 2005, the Prepaid Dental Health Plan shall make available written fraud and abuse policies to all employees. If the Prepaid Dental Health Plan has an employee handbook, the Prepaid Dental Health Plan shall include specific information about s. 6032, the Prepaid Dental Health Plan's policies, and the rights of employees to be protected as whistleblowers.

e. The Prepaid Dental Health Plan shall meet with the Agency periodically, at the Agency's request, to discuss fraud, abuse, neglect, exploitation and overpayment issues.

f. The Agency may impose sanctions and/or liquidated damages for failure to timely comply with the provisions of this Section.

2. Compliance Officer

The Prepaid Dental Health Plan's compliance officer as described in Section X., Administration and Management, shall have unrestricted access to the Prepaid Dental Health Plan's governing body for compliance reporting, including fraud, abuse, waste and overpayment.

3. Fraud Investigation Unit

a. The Prepaid Dental Health Plan shall establish and maintain a fraud investigative unit to investigate possible acts of fraud, abuse, waste, or overpayment, or may subcontract such functions.

b. If a Prepaid Dental Health Plan subcontracts for the investigation of fraudulent claims and other types of program abuse by enrollees or service providers, the Prepaid Dental

Health Plan shall file the following with the Bureau of MPI for approval at least sixty (60) days before subcontract execution:

(1) The names, addresses, telephone numbers, email addresses and fax numbers of the principals of the entity with which the Prepaid Dental Health Plan wishes to subcontract;

(2) A description of the qualifications of the principals of the entity with which the Prepaid Dental Health Plan wishes to subcontract; and

(3) The proposed subcontract.

c. The Prepaid Dental Health Plan shall submit to MPI such executed subcontracts, attachments, addendums or amendments thereto, within thirty (30) days after execution.

4. Compliance Plan and Anti-Fraud Plan

a. The Prepaid Dental Health Plan shall submit its compliance plan and anti-fraud plan, including its fraud and abuse procedures, and any changes to these items, to MPI for written approval at least forty-five (45) days before those plans and procedures are implemented. (ss. 409.91212, F.S., and 409.967(2)(g), F.S.) The Prepaid Dental Health Plan shall submit these documents via the MPI-MC SFTP site. Failure to implement an MPI approved anti-fraud plan within ninety (90) days may result in liquidated damages. MPI may reassess the implementation of the anti-fraud plan every ninety (90) days until MPI deems the Prepaid Dental Health Plan to be in compliance. (Section XIV., Liquidated Damages.)

b. At a minimum, the Prepaid Dental Health Plan shall submit its compliance plan to MPI September 1 of each Contract year. The compliance plan shall comply with 42 CFR 438.608 and include:

(1) Written policies, procedures and standards of conduct that articulate the Prepaid Dental Health Plan's commitment to comply with all applicable federal and State standards;

(2) The designation of a compliance officer and a compliance committee accountable to senior management;

(3) Effective training and education of the compliance officer and the Prepaid Dental Health Plan's employees;

(4) Effective lines of communication between the compliance officer and the Prepaid Dental Health Plan's employees;

(5) Enforcement of standards through well-publicized statutory and contractual requirements and related disciplinary guidelines;

(6) Provision for internal monitoring and auditing; and

(7) Provisions for prompt response to detected offenses and for development of

corrective action initiatives.

c. At a minimum, the Prepaid Dental Health Plan shall submit its anti-fraud plan to MPI September 1 of each Contract year. The anti-fraud plan shall comply with s. 409.91212, F.S., and, at a minimum, must include:

(1) A written description or chart outlining the organizational arrangement of the Prepaid Dental Health Plan's personnel who are responsible for the investigation and reporting of possible overpayment, abuse or fraud;

(2) A description of the Prepaid Dental Health Plan's procedures for detecting and investigating possible acts of fraud, abuse and overpayment;

(3) A description of the Prepaid Dental Health Plan's procedures for the mandatory reporting of possible overpayment, abuse or fraud to MPI;

(4) A description of the Prepaid Dental Health Plan's program and procedures for educating and training personnel on how to detect and prevent fraud, abuse, waste and overpayment;

(a) At a minimum, training shall be conducted within thirty (30) days of new hire and annually thereafter;

(b) The Prepaid Dental Health Plan shall have a methodology to verify training occurs as required; and

(c) The Prepaid Dental Health Plan shall also include Deficit Reduction Act requirements in the training curriculum.

(5) The name, address, telephone number, email address and fax number of the individual responsible for carrying out the anti-fraud plan; and

(6) A summary of the results of the investigations of fraud, abuse, waste, or overpayment which were conducted during the previous fiscal year by the Prepaid Dental Health Plan's fraud investigative unit. For purposes of this summary, a case includes any action, whether an investigation, audit, provider payment review, provider on-site review, or other provider-specific evaluation. This summary shall include information pertaining to the State fiscal year that concluded immediately prior to the submission of this report. This summary shall include:

(a) Total number of cases opened;

(b) Total number of cases closed;

(c) Total number of cases that remain open as of the last day of the previous fiscal year;

(d) Total of overpayments identified for recovery which were identified as waste;

(e) Total amount of overpayments identified for recovery which were identified as fraud or abuse;

(f) Total amount of overpayments identified as waste which were actually recovered; and

(g) Total amount of overpayments identified as fraud or abuse that was actually recovered.

(42 CFR 438.608(a); 42 CFR 438.608(a)(1)(i)-(vii); 42 CFR 438.604(a)(7); 42 CFR 438.606; 42 CFR 438.608(d)(3))

d. At a minimum, the Prepaid Dental Health Plan's compliance plan, anti-fraud plan, and fraud and abuse procedures shall comply with s. 409.91212, F.S., and with the following:

(1) Ensure that all officers, directors, managers and employees know and understand the provisions;

(2) Include procedures designed to prevent and detect potential or suspected fraud and abuse in the administration and delivery of services under this Contract. Nothing in this Contract shall require that the Prepaid Dental Health Plan assure that non-participating providers are compliant with this Contract, but the Prepaid Dental Health Plan is responsible for reporting suspected fraud and abuse by non-participating providers when detected;

(3) Describe the Prepaid Dental Health Plan's organizational arrangement of anti-fraud personnel, their roles and responsibilities, including a description of the internal investigational methodology and reporting protocols. Such internal investigational methodology and reporting protocols shall ensure the unit's primary purpose is for the investigation (or supervision of the investigation) of suspected insurance/Medicaid fraud and fraudulent claims;

(4) Describe the method(s), including detailed procedures that include provisions to verify, by sampling or other methods, delivery of services by network providers to enrollees. Such methods include, but are not limited to, electronic verification, biometric technology, sending enrollee explanations of Medicaid benefits, contacting enrollees by telephone, mailing enrollees a questionnaire, contacting a representative sample of enrollees, or sampling enrollees based on business analyses; (42 CFR 438.608(a)(5)

(5) Incorporate a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to:

(a) An effective pre-payment and post-payment review process, including but not limited to data analysis, claims and other system edits, and auditing of participating providers. (s. 409.967(2)(g), F.S.);

(b) Provider profiling, credentialing, and recredentialing, and ongoing provider monitoring including a review process for claims and encounters that shall include providers and non-participating providers who:

(i) Demonstrate a pattern of submitting falsified encounter data or service reports;

(ii) Demonstrate a pattern of overstated reports or up-coded levels of service;

(iii) Alter, falsify, or destroy enrollee record documentation;

(iv) Make false statements related to credentials;

(v) Misrepresent medical information to justify enrollee referrals;

(vi) Fail to render medically necessary covered services they are obligated to provide according to their provider agreements;

(vii) Charge enrollees for covered services; and

(viii) Bill for services not rendered;

(c) Prior authorization;

(d) UM;

(e) Subcontract and provider agreement provisions;

(f) Provisions from the provider and the enrollee handbooks; and

(g) Standards for a code of conduct.

(42 CFR 438.608(a)(7))

(6) Contain provisions pursuant to this Section for the confidential reporting of Prepaid Dental Health Plan violations to MPI and other agencies as required by law;

(7) Include provisions for the investigation and follow-up of any reports;

(8) Ensure that the identities are protected for individuals reporting in good faith alleged acts of fraud and abuse;

(9) Require all suspected or confirmed instances of internal and external fraud and abuse relating to the provision of, and payment for, Medicaid services including but not limited to Prepaid Dental Health Plan employees/management, providers, subcontractors, vendors, delegated entities, or enrollees under State and/or federal law be reported to MPI within fifteen (15) days of detection, as specified in s. 409.91212, F.S., and in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide. Additionally, any final resolution reached by the Prepaid Dental Health Plan shall include a written statement that provides notice to the provider or enrollee that the resolution in no way binds the State of Florida nor precludes the State of

Florida from taking further action for the circumstances that brought rise to the matter;

(10) Ensure that the Prepaid Dental Health Plan and all providers and subcontractors, upon request and as required by State and/or federal law, shall:

(a) Make available to all authorized federal and State oversight agencies and their agents, including but not limited to the Agency, the Florida Attorney General, and DFS any and all administrative, financial and enrollee records and data relating to the delivery of items or services for which Medicaid monies are expended; (42 CFR 438.242(b)(4)) and

(b) Allow access to all authorized federal and state oversight agencies and their agents, including but not limited to the Agency, the Florida Attorney General, and DFS to any place of business and all enrollee records and data, as required by State and/or federal law. Access shall be during Normal Business Hours, except under special circumstances when the Agency, the Florida Attorney General, and DFS shall have After Hours admission. The Agency and the Florida Attorney General shall determine the need for special circumstances.

(11) Ensure that the Prepaid Dental Health Plan shall cooperate fully in any investigation by federal and State oversight agencies and any subsequent legal action that may result from such an investigation;

(12) Ensure that the Prepaid Dental Health Plan does not retaliate against any individual who reports violations of the Prepaid Dental Health Plan's fraud and abuse procedures or suspected fraud and abuse;

(13) Not knowingly employ or contract with individuals or entities debarred or excluded from participation in any federal health care program under ss. 1128 and 1128A of the Social Security Act, nor with an individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in 42 CFR 438.610 (a)(1); or subcontractors on the discriminatory vendor list maintained by the Department of Management Services in accordance with s. 287.134, F.S.; (42 CFR 438.808(a) and (b)(2); 42 CFR 431.55(h); 42 CFR 438.610(b); ss. 1128(b)(8) and 1903(i)(2) of the Social Security Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); State Medicaid Director Letters 6/12/08 and 1/16/09; Executive Order No. 12549)

(14) On at least a monthly basis check current staff, subcontractors and providers against the federal LEIE and the federal SAM (includes the former EPLS) or their equivalent, to identify excluded parties. The Prepaid Dental Health Plan shall also check monthly the Agency's listing of suspended and terminated providers at the Agency website below, to ensure the Prepaid Dental Health Plan does not include any non-Medicaid eligible providers in its network: http://apps.ahca.myflorida.com/dm_web.

The Prepaid Dental Health Plan shall also conduct these checks during the process of engaging the services of new employees, subcontractors and providers and during renewal of agreements and recredentialing. The Prepaid

Dental Health Plan shall not employ or contract with an entity that is in nonpayment status or is excluded from participation in federal health care programs under ss. 1128 and 1128A of the Social Security Act; (42 CFR 438.214(d)(1))

(15) Provide details and educate employees, subcontractors and providers about the following as required by s. 6032 of the federal Deficit Reduction Act of 2005:

(a) The Federal False Claims Act;

(b) The penalties and administrative remedies for submitting false claims and statements;

(c) Whistleblower protections under federal and State law;

(d) The entity's role in preventing and detecting fraud, waste and abuse;

(e) Each person's responsibility relating to detection and prevention; and

(f) The toll-free State telephone numbers for reporting fraud and abuse.

(16) If the Prepaid Dental Health Plan provides telemedicine, the Prepaid Dental Health Plan shall include procedures specific to prevention and detection of potential or suspected fraud and abuse of telemedicine in its fraud and abuse detection activities.

5. Retention Policy for the Treatment of Fraud, Abuse, and Waste Recoveries

a. The Prepaid Dental Health Plan shall diligently engage in efforts to recover overpayments. Where the recovery efforts are time barred by the provisions of section 641.3155, F.S., (hereinafter "time barred") and the Prepaid Dental Health Plan has properly reported the suspected fraud, abuse, or waste as required by 42 CFR 438.608 and s. 409.91212, F.S., recoveries made by the Agency may be shared with the Prepaid Dental Health Plan. Where the recovery efforts are time barred and the Prepaid Dental Health Plan has not properly reported the suspected waste, abuse, or fraud, recoveries made by the Agency are retained by the Agency. Where the recovery efforts are not time barred, the Prepaid Dental Health Plan retains the recoveries. However, the Agency may identify overpayments that are not time barred, and after notice to the Prepaid Dental Health Plan, if the Prepaid Dental Health Plan does not engage in recovery efforts and the Agency recovers the overpayments, the Agency will retain the recoveries. Prepaid Dental Health Plan subcontracts with providers shall ensure that providers are obligated to cooperate with recovery efforts, including participate in audits and repay overpayments.

b. In addition to the Prepaid Dental Health Plan's obligations to establish and maintain comprehensive program integrity efforts, the Prepaid Dental Health Plan shall maximize efforts to recover overpayments. Overpayments may be in the form of fraud, abuse, or waste.

c. The provisions of 42 CFR 438.608 and s. 409.91212, F.S., require the Prepaid Dental

Health Plan to timely report to the Agency's Bureau of MPI the identification of suspected or confirmed fraud, abuse, and waste.

(1) The Office of Attorney General, MFCU, and MPI evaluate reports of fraud. Fraud is further investigated, and as appropriate prosecuted or pursued civilly by MFCU or other law enforcement/prosecutorial entities. The Prepaid Dental Health Plan shall fully participate in fraud investigations and prosecutions, and may be entitled to recoveries related to fraud reports initiated by the Prepaid Dental Health Plan.

(2) The Agency's Bureau of MPI also evaluates abuse and waste. When MPI pursues recoveries related to abuse and waste, except as specified in this retention policy regarding time barred overpayments, the Agency retains the recoveries. MPI shall refrain from engaging in duplicative recovery efforts

d. The Prepaid Dental Health Plan shall ensure that all participating providers are required to cooperate with recovery efforts, including participate in audits and repay overpayments, whether such efforts are taken by the Prepaid Dental Health Plan, the Agency, MFCU, or other authorized entity.

6. Reporting and Disclosure Requirements

a. The Prepaid Dental Health Plan shall comply with all reporting requirements as set forth below and in 42 CFR 438.608 and s. 409.91212, F.S.

b. The Prepaid Dental Health Plan shall report on a quarterly basis a comprehensive fraud and abuse prevention activity report regarding its investigative, preventive and detective activity efforts, as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide

c. The Prepaid Dental Health Plan shall, by September 1 of each year, report to MPI its experience in implementing an anti-fraud plan, and on conducting or subcontracting for investigations of possible fraudulent or abusive acts during the prior State fiscal year, as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide. The report must include, at a minimum:

(1) The dollar amount of Prepaid Dental Health Plan losses and recoveries attributable to overpayment, abuse and fraud; and

(2) The number of Prepaid Dental Health Plan referrals to MPI.

d. The Prepaid Dental Health Plan shall notify DHHS OIG and MPI within ten (10) business days of discovery of individuals who have met the conditions giving rise to mandatory or permissive exclusions per s. 1128, s. 1156, and s.1892 of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1.

e. In accordance with 42 CFR 455.106, the Prepaid Dental Health Plan shall disclose to DHHS OIG, with a copy to MPI within ten (10) business days after discovery, the identity of any person who:

(1) Has ownership or control interest in the Prepaid Dental Health Plan, or is an agent or managing employee of the Prepaid Dental Health Plan; and

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

f. In addition to the disclosure required under 42 CFR 455.106, the Prepaid Dental Health Plan shall also disclose to DHHS OIG with a copy to MPI within ten (10) business days after discovery, the identity of any person described in 42 CFR 1002.3 and 42 CFR 1001.1001(a)(1), and to the extent not already disclosed, to additionally disclose any person who has ownership or control interest in a Prepaid Dental Health Plan participating provider, or subcontractor, or is an agent or managing employee of a Prepaid Dental Health Plan participating provider or subcontractor, and meets at least one of the following requirements:

(1) Has been convicted of a crime as identified in s. 1128 of the Social Security Act and/or conviction of a crime related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs;

(2) Has been denied entry into the Prepaid Dental Health Plan's network for program integrity-related reasons; or

(3) Is a provider against whom the Prepaid Dental Health Plan has taken any action to limit the ability of the provider to participate in the Prepaid Dental Health Plan's provider network, regardless of what such an action is called. This includes, but is not limited to, suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the program or Prepaid Dental Health Plan provider network to avoid a formal sanction.

g. The Prepaid Dental Health Plan shall submit the written notification referenced above to DHHS OIG as instructed by the Agency. Document information examples include, but are not limited to, court records such as indictments, plea agreements, judgments and conviction/sentencing documents.

h. The Prepaid Dental Health Plan shall notify MPI and provide a copy of any corporate integrity or corporate compliance agreements within thirty (30) days after execution of such agreements.

i. The Prepaid Dental Health Plan shall notify MPI and provide a copy of any CAPs required by the DFS and/or federal governmental entities, excluding the Agency, within thirty (30) days after execution of such plans.

j. The Prepaid Dental Health Plan shall query its potential non-provider subcontractors before contracting to determine whether the subcontractor has any existing or pending contract(s) with the Agency and, if any, notify MPI.

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Section XI. Method of Payment

A. General Provisions

1. The Agency will deny payments to the Prepaid Dental Health Plan for new enrollees when payment for those enrollees is denied by CMS based on the Agency's recommendation in accordance with 42 CFR 438.726(b) and 42 CFR 438.730(e).

2. In accordance with s. 409.967(3), F.S., the Agency will be responsible for verifying the Prepaid Dental Health Plan's ASR as specified in Section XI., Method of Payment in this Contract. The Agency will contract with independent certified public accountants (CPAs) to conduct compliance audits for the purpose of auditing Prepaid Dental Health Plan financial information in order to determine and validate the Prepaid Dental Health Plan's ASR.

B. Fixed Price Unit Contract

This is a fixed price (unit cost) Contract awarded through procurement. The Agency, through its fiscal agent, shall make payment to the Prepaid Dental Health Plan on a monthly basis for the Prepaid Dental Health Plan's satisfactory performance of its duties and responsibilities as set forth in this Contract.

C. Payment Provisions

1. Prepaid Dental Health Plans

a. Capitation Rates

(1) The Prepaid Dental Health Plan shall be paid the applicable capitation rate for each Medicaid-eligible enrollee whose name appears on the HIPAA-compliant X12 820 file for each month, except that the Agency will not pay for, and shall recoup, any part of the total payment for enrollment that exceeds the maximum authorized payment amount expressed in this Contract, as applicable. The total payment amount to the Prepaid Dental Health Plan shall depend upon the number of enrollees in each eligibility category and each rate group, as provided for by this Contract, or as adjusted pursuant to this Contract when necessary. The Prepaid Dental Health Plan is obligated to provide services pursuant to the terms of this Contract for all enrollees for whom the Prepaid Dental Health Plan has received capitation payment or for whom the Agency has assured the Prepaid Dental Health Plan that capitation payment is forthcoming. (42 CFR 438.3(c)(2))

(2) In accordance with ss. 409.968, 409.976 and 409.983, F.S., the capitation rates reflect historical utilization and spending for covered services projected forward.

(3) Utilization and expenditures for services by a provider outside the U.S. shall not be included in the development of capitation rates.

(4) The rates shall be actuarially sound in accordance with 42 CFR 438.6(c).

(5) The capitation rates shall be included in this Contract.

(6) The Agency may use, or may amend and use these rates, only after certification by its actuary and approval by CMS. Inclusion of these rates is not intended to convey or imply any rights, duties or obligations of either party, nor is it intended to restrict, restrain or control the rights of either party that may have existed independently of this Section of this Contract.

(7) By signature on this Contract, the parties explicitly agree that this Section shall not independently convey any inherent rights, responsibilities or obligations of either party, relative to these rates, and shall not itself be the basis for any cause of administrative, legal or equitable action brought by either party. In the event that the rates certified by the actuary and approved by CMS are different from the rates included in this Contract, the Prepaid Dental Health Plan agrees to accept a reconciliation performed by the Agency to bring payments to the Prepaid Dental Health Plan in line with the approved rates. The Agency may amend and use the CMS-approved rates by notice to the Prepaid Dental Health Plan through an amendment to this Contract.

(8) Unless otherwise specified in this Contract, the Prepaid Dental Health Plan shall accept the capitation payment received each month as payment in full by the Agency for all services provided to enrollees covered under this Contract and the administrative costs incurred by the Prepaid Dental Health Plan in providing or arranging for such services. Any and all costs incurred by the Prepaid Dental Health Plan in excess of the capitation payment shall be borne in total by the Prepaid Dental Health Plan.

(9) The Agency will pay the Prepaid Dental Health Plan a capitation rate for each newborn enrolled in a Prepaid Dental Health Plan, retroactive to the month of birth. (s. 409.977(3), F.S.)

(10) The Prepaid Dental Health Plan shall be responsible for payment of all covered services provided to newborns.

b. Rate Adjustments and Reconciliations

(1) The Prepaid Dental Health Plan and the Agency acknowledge that the capitation rates paid under this Contract are subject to approval by the federal government.

(2) The Prepaid Dental Health Plan and the Agency acknowledge that adjustments to funds previously paid, and to funds yet to be paid, may be required. Funds previously paid shall be adjusted when capitation rate calculations are determined to have been in error, or when capitation rate payments have been made for enrollees who are determined not to have been eligible for Prepaid Dental Health Plan membership during the period for which the capitation rate payments were made. In such events, the Prepaid Dental Health Plan and any subcontractor shall report to the State within sixty (60) days when it has identified capitation payments or other payments in excess of amounts specified in this Contract. The Prepaid Dental Health Plan agrees to refund any overpayment and

the Agency agrees to pay any underpayment. (42 CFR 438.608(c)(3))

(3) Capitation rates shall be adjusted to reflect budgetary changes in the Medicaid program. The rate of payment and total dollar amount may be adjusted with a properly executed amendment when Medicaid expenditure changes have been established through the appropriations process and subsequently identified in the Agency's operating budget. Legislatively-mandated changes shall take effect on the dates specified in the legislation. The Agency may not approve any Prepaid Dental Health Plan request for a rate increase unless sufficient funds to support the increase have been authorized in the General Appropriations Act. (s. 409.968(3), F.S.).

(4) In accordance with s. 409.967(3), F.S., the Prepaid Dental Health Plan's ASR shall be verified as specified in this Contract.

(5) The Agency will be responsible for adjusting applicable capitation rates to reflect budgetary changes in the Medicaid program.

c. Errors

The Prepaid Dental Health Plan shall carefully prepare all reports and monthly payment requests for submission to the Agency. If after preparation and electronic submission, the Prepaid Dental Health Plan discovers an error, including but not limited to errors resulting in capitated payments or other payments in excess of amounts specified in this Contract, either by the Prepaid Dental Health Plan or the Agency, the Prepaid Dental Health Plan has sixty (60) days from its discovery of the error, or sixty (60) days after receipt of notice by the Agency, to correct the error and re-submit accurate reports. Failure to respond within the sixty (60)-day period shall result in a loss of any money due to the Prepaid Dental Health Plan for such errors and/or sanctions against the Prepaid Dental Health Plan pursuant to Section XIII., Sanctions.

d. Enrollee Payment Liability Protection

(1) Pursuant to s. 1932(b)(6), Social Security Act (as enacted by Section 4704 of the Balanced Budget Act of 1997), the Prepaid Dental Health Plan shall not hold enrollees liable for debts of the Prepaid Dental Health Plan, in the event of the Prepaid Dental Health Plan's insolvency; (42 CFR 438.106(a))

(2) The Prepaid Dental Health Plan shall not hold enrollees liable for payment of covered services provided by the Prepaid Dental Health Plan if the Prepaid Dental Health Plan has not received payment from the Agency for the covered services, or if the provider, under contract or other arrangement with the Prepaid Dental Health Plan, fails to receive payment from the Agency or the Prepaid Dental Health Plan; (42 CFR 438.106(b)(1)-(2); 42 CFR 438.3(k); 42 CFR 438.230) and/or

(3) The Prepaid Dental Health Plan shall not hold enrollees liable for payments to a provider, including referral providers, that furnished covered services under a contract or other arrangements with the Prepaid Dental Health Plan, that are in

excess of the amount that normally would be paid by the enrollee if the covered services had been received directly from the Prepaid Dental Health Plan. (42 CFR 438.106(c); 42 CFR 438.3(k); 42 CFR 438.230)

e. Health Insurance Providers Fee

(1) General

Pursuant to Section 26 CFR Part 57 (2013) (the applicable regulations providing guidance to section 9010 of the ACA), the Prepaid Dental Health Plan is required to pay the "Health Insurance Providers" Fee annually. The Agency will pay the portion of this fee specifically related to the Prepaid Dental Health Plan's performance of this Contract with an adjustment related to the federal and State income tax impact of this Fee using the methodology described below under the following conditions:

(a) The entity which comprises the Prepaid Dental Health Plan or of which the Prepaid Dental Health Plan is a part and which is required to submit the IRS Form 8963 pursuant to the above mentioned federal regulations (referred to hereinafter as the "Reporting Plan") shall submit to the Agency a copy of the IRS Form 8963 submitted to the IRS by April 15 after each year for which it intends to be reimbursed.

(b) The Reporting Plan shall submit to the Agency a copy of the IRS Notice of final fee calculation (as described in 26 CFR s. 57.7) by September 5 after each year for which it intends to be reimbursed.

(c) The Reporting Plan shall submit its annual statement (which includes information pertinent to the tax impact of this subject fee) once it is issued for the preceding year for which it intends to be reimbursed.

(d) All documents listed above and any additional data or information requested by the Agency will be submitted with an attestation by the Reporting Plan in accordance with the certification requirements specified in Section XVI., Reporting Requirements, of this Contract. Following the determination of the amount to be reimbursed and the federal and State income tax impact related to this health insurance providers fee, the capitated per-member, per month fee for the Prepaid Dental Health Plan shall be timely reprocessed. This process is subject to approval by the Centers for Medicare and Medicaid Services and any change in federal or State law.

(2) Health Insurance Providers Fee Methodology

(a) Table 1 is to be used to enter revenue information for the data year related to the fee payment year. The data year is the year preceding the year in which the fee is to be paid. The total premiums taken into account are to be allocated proportionately to total premiums by State and line of business.

(b) The information in Table 1 will be used by the Agency to calculate the portion of the Health Insurance Providers Fee related to Medicaid activities

for the Reporting Plan using the formula (A / I) * J. The proportion denoted by (A / I) represents the percentage of total premiums taken into account related to Medicaid for the Reporting Plan, and J represents the total Health Insurance Providers Fee amount allocated to the Reporting Plan as documented by the Reporting Plan's IRS notice. Note that items I and J should be taken directly from the IRS memos received by the Reporting Plan.

Table 1
Florida AHCA
Illustrative Health Insurance Providers Fee Information Collection

Business Location	Medicaid Premiums Taken into Account	Other Health Insurance Premiums Taken into Account	Total Premiums Taken into Account
Florida	A	B	C = A + B
Other States	D	E	F = D + E
Total	G	H	I = G + H
Insurer Fee (Estimated or Final)		J	

(3) An actuarially sound approach will be developed to calculate the amount of federal and State income tax related to the Health Insurance Providers Fee.

f. Achieved Savings Rebate

(1) In order to be eligible to retain up to an additional one percent (1%) of revenue, the Prepaid Dental Health Plan shall achieve the performance measure rates as specified below.

(a) FFY 2018-19/Calendar Year 2019:
- Annual Dental Visit: 60% or higher
- Preventive Dental Services: 50% or higher

(b) FFY 2019-20/Calendar Year 2020:
- Annual Dental Visit: 60% or higher
- Preventive Dental Services: 50% or higher

(c) FFY 2020-21/Calendar Year 2021:
- Annual Dental Visit: 62% or higher
- Preventive Dental Services: 52% or higher

(d) FFY 2021-22/Calendar Year 2022:
- Annual Dental Visit: 63% or higher
- Preventive Dental Services: 54% or higher

(e) FFY 2022-23/Calendar Year 2023:
- Annual Dental Visit: 65% or higher
- Preventive Dental Services: 56% or higher

(2) In accordance with 42 CFR 438.6(b)(3)(i)-(iv), 42 CFR 438.340, s. 409.967(3),

F.S., and as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Report Guide, the Prepaid Dental Health Plan shall submit:

(a) Quarterly and annual unaudited ASR Financial Reports, and an annual financial statement audit conducted by an independent CPA;

(b) Quarterly and annual NAIC Financial Statements filed with the OIR and prepared in accordance with statutory accounting principles.

(3) The Prepaid Dental Health Plan shall pay to the Agency the expenses of the Agency's ASR audit at the rates established by the Agency. Expenses shall include actual travel expenses, reasonable living expense allowances, compensation of the CPA, and necessary attendant administrative costs of the Agency directly related to the audit/examination. The Prepaid Dental Health Plan shall pay the Agency within twenty-one (21) days after presentation by the Agency of the detailed account of the charges and expenses. Failure to pay shall result in liquidated damages as specified in Section XIV., Liquidated Damages.

(4) The Prepaid Dental Health Plan shall make available all books, accounts, documents, files and information that relate to the Prepaid Dental Health Plan's Medicaid transactions at a Florida location by the Agency's contracted CPA.

(a) The Prepaid Dental Health Plan shall cooperate in good faith with the Agency and the CPA.

(b) Records not in the Prepaid Dental Health Plan's immediate possession must be made available to the Agency or the CPA in the Florida location specified by the Agency or the CPA within three (3) days after a request is made by the Agency or the CPA. If original records are required, and they cannot be made available in a Florida location as specified herein, the Prepaid Dental Health Plan shall make the records available for the CPA to review at the applicable location and shall pay any expenses related to the CPA's review at that location.

(c) Failure to comply with such record requests, including failure to provide records, reports, and documentation to the Agency or CPA by the dates requested, shall be deemed a breach of Contract, and the Prepaid Dental Health Plan shall be subject to sanctions as specified in Section XIII., Sanctions.

(5) In accordance with s. 409.967(3)(g), F.S., and as specified below, if the Prepaid Dental Health Plan exceeds the Agency-defined quality measures as specified in the Contract, the Prepaid Dental Health Plan may retain up to an additional one percent (1%) of its revenue.

(a) Prepaid Dental Health Plans that meet the quality standards may retain up to one percent (1%) of ASR-allowed revenue associated with the component for which they meet the quality standards.

(b) The Agency may amend the performance measures and the thresholds required for an Prepaid Dental Health Plan to retain up to an additional one percent (1%) of revenue with sixty (60) days' advance notice.

(6) The Agency CPA shall validate the ASR, and the results shall be provided to the Agency. If the CPA validates the ASR submitted by the Prepaid Dental Health Plan in accordance with the Statewide Medicaid Prepaid Dental Health Plan Report Guide, these results shall be final and dispositive. If the CPA fails to validate the ASR submitted by the Prepaid Dental Health Plan, the Prepaid Dental Health Plan shall receive written notice of the CPA's findings and be provided with the opportunity to review and respond to the CPA's findings in writing within the timeframe specified by the Agency. The CPA shall review the Prepaid Dental Health Plan's response and issue final results. These results are dispositive.

(7) The Prepaid Dental Health Plan shall receive the final results of the audit, and the Prepaid Dental Health Plan shall pay the rebate to the Agency within thirty (30) days after the results are provided.

(8) The ASR is established by determining pretax income as a percentage of revenues and applying the following income ratios:

(a) One hundred percent (100%) of income up to and including five percent (5%) of revenue shall be retained by the Prepaid Dental Health Plan.

(b) Fifty percent (50%) of income above five percent (5%) and up to ten percent (10%) shall be retained by the Prepaid Dental Health Plan, and the other fifty percent (50%) refunded to the State.

(c) One hundred percent (100%) of income above ten percent (10%) of revenue shall be refunded to the State.

(9) As further specified in the Statewide Medicaid Prepaid Dental Health Plan Report Guide, for purposes of the ASR, retax income is defined as pre-tax revenue minus those expenses permitted in the Statewide Medicaid Prepaid Dental Health Plan Report Guide.

(10) Revenue includes but is not limited to all capitation premium payments made by the State to the Prepaid Dental Health Plan. Revenue does not include additions to, or components of, premium payments made to provide funds for payment of the ACA Section 9010 Health Insurance Providers Fee, or the additional amounts to provide for the payment of State premium taxes or federal income tax on such amounts. Revenue is to be reduced by the State premium tax or other State assessments based on the premium.

(11) Expenses generally include reasonable and appropriate medical expenses and general and administrative expenses, as determined by the Agency, other than interest expense, of operating the Prepaid Dental Health Plan in accordance with the requirements of this Contract. Any State premium tax or other State assessment based on premium that is treated as a reduction to premium revenue

cannot be included in the allowable expenses.

(12) In accordance with s. 409.967(3)(h), F.S., the following expenses are not allowable expenses for purposes of determining the pre-tax income subject to the ASR:

(a) Payment of ASRs;

(b) Any financial incentive payments made to the Prepaid Dental Health Plan outside of the capitation rate;

(c) Expenses associated with any lobbying or political activities;

(d) Cash value or equivalent cash value of bonuses of any type paid or awarded to the Prepaid Dental Health Plan's executive staff other than base salary;

(e) Reserves and reserve accounts other than those expressly permitted by the Statewide Medicaid Prepaid Dental Health Plan Report Guide;

(f) Administrative costs in excess of actuarially sound maximum amounts set by the Agency; and

(g) Other costs excluded in accordance with 42 CFR 438.6.

(13) The actuarially sound maximum amount for administrative costs shall be set by the Agency in consultation with the actuary developing the capitation rates as part of the rate setting process.

(14) In accordance with s. 409.967(3)(i), F.S., if the Prepaid Dental Health Plan incurs a loss in the first year of operation subject to the achieved saving rebate, it may apply the full amount of such loss as an offset to income in the second year. If the Prepaid Dental Health Plan elects to carry forward such a loss, then the life-years of coverage for the first year of coverage shall also carry over to the second year.

(15) In accordance with s. 409.967(3)(j), F.S., if the Agency later determines that the Prepaid Dental Health Plan owes an additional rebate, the Prepaid Dental Health Plan shall have thirty (30) days after notification by the Agency to make payment. If the Prepaid Dental Health Plan fails to pay the rebate, future payments shall be withheld until the entire amount of the rebate is recouped. If the Agency determines that the Prepaid Dental Health Plan made an overpayment, the Prepaid Dental Health Plan shall be returned the overpayment within thirty (30) days of such determination.

(16) If the Prepaid Dental Health Plan purchases or acquires part or all of the business of another Prepaid Dental Health Plan, the Prepaid Dental Health Plan's information and reports regarding its ASR shall include information for the purchased business, including for that part of the reporting period that was prior to the purchase. If the Prepaid Dental Health Plan is unable to include information for the purchased business prior to the purchase date, the Prepaid Dental Health

Plan shall pay for the cost of the audit for the reporting period prior to the purchase date.

(17) If the Prepaid Dental Health Plan's enrollment in a reporting period is fewer than five thousand (5,000) life-years, the Prepaid Dental Health Plan shall not owe a rebate for the reporting period. However, the information from that reporting period shall be carried over and included with information for the next reporting period. When the cumulative life-years of such combined reporting periods equal or exceed five thousand (5,000) life-years, the achieved saving rebate calculation shall be performed.

(18) If the Agency determines that payment of an ASR by the Prepaid Dental Health Plan would result in the Prepaid Dental Health Plan being put at significant risk of insolvency, the Agency may defer all or a portion of the rebate payment owed by the Prepaid Dental Health Plan.

(19) The ASR shall be calculated in accordance with s. 409.967(3)(f), F.S., as illustrated below.

Note: The following three (3) increments shall be applied to the Prepaid Dental Health Plan's (Plan's) pre-tax income (AKA: net operating income [NOI])

Achieved Savings Rebates Table – Effective 8/1/2018 – 12/31/2023			
	NOI Range Category	**Amount Prepaid Dental Health Plans shall retain**	**Amount Prepaid Dental Health Plans shall be required to refund to the Agency**
I	NOI ranging from Zero (0) up to and including five percent (5%) of the Prepaid Dental Health Plan's premium revenue:	Prepaid Dental Health Plans shall retain 100% of NOI within this range.	Prepaid Dental Health Plans shall not be required to refund any of their NOI within this range.
II	NOI above five percent (5%) and up to and including ten percent (10%) of the Prepaid Dental Health Plan's premium revenue:	Prepaid Dental Health Plans shall retain 50% of the NOI within this range.	Prepaid Dental Health Plans shall be required to refund 50% of the NOI within this range.
III	NOI above ten percent (10%) of the Prepaid Dental Health Plan's premium revenue:	Prepaid Dental Health Plans shall not be allowed to retain any of the NOI within this range.	Prepaid Dental Health Plans shall have to refund to the Agency 100% of the NOI within this range.

Example: If the Prepaid Dental Health Plan's premium revenues are **$1,000,000** and allowed expenses are **$850,000**, the Prepaid Dental Health Plan has a pre-tax net operating income (NOI) of **$150,000**. The NOI is calculated to be 15% of premium revenue (NOI/Revenue):

NOI Range as Percent of Revenue	**Plan Retains**		**Plan Refunds to the State**	
0.00% to 5.00% = **$50,000.00**	100% of NOI within this range	**$50,000.00**	0% of NOI within this range:	**$0.00**

5.00% to 10.00% = **$50,000.00**	50% of NOI within this range	**$25,000.00**	50% of NOI within this range:	**$25,000.00**
above 10.00% = **$50,000.00**	0% of NOI within this range	**$0.00**	100% of NOI within this range:	**$50,000.00**
TOTAL = **$150,000.00**		**$75,000.00**		**$75,000.00**

g. Value Based Purchasing Programs

The Prepaid Dental Health Plan shall develop and implement a value-based purchasing program to reduce costs associated with preventable care and improved dental outcomes. The Agency reserves the right to develop mandatory program parameters, performance metrics, and alternative payment methodologies at a later date.

h. Incentive Arrangements

The Agency reserves the right, beginning in the second year of the Contract, to withhold a percentage of the Prepaid Dental Health Plan's capitation rate, with the withhold to be released only if the Prepaid Dental Health Plan meets specific performance standards during a timeframe to be specified by the Agency. The Agency will be responsible for developing the methodology associated with this withhold arrangement.

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Section XII. Financial Requirements

The Prepaid Dental Health Plan shall meet all financial requirements established by this Contract and report financial information, including but not limited to quarterly and annual financial statements, in accordance with Section XVI., Reporting Requirements, the Statewide Medicaid Prepaid Dental Health Plan Report Guide and other Agency instructions. The Prepaid Dental Health Plan shall certify that information it submits to the Agency is accurate, truthful, and complete in accordance with 42 CFR 438.606.

A. Insolvency Protection

1. Insolvency Protection Requirements

a. The Prepaid Dental Health Plan shall establish a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in Florida in accordance with s. 1903(m)(1) of the Social Security Act (amended by s. 4706 of the Balanced Budget Act of 1997). The Prepaid Dental Health Plan shall deposit into that account five percent (5%) of the capitation payments made by the Agency each month until a maximum total of two percent (2%) of the annualized total current Contract amount is reached and maintained. No interest may be withdrawn from this account until the maximum Contract amount is reached and withdrawal of the interest shall not cause the balance to fall below the required maximum amount. This provision shall remain in effect as long as the Prepaid Dental Health Plan continues this Contract with the Agency.

b. The restricted insolvency protection account may be drawn upon with the authorized signatures of two (2) persons designated by the Prepaid Dental Health Plan and two (2) representatives of the Agency. The Multiple Signature Verification Agreement Form shall be resubmitted to the Agency within thirty (30) days of Contract execution and resubmitted within thirty (30) days after a change in authorized Prepaid Dental Health Plan personnel occurs. If the authorized persons remain the same, the Prepaid Dental Health Plan shall submit to the Agency an attestation to this effect April 1 of each Contract year to the Agency along with a copy of the latest bank statement. The Prepaid Dental Health Plan may obtain a sample Multiple Signature Verification Agreement form from the Agency or its agent or download from the Agency website at:

   http://ahca.myflorida.com/Medicaid/statewide_mc/report_guide.shtml .

   The Prepaid Dental Health Plan shall submit all such agreements or other signature cards to the Agency for prior approval.

c. In the event that the Agency determines the Prepaid Dental Health Plan is insolvent, the Agency may draw upon the amount solely with the two (2) authorized signatures of representatives of the Agency, and the Agency may disburse funds to meet financial obligations incurred by the Prepaid Dental Health Plan under this Contract. A statement of account balance shall be provided by the Prepaid Dental Health Plan within fifteen (15) days of the request from the Agency.

d. If the Agency terminates or does not renew this Contract, the Agency will release the

account balance to the Prepaid Dental Health Plan upon receipt of proof of satisfaction of all outstanding obligations incurred under this Contract.

e. In the event the Agency terminates or does not renew this Contract and the Prepaid Dental Health Plan is insolvent, the Agency may draw upon the insolvency protection account to pay any outstanding debts the Prepaid Dental Health Plan owes the Agency, including, but not limited to, overpayments made to the Prepaid Dental Health Plan and fines imposed under this Contract or, for HMOs, s. 641.52, F.S. and for health insurers, Chapter 624, F.S., for which a final order has been issued. In addition, if the Agency terminates or does not renew this Contract, and the Prepaid Dental Health Plan is unable to pay all of its outstanding debts to health care providers, the Agency and the Prepaid Dental Health Plan shall agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to the Agency priority over other claims.

2. Insolvency Protection Account Waiver

The Agency may waive the insolvency protection account in writing when evidence of adequate insolvency insurance and reinsurance are on file with the Agency to protect enrollees in the event the Prepaid Dental Health Plan is unable to meet its obligations. (42 CFR 438.6(b)(1))

3. Insolvency Protection Investment Option

a. At the discretion of and upon written permission granted by the Agency, a Prepaid Dental Health Plan that has fully funded their restricted insolvency protection account in accordance with this Section, and has met surplus requirements in accordance with this Section for the previous six (6) consecutive quarters may invest the full value of the required insolvency protection account balance in U.S. Treasury Securities (Securities) which are backed by the full faith and credit of the U.S. government through the utilization of a custodial account at a federally guaranteed financial institution licensed to do business in Florida in accordance with s. 1903(m)(1) of the Social Security Act (amended by s. 4706 of the Balanced Budget Act of 1997), and s. 409.912, F.S. A listing of approved Securities is specified in the table below. Securities held in the custodial account shall not be pledged to any entity other than the Agency, and trading on margin shall be prohibited.

b. The Prepaid Dental Health Plan shall safeguard against potential losses in value by depositing an additional amount equal to the estimated decrease in account value that would occur for a one hundred (100) basis points (1%) increase in the Federal Funds rate. The amount of this deposit shall be approved by the Agency upon account inception and can be held in either Securities or cash.

c. The custodial investment insolvency protection account may be drawn upon with the authorized signatures of two (2) persons designated by the Prepaid Dental Health Plan and two (2) representatives of the Agency. The Multiple Signature Verification Agreement for Custody Arrangements Form shall be submitted to the Agency within thirty (30) calendar days of account execution and resubmitted within thirty (30) calendar days after a change in authorized Prepaid Dental Health Plan personnel occurs. If the authorized persons remain the same, the Prepaid Dental Health Plan

shall submit an attestation to this effect April 1 of each Contract year to the Agency along with a copy of the latest bank statement and summary of transactions for the month prior.

d. The Prepaid Dental Health Plan assumes sole responsibility for monitoring the custodial investment insolvency account to ensure the total value of all Securities shall not fall below the required insolvency protection account balance pursuant this Section. The Prepaid Dental Health Plan shall submit to the Agency a monthly account valuation within fifteen (15) calendar days after the end of each reporting month. The monthly account valuation shall include a complete transaction history of purchased and/or sold Securities within the reporting period, the custodial investment insolvency protection account balance, and shall take into consideration all factors that may affect the total value of the custodial investment insolvency protection account. In the event that the total value of the custodial investment insolvency protection account is less than the required insolvency protection account balance at any time, the Prepaid Dental Health Plan shall make a capital contribution in the form of cash and/or Securities within five (5) business days equal to the difference between the current value and the required insolvency protection account balance. Documentation evidencing this contribution shall be included with the monthly valuation. Should the Prepaid Dental Health Plan fail to maintain the required insolvency protection account balance, the Agency, at its sole discretion, reserves the right to require the Prepaid Dental Health Plan to re-establish a restricted insolvency protection account in accordance with Section X.A.1. (42 CFR 438.604(a)(4); 42 CFR 438.606)

e. The Agency, at its sole discretion, may require the plan to re-establish a restricted insolvency protection account in accordance with this Section. The re-established account shall be funded by the liquidated proceeds of all Securities held in the insolvency protection investment account at the time the Agency required its re-establishment, plus any additional cash required to fund the account fully on its opening.

f. Upon receipt of the executed Multiple Signature Verification Agreement for Custody Arrangements, the Prepaid Dental Health Plan may initiate the purchase or sale of Securities with only the Prepaid Dental Health Plan's authorized representatives' signatures, provided that the Securities sold or purchased are in accordance with the Agency's guidelines of approved Securities as listed in the table below, and the transaction results in an equal amount of incoming cash or Securities on the same day of the transaction. Withdrawals from the investment insolvency protection account that do not result in an equal amount of incoming cash or Agency-approved Securities on the same day of the transaction requires the authorized signatures of two (2) Prepaid Dental Health Plan representatives and two (2) Agency representatives.

g. In the event that a determination is made by the Agency that the Prepaid Dental Health Plan is insolvent, the Agency may draw upon or initiate the sale of Securities from the custodial investment insolvency protection account solely with the two (2) authorized signatures of representatives of the Agency and funds may be disbursed to meet financial obligations incurred by the Prepaid Dental Health Plan under this Contract. The Prepaid Dental Health Plan shall not initiate any transactions subsequent to notification by the Agency that the Agency has determined the Prepaid Dental Health Plan to be insolvent. The Prepaid Dental Health Plan shall provide a statement of account balance within fifteen (15) calendar days of request of the Agency.

h. If this Contract is terminated or not renewed, the custodial investment insolvency protection account balance shall be released by the Agency to the Prepaid Dental Health Plan upon the receipt of proof of satisfaction for all outstanding obligations incurred under this Contract.

i. In the event this Contract is terminated, not renewed, and/or the Prepaid Dental Health Plan is declared insolvent, the Agency may draw upon or initiate the sale of Securities from the investment insolvency protection account to pay any outstanding debts the Prepaid Dental Health Plan owes the Agency, including but not limited to overpayments made to the Prepaid Dental Health Plan, and fines imposed under this Contract or, for HMOs, s. 641.52, F.S., for EPOs, s. 627, F.S., and for health insurers, s. 624, F.S. In addition, if the above occurs and the Agency, in its sole discretion, determines that it would be in the best interest of the providers for the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the custodial or controlled account, the Prepaid Dental Health Plan shall agree to the appointment. An appointed receiver shall give outstanding debts owed to the Agency priority over other claims.

Custodial Investment Insolvency Protection Account Approved Securities		
Security	**Maturity Term**	**Guarantee**
U.S Treasury Bills	All	Full Faith & Credit of the U.S. Government
U.S. Treasury Notes	Not to Exceed 3 Years	Full Faith & Credit of the U.S. Government

B. Surplus

1. Surplus Requirement

a. The Prepaid Dental Health Plan shall maintain at all times in the form of cash and investments allowable as admitted assets by the DFS and restricted funds of deposits controlled by the Agency (including the Prepaid Dental Health Plan’s insolvency protection account) or the DFS, a surplus amount equal to the greater of **$1.5 million**, ten percent (10%) of total liabilities, or two percent (2%) of the annualized amount of the Prepaid Dental Health Plan’s prepaid revenues. In the event that the Prepaid Dental Health Plan’s surplus (as defined in Section I., Definitions and Acronyms) falls below the amount specified in this paragraph, the Prepaid Dental Health Plan is prohibited from engaging in marketing activities, shall not receive new enrollments until the required balance is achieved, or may have its Contract terminated statewide.

b. In lieu of the surplus requirements under this Section, the Agency may consider the following:

(1) If the organization is a public entity, the Agency may take under advisement a statement from the public entity that a county supports the Prepaid Dental Health Plan with the county’s full faith and credit. In order to qualify for the Agency’s consideration, the county must own, operate, manage, administer or oversee the Prepaid Dental Health Plan, either partly or wholly, through a county department

or agency;

(2) The State guarantees the solvency of the organization;

(3) The organization is a FQHC or is controlled by one (1) or more FQHCs and meets the solvency standards established by the State for such organization pursuant to s. 409.912(4)(b), F.S.; or

(4) The entity meets the financial standards for federally approved provider-sponsored organizations as defined in 42 CFR 422.380 through 422.390 and the solvency requirements established in approved federal waivers or Florida's Medicaid State Plan.

C. Interest

Interest generated through investments made by the Prepaid Dental Health Plan under this Contract shall be the property of the Prepaid Dental Health Plan and shall be used at the Prepaid Dental Health Plan's discretion.

D. Third Party Resources

1. Covered Third Party Collections

a. The Prepaid Dental Health Plan shall identify and seek recovery up to the Plan's full legal ability from any third party, as defined by s. 409.901(27), F.S., to pay for services rendered to enrollees under this Contract and notify the Agency when any third party liability was identified and when recovery was made.

b. The Prepaid Dental Health Plan shall assume full responsibility for all third party recovery actions initiated within one (1) year of identification. All recovery actions not initiated by the Prepaid Dental Health Plan within one (1) year of identification may be pursued by the Agency, at its sole discretion.

c. The Prepaid Dental Health Plan shall enter into a coordination of benefits agreement with Medicare and participate in the automated claims crossover process. (42 CFR 438.3(t))

d. The following standards govern third party recoveries:

(1) If the Prepaid Dental Health Plan has determined that third party liability exists for part or all of the services provided to an enrollee by a subcontractor or referral provider, and the third party is reasonably expected to make payment within one hundred twenty (120) days, the Prepaid Dental Health Plan may pay the subcontractor or referral provider only the amount, if any, by which the subcontractor's allowable claim exceeds the amount of the anticipated third party payment; or, the Prepaid Dental Health Plan may assume full responsibility for third party collections for service provided through the subcontractor or referral provider.

(2) The Prepaid Dental Health Plan may not withhold payment for services provided to an enrollee if third party liability or the amount of liability cannot be determined,

or if payment shall not be available within a reasonable time, beyond one hundred twenty (120) days from the date of receipt.

e. When the Agency has a FFS lien against a third party and the Prepaid Dental Health Plan has also extended services potentially reimbursable from the same third party resource, the Agency's lien shall be entitled to priority.

f. The Prepaid Dental Health Plan shall provide necessary data for third party identification and recoveries in a format prescribed by the Agency.

2. Optional Third Party Recovery Services

a. The Agency may, at its sole discretion, offer to provide third party recovery services to the Prepaid Dental Health Plan for covered third party collections.

b. If the Prepaid Dental Health Plan elects to authorize the Agency to recover covered third party collections on its behalf, the Prepaid Dental Health Plan shall be required to provide the necessary data for recovery in the format prescribed by the Agency.

c. If the Prepaid Dental Health Plan elects to authorize the Agency to recover covered third party collections on its behalf, all recoveries, less the Agency's cost to recover, shall be income to the Prepaid Dental Health Plan. The cost to recover shall be expressed as a percentage of recoveries and shall be fixed at the time the Prepaid Dental Health Plan elects to authorize the Agency to recover on its behalf.

d. All funds recovered from third parties shall be treated as income for the Prepaid Dental Health Plan.

E. Assignment

Except as provided below, or with the prior written approval of the Agency, this Contract and the monies which may become due are not to be assigned, transferred, pledged or hypothecated in any way by the Prepaid Dental Health Plan, including by way of an asset or stock purchase of the Prepaid Dental Health Plan, and shall not be subject to execution, attachment or similar process by the Prepaid Dental Health Plan.

1. No plan subject to this procurement or any entity outside this procurement shall be allowed to be merged with or acquire all the Prepaid Dental Health Plans within the State. When a merger or acquisition of a Prepaid Dental Health Plan has been approved, the assignment or transfer of the appropriate Medicaid Prepaid Dental Health Plan Contract upon the request of the surviving entity of the merger or acquisition if the Prepaid Dental Health Plan and the surviving entity have been in good standing with the Agency for the most recent twelve (12) month period, unless the Agency determines that the assignment or transfer would be detrimental to Medicaid recipients or the Medicaid program. The entity requesting the assignment or transfer shall notify the Agency of the request ninety (90) days before the anticipated effective date.

a. Entities regulated by the DFS or OIR must comply with provisions of s. 628.4615, F.S., and receive OIR approval before a merger or acquisition can occur.

b. For the purposes of this Section, a merger or acquisition means a change in controlling

interest of a Prepaid Dental Health Plan, including an asset or stock purchase.

c. To be in good standing, a Prepaid Dental Health Plan shall not have failed accreditation or committed any material violation of the requirements of s. 641.52, F.S., and shall meet the Medicaid Contract requirements.

2. The Prepaid Dental Health Plan requesting the assignment or transfer of its enrollees and the acquiring/merging entity must work with the Agency to develop and implement an Agency-approved transition plan, to include a timeline and appropriate notices to all enrollees and all providers as required by the Agency and to ensure a seamless transition for enrollees, as required by the Agency and to ensure a seamless transition for enrollees, particularly those requiring care coordination/case management and those with complex medical needs. The notice to enrollees shall contain the same information as required for a notice of termination according to Section XV.G., Termination Procedures. The Prepaid Dental Health Plan requesting assignment or transfer of its enrollees shall perform as follows:

   a. Notice its enrollees, providers and subcontractors of the change in accordance with this Contract; and

   b. Provide to the Agency the data needed, including encounter data, by the Agency to maintain existing case relationships.

F. Financial Reporting

1. Financial Reports

a. The Prepaid Dental Health Plan shall submit to the Agency quarterly and annual NAIC Health Statements, quarterly and annual Achieved Savings Rebate Financial Reports, and annual audited financial statements.

b. The Prepaid Dental Health Plan shall submit to the Agency the annual NAIC Health Statement and annual audited financial statements no later than three (3) calendar months after the end of the calendar year. The Prepaid Dental Health Plan shall submit the quarterly NAIC Health Statements no later than forty-five (45) days after the end of each calendar quarter. A quarterly NAIC Health Statement is not required for the quarter ending December 31. The quarterly and annual NAIC Health Statement, as well as the annual audited financial statements, shall be prepared using statutory accounting principles. The quarterly and annual Achieved Savings Rebate Financial Report shall be submitted in accordance with Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide.

c. The Prepaid Dental Health Plan shall submit annual and quarterly financial statements that are specific to the processes of the Prepaid Dental Health Plan rather than to a parent or umbrella organization.

d. The Prepaid Dental Health Plan shall submit all financial reports to the Agency in accordance with Section XVI., Reporting Requirements, and the instructions for Achieved Savings Rebate Financial Reports in the Statewide Medicaid Prepaid Dental Health Plan Report Guide. (42 CFR 438.3(m))

2. Medical Loss Ratio

a. The Prepaid Dental Health Plan shall maintain an annual (January 1 – December 31) medical loss ratio (MLR) of a minimum of eighty-five percent (85%) for the first full year of program operation and subsequent years, beginning January 1, 2019.

b. The Agency will calculate the MLR in a manner consistent with 42 CFR 438.8, 45 CFR Part 158, 42 CFR 438.8(k), and s. 409.9122(9)(a), (b), and (c), F.S., To demonstrate ongoing compliance, the Prepaid Dental Health Plan shall complete and submit appropriate financial reports, as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide.

c. The Prepaid Dental Health Plan shall submit an attestation with its MLR reporting in compliance with 42 CFR 438.8(k) and (n).

d. The federal Centers for Medicare & Medicaid Services will determine the corrective action for non-compliance with this requirement.

G. Inspection and Audit of Financial Records

The State, CMS, and DHHS may inspect and audit any financial records of the Prepaid Dental Health Plan or its subcontractors, as well as financial records from parent companies relating to corporate or administrative charges included on financial reports submitted by the Prepaid Dental Health Plan to the Agency. Pursuant to s. 1903(m)(4)(A) of the Social Security Act and the State Medicaid Manual 2087.6(A-B), non-federally qualified Prepaid Dental Health Plans shall report to the State, upon request, and to the Secretary and the Inspector General of DHHS, a description of certain transactions with parties of interest as defined in s. 1318(b) of the Social Security Act. The Prepaid Dental Health Plan shall make any reports of transactions between the Prepaid Dental Health Plans and parties in interest that are provided to the State or other agencies to its enrollees, upon reasonable request. (Section 1903(m)(4)(A)-(B) of the Social Security Act)

Upon request of the Agency, the Prepaid Dental Health Plan shall disclose to the Agency all financial terms and arrangements for payment of any kind that apply between the Prepaid Dental Health Plan or the Prepaid Dental Health Plan's Pharmacy Benefits Manager and any provider of outpatient drugs, any prescription drug manufacturer, or labeler. Such financial terms and arrangements include: formulary/PDL management; drug-switch programs; educational support; claims processing; discounts, including but not limited to end of period discounts, pharmacy network fees, data sales fees, and any other fees.

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Section XIII. Sanctions

A. Contract Violations and Non-Compliance

1. The Prepaid Dental Health Plan shall comply with all requirements and performance standards set forth in this Contract.

2. The Prepaid Dental Health Plan agrees that failure to comply with all provisions of this Contract and 42 CFR 438.100 may result in the assessment of sanctions and/or termination of this Contract, in whole or in part, in accordance with Section XIII., Sanctions.

3. The Agency will be responsible for imposing sanctions for Contract violations or other non-compliance and requiring corrective actions for a violation of or any other non-compliance with this Contract.

4. In the event the Agency identifies a violation of or other non-compliance with this Contract (to include the failure to meet performance standards), the Agency may sanction the Prepaid Dental Health Plan pursuant to any of the following, as allowable: s. 409.912 (6), F.S., s. 409.91212, F.S.; Rule 59A-12.0073, F.A.C.; s. 409.967; F.S., 42 CFR Part 438, Subpart I (Sanctions) and ss.1905(t), 1932 and s. 1903(m) of the Social Security Act. The Agency may impose sanctions in addition to any liquidated damages imposed pursuant to Section XIV., Liquidated Damages.

   a. The Agency may impose temporary management in accordance with 42 CFR 438.706(a) only if it finds any of the following:

      (1) There is continued egregious behavior by the Prepaid Dental Health Plan, including but not limited to behavior described in 42 CFR 438.700 or that is contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act.

      (2) There is substantial risk to enrollees' health.

      (3) The sanction is necessary to ensure the health of the Prepaid Dental Health Plan's enrollees while improvements are made to remedy violations or until there is an orderly termination or reorganization of the Prepaid Dental Health Plan.

   b. The Prepaid Dental Health Plan shall be subject to mandatory temporary management when the Prepaid Dental Health Plan repeatedly fails to meet substantive requirements in ss. 1903(m) or 1932 of the Social Security Act or 42 CFR 438. The imposition of such temporary management must not be delayed to provide a hearing and may not be terminated until it is determined that the Prepaid Dental Health Plan may ensure the sanctioned behavior shall not reoccur. (42 CFR 438.706(b)-(d); s. 1932(e)(2)(B)(ii) of the Social Security Act)

   c. The Prepaid Dental Health Plan may be subject to temporary management and enrollees shall notified by the Agency of the right to terminate enrollment without cause, when the Prepaid Dental Health Plan repeatedly fails to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act, or 42 CFR 438.706. (42 CFR 438.706(b))

d. If the Agency imposes a civil monetary penalty on the Prepaid Dental Health Plan pursuant to 42 CFR 438.704 for charging premiums or charges in excess of the amounts permitted under Medicaid, the amount of the overcharge shall be deducted from the penalty and return it to the affected enrollee. (42 CFR 438.704(c))

5. For purposes of this Section, violations involving individual, unrelated acts shall not be considered arising out of the same action.

6. In addition to imposing sanctions for a Contract violation or other non-compliance, the Agency may require the Prepaid Dental Health Plan to submit to the Agency a CAP within a timeframe specified by the Agency. The Agency may also require the Prepaid Dental Health Plan to submit a CAP for a violation of or any other non-compliance with this Contract.

7. If the Agency imposes monetary sanctions, the Prepaid Dental Health Plan shall pay the monetary sanctions to the Agency within thirty (30) days from receipt of the notice of sanction, regardless of any dispute in the monetary amount or interpretation of policy that led to the notice. If the Prepaid Dental Health Plan fails to pay, the Agency reserves the right to recover the money by any legal means, including but not limited to the withholding of any payments due to the Prepaid Dental Health Plan. If the Deputy Secretary determines that the Agency should reduce or eliminate the amount imposed, the appropriate amount shall be returned to the Prepaid Dental Health Plan within sixty (60) days from the date of a final decision rendered.

8. The Agency may terminate the Prepaid Dental Health Plan Contract and place enrollees into a different Prepaid Dental Health Plan or provide Medicaid benefits through other State plan authority, if the Agency determines that the Prepaid Dental Health Plan has failed to carry out the substantive terms of its Contract or meet the applicable requirements of ss. 1932, 1903(m), or 1905(t) of the Social Security Act. (42 CFR 438.708(a)-(b))

B. Corrective Action Plans

1. If a CAP is required as determined by the Agency, the Prepaid Dental Health Plan's proposed CAP shall be approved or disapproved by the Agency. If the Agency disapproves the CAP, the Prepaid Dental Health Plan shall submit a new CAP within ten (10) business days, or an expedited timeframe if required by the Agency, that addresses the concerns identified by the Agency. The Prepaid Dental Health Plan shall accept and implement an Agency-defined CAP if required by the Agency.

2. The Agency may impose a monetary sanction of **$200** per day on the Prepaid Dental Health Plan for each day the Prepaid Dental Health Plan does not implement, to the satisfaction of the Agency, the approved CAP.

C. Performance Measure Sanctions

1. The Prepaid Dental Health Plan may be subject to sanctions for failure to achieve minimum performance scores on performance measures specified by the Agency after the first year of poor performance, as specified in this Contract, as applicable. The Agency will develop performance measures and may impose monetary sanctions for some or all performance measures. The Agency will develop performance targets for each

performance measure with a methodology for application of the sanction specified by the Agency.

2. The Agency may sanction the Prepaid Dental Health Plan for failure to maintain and/or improve scores on performance measures. The Agency may impose monetary sanctions and/or CAPs as described above.

3. For each of the performance measures listed below where the Prepaid Dental Health Plan's rate decreases more than two (2) percentage points compared to the previous year, the Prepaid Dental Health Plan may receive a monetary sanction of **$10,000**.

Performance Measures Sanction Table **Effective as of CY 2020 Performance Measure Reporting (due to the Agency 7/1/2021)**
1. Annual Dental Visit
2. Preventive Dental Services
3. Sealants for 6-9 Year-Old Children at Elevated Caries Risk
4. Dental Treatment Services
5. Oral Evaluation
6. Topical Fluoride for Children at Elevated Caries Risk
7. Follow-up after Emergency Department Visits for Dental Caries in Children

D. Additional Sanctions

1. Pursuant to s. 409.967(2)(i)2., F.S., if the Prepaid Dental Health Plan fails to comply for thirty (30) days with the encounter data reporting requirements as specified in this Contract, the Prepaid Dental Health Plan shall be subject to the following actions on the thirty-first (31st) day:

   (a) The Prepaid Dental Health Plan shall be assessed a fine of five thousand dollars (**$5,000**) per day for each day of noncompliance; and

   (b) The Prepaid Dental Health Plan shall be notified that the Agency will initiate Contract termination procedures on the ninetieth (90th) day unless the Prepaid Dental Health Plan comes into compliance before that date.

2. Fraud and Abuse – See Section X.F., Fraud and Abuse Prevention.

3. Pursuant to s. 409.967(2)(i)1., F.S., if the Prepaid Dental Health Plan leaves the Contract before the end of this Contract term, the Prepaid Dental Health Plan shall reimburse the Agency for the cost of enrollment changes and other transition activities. If more than one (1) Prepaid Dental Health Plan providing services under the same program component leave its Contract at the same time, the exiting Prepaid Dental Health Plans shall share the costs in a manner proportionate to their enrollments. In addition to payment of costs, all other departing Prepaid Dental Health Plans must pay a penalty of twenty-five percent (25%) of that portion of the minimum surplus maintained pursuant to s. 641.225(1), F.S., which is attributable to the provision of coverage to Medicaid enrollees. The Prepaid Dental Health Plan shall provide at least one hundred eighty (180) days' notice to the Agency before withdrawing from the Contract. If the Prepaid Dental Health Plan withdraws from the Contract before the end of this Contract term, all of the Prepaid Dental Health Plan's affiliated Contracts shall be terminated.

4. Pursuant to 42 CFR 438.702(a)(4), after the date the Secretary of DHHS or the Agency notifies the Prepaid Dental Health Plan of a determination of a violation of any requirement under Sections 1903(m) or 1932 of the Act the Prepaid Dental Health Plan may be subject to suspension of all new enrollment, including default enrollment.

5. Pursuant to 42 CFRF 438.702(a)(5), the Prepaid Dental Health Plan may be subject to suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or the Agency is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

E. Notice of Sanctions

1. Except as noted in 42 CFR Part 438, Subpart I (Sanctions), before imposing any of the sanctions specified in this Section, the Agency will provide written notice to the Prepaid Dental Health Plan that explains the basis and nature of the sanction, cites the specific Contract section(s) and/or provision of law and the methodology for calculation of any fine, and the process to dispute sanctions. (42 CFR 438.710(a)(1))

2. If the Prepaid Dental Health Plan fails to carry out any substantive terms of this Contract or fails to meet applicable requirements in Sections 1932, 1903(m), or 1905(t) of the Social Security Act, the Agency may terminate the Prepaid Dental Health Plan's Contract for cause.

   (a) Before terminating this Contract, the Agency must provide to the Prepaid Dental Health Plan a pre-termination hearing and give advance written notice of intent to terminate, which includes the reason for termination and the time and place of the hearing.

   (b) After the hearing, Prepaid Dental Health Plan shall receive written notice of the decision affirming or reversing the proposed termination of this Contract and, if affirmed, the effective date of termination.

   (c) The Agency must notify Prepaid Dental Health Plan enrollees of the termination and provide information on their options for receiving Medicaid services following the effective date of termination, which may include disenrolling from the Prepaid Dental Health Plan immediately and without cause.

3. Unless the Agency specifies the duration of a sanction, a sanction shall remain in effect until the Agency is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.

F. Dispute of Sanctions

1. To dispute a sanction, the Prepaid Dental Health Plan shall request that the Agency's Deputy Secretary for Medicaid or designee hear and decide the dispute.

   a. The Prepaid Dental Health Plan shall submit a written dispute of the sanction directly to the Deputy Secretary or designee by U.S. mail and/or commercial courier service (hand delivery shall not be accepted); this submission must be received by the Agency within twenty-one (21) days after the issuance of a sanction and shall include all

arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits). A Prepaid Dental Health Plan submitting such written requests for appeal or dispute as allowed under this Contract by U.S. mail and/or commercial courier service, shall submit such appeal or dispute to the following mailing address:

Deputy Secretary for Medicaid
Agency for Health Care Administration
Attn: Managed Care Appeals/Disputes, MS 70
2727 Mahan Drive
Building 2, Suite 1500
Tallahassee, FL 32308

Regardless of whether delivered by U.S. mail or commercial courier service, appeals not delivered to the address above shall be denied.

b. The Prepaid Dental Health Plan waives any dispute not raised within twenty-one (21) days of receiving the sanction. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving the sanction, and waives the right to use any materials, data, and/or information not contained in or accompanying the Prepaid Dental Health Plan's submission submitted within the twenty-one (21) days following its receipt of the sanction in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).

(1) The Deputy Secretary or his/her designee shall decide the dispute under the reasonableness standard, reduce the decision to writing and serve a copy to the Prepaid Dental Health Plan. This written decision shall be final.

(2) The exclusive venue of any legal or equitable action that arises out of or relating to this Contract, including an appeal of the final decision of the Deputy Secretary or his/her designee, shall be Circuit Court in Leon County, Florida; in any such action, the Prepaid Dental Health Plan agrees to waive its right to a jury trial, and that the Circuit Court can only review the final decision for reasonableness, and Florida law shall apply. In the event the Agency issues any action under Florida Statutes or Florida Administrative Code apart from this Contract, the Prepaid Dental Health Plan shall receive notice of the appropriate administrative remedy.

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Section XIV. Liquidated Damages

The Agency will be responsible for imposing liquidated damages as a result of failure to meet any aspect of the responsibilities of this Contract.

The Prepaid Dental Health Plan agrees that failure to meet any aspect of the responsibilities of this Contract may result in the assessment of damages in accordance with Section XIV., Liquidated Damages.

A. Damages

1. If the Prepaid Dental Health Plan breaches this Contract, the Agency will be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In some cases, the actual damage to the Agency as a result of the Prepaid Dental Health Plan's failure to meet any aspect of the responsibilities of this Contract and/or to meet specific performance standards set forth in this Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of a breach of this Contract, the Prepaid Dental Health Plan shall be subject to the imposition of liquidated damages in writing against the Prepaid Dental Health Plan. The Prepaid Dental Health Plan shall be assessed liquidated damages regardless of whether the breach is the fault of the Prepaid Dental Health Plan (including the Prepaid Dental Health Plan's subcontractors, agents and/or consultants), provided the Agency has not materially caused or contributed to the breach. The Agency may impose liquidated damages in addition to any sanctions imposed pursuant to Section XIII., Sanctions.

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

3. If the Prepaid Dental Health Plan fails to perform any of the services described in this Contract, the Agency may assess liquidated damages for each occurrence listed in the table in this Section. Any liquidated damages assessed by the Agency will be due and payable to the Agency within thirty (30) days after the Prepaid Dental Health Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation that led to the notice. The Agency will have sole authority to determine the application of an occurrence (e.g., per unit of service, per date of service, per episode of service, per complaint, per enrollee, etc.).

4. The Agency may elect to collect liquidated damages:

    a. Through direct assessment and demand for payment delivered to the Prepaid Dental Health Plan; or

    b. By deduction of amounts assessed as liquidated damages from, and as set-off against payments then due to the Prepaid Dental Health Plan or that become due at any time after assessment of the liquidated damages. The Prepaid Dental Health Plan shall be subject to deductions until the Agency has collected the full amount payable by the

Prepaid Dental Health Plan.

5. The Prepaid Dental Health Plan shall not pass through liquidated damages imposed under this Contract to a provider and/or subcontractor, unless the provider and/or subcontractor caused the damage through its own action or inaction. Nothing described herein shall prohibit a provider and/or a subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction.

6. All liquidated damages imposed pursuant to this Contract, whether paid or due, shall be paid by the Prepaid Dental Health Plan out of administrative costs and profits.

7. Subject to legislative approval, the Agency reserves the right to redirect any amounts assessed as liquidated damages towards QI activities that target and support Agency goals or initiatives.

8. To dispute the imposition of liquidated damages, the Prepaid Dental Health Plan shall request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute.

   a. The Prepaid Dental Health Plan shall submit a written dispute of the liquidated damages directly to the Deputy Secretary for Medicaid or designee by U.S. mail and/or commercial courier service (hand delivery shall not be accepted. This submission must be received by the Agency within twenty-one (21) days after receiving notice of the imposition of liquidated damages and shall include all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits). A Prepaid Dental Health Plan submitting such written requests for dispute as allowed under this Contract by U.S. mail and/or commercial courier service, shall submit such dispute to the following mailing address:

      Deputy Secretary for Medicaid
      Agency for Health Care Administration
      Attn: Managed Care Appeals/Disputes, MS 70
      2727 Mahan Drive
      Building 2, Suite 1500
      Tallahassee, FL 32308

      Regardless of whether delivered by U.S. mail or commercial courier service, disputes not delivered to the address above shall be denied.

   b. The Prepaid Dental Health Plan waives any dispute not raised within twenty-one (21) days of receiving notice of the imposition of liquidated damages. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving said notice, and waives the right to use any materials, data, and/or information not contained in or accompanying the Prepaid Dental Health Plan's submission within the twenty-one (21) days following its receipt of the notice in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).

9. The Deputy Secretary or his/her designee shall decide the dispute under the reasonableness standard, reduce the decision to writing and serve a copy to the Prepaid

Dental Health Plan. This written decision shall be final.

10. The exclusive venue of any legal or equitable action that arises out of or relating to this Contract, including an appeal of the final decision of the Deputy Secretary or his/her designee shall be Circuit Court in Leon County, Florida. In any such action, the Prepaid Dental Health Plan agrees to waive its right to a jury trial, and that the Circuit Court can only review the final decision for reasonableness, and Florida law shall apply. In the event the Agency issues any action under Florida Statutes or Florida Administrative Code apart from this Contract, the Prepaid Dental Health Plan shall receive notice of the appropriate administrative remedy.

B. Issues and Amounts

The Prepaid Dental Health Plan shall pay the Agency up to the amount for each issue as specified below.

Liquidated Damages Issues and Amounts		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
1.	Failure to respond to an Agency communication within the time prescribed by the Agency as described in this Contract.	**$500** for each day beyond the due date until provided to the Agency.
2.	Failure to provide covered services with reasonable promptness.	**$2,500** per occurrence.
3.	Failure by the Prepaid Dental Health Plan to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach as described in this Contract. See also ancillary BAA between the parties.	**$500** per enrollee per occurrence, not to exceed **$10,000,000**.
4.	Failure to meet plan readiness goals set by the Agency	**$5,000** per occurrence.
5.	Failure to process enrollment files as specified in the Contract.	**$1,000** per occurrence.
6.	Failure to submit a timely notice of involuntary disenrollment to the enrollee as described in this Contract.	**$1,000** per occurrence.
7.	Failure to comply with marketing requirements as described in this Contract.	**$2,500** per occurrence.
8.	Failure to timely report staff or marketing agent violations as described in this Contract.	**$250** per occurrence.

Liquidated Damages Issues and Amounts		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
9.	Failure to obtain approval of enrollee materials, as required by this Contract.	**$1,000** per occurrence.
10.	Failure to comply with enrollee notice requirements as described in this Contract (excluding denials, reductions, terminations, or suspensions of services).	**$250** per occurrence.
11.	Failure to comply with time frames for providing Enrollee Handbooks, I.D. cards, and Provider Directories, as required in this Contract.	**$5,000** per occurrence.
12.	Failure to update online and printed provider directory as described in this Contract.	**$1,000** per occurrence.
13.	Failure to comply in any way with the toll-free enrollee help line requirements as described in this Contract (excluding the failure to respond to individual messages on the automated system of the toll-free enrollee help line in a timely manner as required by the Agency).	**$10,000** per month, for each month that the Agency determines that the Prepaid Dental Health Plan is not in compliance.
14.	Failure to respond to individual messages on the automated system of the toll-free enrollee help line in a timely manner as described this Contract.	**$500** per day, per occurrence
15.	Failure to timely submit any complete plan as described in this Contract, including, but not limited to a CCP. Note: The Anti-Fraud plan liquidated damages listed in this table is separate and not included in this program issue.	**$250** per day for every day plans are late.
16.	Failure to provide the Agency with fair hearing and Good Cause documentation in accordance with the Contract.	$1,000 per occurrence.

Liquidated Damages Issues and Amounts		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
17.	Failure to comply with the notice requirements described in this Contract, the Agency rules and regulations, and all court orders governing appeal procedures, as they become effective.	**$500** per occurrence in addition to **$500** per day for each day required notices are late or deficient or for each day beyond the required time frame that the appeal is unanswered in each and every aspect and/or day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Contract or required by the Agency. **$1,000** per occurrence if the Agency notice remains defective plus a per day assessment in increasing increments of **$500** (**$500** for the first day, **$1,000** for the second day, **$1,500** for the third day, etc.) for each day the notice is late and/or remains defective.
18.	Failure to comply with all orders/official decisions relating to claim disputes, grievances, appeals and/or fair hearings, as they are issued.	**$10,000** per occurrence.
19.	Failure to provide continuation of services during the pendency of a Medicaid fair hearing and/or the Prepaid Dental Health Plan's appeal process where the enrollee has challenged a reduction or elimination of services as required by this Contract, applicable State or federal law, and all court orders governing appeal procedures as they become effective.	The value of the reduced or eliminated services as determined by the Agency for the timeframe specified by the Agency and **$500** per day for each day the Prepaid Dental Health Plan fails to provide continuation or restoration as required by the Agency.
20.	Failure to submit a fair hearing evidence packet with the required materials described in this Contract.	**$1,000** per occurrence.
21.	Failure to submit a fair hearing evidence packet within the time-frame described in this Contract and prehearing instructions.	**$1,000** per occurrence.

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
22.	Failure to provide necessary witnesses and evidentiary materials for fair hearings in accordance with this Contract.	**$1,000** per occurrence.
23.	Failure to attend fair hearings as scheduled in accordance with this Contract.	**$2,500** per occurrence.
24.	Failure to provide restoration of services after the Prepaid Dental Health Plan receives an adverse determination as a result of a Medicaid fair hearing or the Prepaid Dental Health Plan's appeal process as required by this Contract, applicable State or federal law and all court orders governing appeal procedures as they become effective.	The value of the reduced or eliminated services as determined by the Agency and **$500** per day for each day that the Prepaid Dental Health Plan fails to provide continuation or restoration as required by the Agency.
25.	Failure to provide medically necessary services to enrollees under the age of twenty-one (21) years in accordance with this Contract.	**$2,500** per occurrence.
26.	Imposition of arbitrary utilization guidelines or other quantitative coverage limits as prohibited in this Contract.	**$25,000** per occurrence.
27.	Failure to complete a comprehensive assessment, develop a treatment or service plan or plan of care, or authorize and initiate all services specified in the plan for an enrollee within specified timelines as described in this Contract.	**$5,000** per occurrence.
28.	Failure to develop and/or implement a transition plan for recipients including the provision of data to the Agency, as specified in this Contract.	**$10,000** per occurrence.
29.	Failure to develop and document a treatment or service plan for an enrollee, that shall be documented in writing as described in this Contract.	**$500** per deficient/missing treatment or service plan.
30.	Failure to comply with provider network requirements specified in this Contract.	**$1,000** per occurrence.
31.	Failure to submit a Provider Network File that meets the Agency's specifications as described in this Contract.	**$250** per occurrence.
32.	Failure to provide covered services within the timely access standards in this Contract.	**$500** per day, per occurrence.

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
33.	Failure to provide covered services within the geographic access standards in this Contract.	**$500** per day, per occurrence.
34.	Failure to timely report, or provide notice for, significant network changes as described in this Contract.	**$5,000** per occurrence.
35.	Failure to meet provider credentialing requirements, including background screening requirements, specified in this Contract.	**$5,000** per occurrence.
36.	Failure to comply with licensure or background screening requirements for Prepaid Dental Health Plan principals in this Contract.	**$5,000** per occurrence that owner/staff is not licensed or qualified as required by applicable State or local law plus the amount paid to the owner/staff during that period.
37.	Failure to comply with licensure or background screening requirements for subcontractors in this Contract.	**$5,000** per occurrence that subcontractor is not licensed or qualified as required by applicable State or local law plus the amount paid to the subcontractor during that period.
38.	Failure to report notice of provider termination, suspension, or denial of participation in the Prepaid Dental Health Plan as described in this Contract.	**$500** per day, per occurrence.
39.	Failure to timely report notice of terminated providers due to imminent danger/impairment as described in this Contract.	**$5,000** per occurrence.
40.	Failure to timely report termination or suspension of providers for cause as described in this Contract.	**$250** per occurrence.
41.	Failure to suspend or terminate providers who become ineligible for Medicaid participation.	**$500** per occurrence, in addition to **$250** per day until the provider is suspended or terminated.
42.	Failure to obtain and/or maintain national accreditation as described in this Contract.	**$500** per day for every day beyond the day accreditation status must be in place as described in this Contract.
43.	Failure to cooperate with the Agency's contracted EQRO as described in this Contract.	**$5,000** per occurrence.

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
44.	Failure to comply with the quality requirements specified in this Contract under Section IX. of Attachment B. and its Exhibits.	**$1,000** per occurrence.
45.	Failure to submit audited HEDIS, CAHPS, and other performance measures results by July 1 as described in this Contract.	**$250** per day for every day reports are late.
46.	Failure to timely submit appropriate PIPs as described in this Contract.	**$1,000** per day for every day PIPs are late.
47.	Failure to timely submit enrollee records within time frames requested by the Agency or the EQRO.	**$250** per day for each day records are late, up to a maximum of $5,000 per occurrence.
48.	Failure to allow an enrollee to obtain a second medical opinion at no expense and regardless of whether the provider is participating or not, as described in this Contract.	**$5,000** per occurrence.
49.	Failure to acknowledge or act timely upon a request for prior authorization in accordance with this Contract.	**$1,000** per occurrence
50.	Failure to comply with any of the standards for timely service authorization as specified in this Contract.	**$5,000** per month, for each month that the Agency determines that the Prepaid Dental Health Plan is not in compliance, per standard.
51.	Failure to comply with enrollee notice for denials, reductions, terminations, or suspensions of services within the timeframes specified in this Contract as described in this Contract.	**$2,500** per occurrence.
52.	Failure to provide continuity of care and a seamless transition consistent with the services in place prior to the new enrollee's enrollment in the Prepaid Dental Health Plan as described in this Contract.	**$2,500** per occurrence.
53.	Failure to comply in any way with Prepaid Dental Health Plan staffing requirements as specified in this Contract.	**$250** per day for each day that staffing requirements are not met.
54.	Failure to timely report changes in Prepaid Dental Health Plan staffing as described in this Contract.	**$500** per occurrence.

Liquidated Damages Issues and Amounts		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
55.	Failure to provide no less than thirty (30) days' written notice before making any changes to the administration and/or management procedures and/or authorization, denial or review procedures, including any delegations, as described in this Contract.	**$25,000** per occurrence.
56.	Failure of a provider agreement to comply with a requirement of this Contract.	**$1,000** per failure per provider agreement
57.	Failure to receive prior written Agency approval of delegation to a subcontractor.	**$25,000** per occurrence
58.	Failure of a subcontract to comply with a requirement of this Contract.	**$5,000** per failure per subcontract
59.	Failure to maintain and/or provide proof of required insurance as described in this Contract.	**$500** per day.
60.	Failure to comply with subcontract requirements for providers dually offering UM and service provision.	**$500** per day.
61.	Failure to maintain and/or provide proof of the Prepaid Dental Health Plan's fidelity bond as required in this Contract.	**$500** per day.
62.	Failure by the Prepaid Dental Health Plan to execute the appropriate agreements to effectuate transfer and exchange of enrollee PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, BAA or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to this Contract. See also ancillary BAA between the parties.	**$500** per enrollee per occurrence.

Liquidated Damages Issues and Amounts		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
63.	Failure by the Prepaid Dental Health Plan to ensure that all data containing PHI, as defined by HIPAA, is secured through commercially reasonable methodology in compliance with the HITECH Act, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Agency enrollee's PHI as specified in this Contract. See also ancillary BAA between the parties.	**$1,000** per enrollee per occurrence. If the State determines credit monitoring and/or identity theft safeguards are needed to protect those enrollees whose PHI was placed at risk by Prepaid Dental Health Plan's failure to comply with the terms of this Contract, the Prepaid Dental Health Plan shall also be liable for all costs associated with the provision of such monitoring and/or safeguard services.
64.	Failure to complete or comply with CAPs as described in this Contract.	**$500** per day for each day the corrective action is not completed or complied with as required.
65.	Failure to provide notice of noncompliance to the Agency within five (5) days or other Contract-specified period of time in accordance with this Contract.	**$500** per day beginning on the next day after default by the Prepaid Dental Health Plan.
66.	Failure to provide proof of compliance to the Agency within five (5) days of a directive from the Agency or within a longer period of time that has been approved by the Agency	**$500** per day beginning on the next day after default by the Prepaid Dental Health Plan.
67.	Failure to comply with claims processing as described in this Contract.	**$10,000** per month, for each month that the Agency determines that the Prepaid Dental Health Plan is not in compliance.
68.	Failure to submit all claims data in accordance with the format and timeframes specified by the Agency.	**$500** per day, per occurrence.
69.	Failure to submit all claims data in accordance with s. 409.967(2)(o), F.S.	**$500** per day, per occurrence.
70.	Inaccurate or incorrect system information resulting in inappropriate adjudication of claims and/or incorrect payment.	**$500** per occurrence.
71.	Failure to resolve claim and non-claim complaints within the timeframes described in the Contract.	**$500** per day beyond the established timeframe, until the issue is resolved.

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
72.	Failure to adhere to Contract timeframes with providers or the Agency as described in the contract.	**$500** per occurrence.
73.	Failure to pay clean claims for services that were prior authorized by the Prepaid Dental Health Plan.	**$500** per occurrence.
74.	Failure to pay claims due to requiring a prior authorization when service does not require prior authorization as outlined in the Contract.	**$500** per occurrence.
75.	Failure to pay non-participating providers as specified in the Contract.	**$500** per occurrence.
76.	Failure to comply with encounter data submission requirements as described in this Contract (excluding the failure to address or resolve problems with individual encounter records in a timely manner as required by the Agency).	**$25,000** per occurrence.
77.	Failure to address or resolve problems with individual encounter records in a timely manner as required by the Agency and described in this Contract.	**$500** per day, per occurrence.
78.	Failure to comply with fraud and abuse provisions as described in this Contract.	**$500** per day per occurrence/issue.
79.	Failure to establish an investigative unit as required in this Contract, by the time the Prepaid Dental Health Plan has enrolled its first recipient.	**$10,000** per occurrence.
80.	Failure to staff the Compliance Officer position with a qualified individual in accordance with this Contract.	**$500** per day starting ninety (90) days from the date of the position vacancy.
81.	Failure to implement an anti-fraud plan as required by this Contract within ninety (90) days of its approval by the Agency.	**$10,000** per occurrence.
82.	Failure to cooperate fully with the Agency and/or State during an investigation of fraud or abuse, complaint, or grievances as described in this Contract.	**$500** per incident for failure to cooperate fully during an investigation.
83.	Failure to timely report, or report all required information for, all suspected or confirmed instances of provider or recipient fraud or abuse as required by this Contract.	**$1,000** per day, until MPI deems the Prepaid Dental Health Plan to be in compliance.

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
84.	Failure to timely submit an acceptable anti-fraud plan, quarterly fraud and abuse report or the annual report required by this Contract.	**$2,000** per day, until MPI deems the Prepaid Dental Health Plan to be in compliance.
85.	Failure to comply with the requirement to pay the expenses of the Agency's Achieved Savings Rebate Audit as described in this Contract.	**$100** per day.
86.	Failure to achieve and/or maintain insolvency requirements in accordance with this Contract.	**$1,000** per day for each day that insolvency requirements are not met.
87.	Failure to submit timely to the Agency all items of the monthly account valuation.	**$250** per day.
88.	Failure to purchase Securities in accordance with Agency guidelines.	**$2,500** per day for every unapproved security purchased until the Security is replaced with an approved Security.
89.	Failure to achieve and/or maintain financial surplus requirements as described in this Contract.	**$1,000** per day for each day Contract requirements are not met.
90.	Failure to timely submit complete and accurate quarterly unaudited and audited annual financial statements as described in this Contract.	**$500** per day for each day that reporting requirements are not met.
91.	Failure to require and ensure compliance with ownership and disclosure requirements as required in this Contract.	**$5,000** per provider disclosure/attestation for each disclosure/attestation that is not received timely or is not in compliance with the requirements outlined in 42 CFR Part 455, Subpart B.
92.	Failure to timely report changes in ownership and control as described in this Contract.	**$5,000** per occurrence.
93.	Failure to timely initiate a background screening via the Clearinghouse for newly hired principals as described in this Contract.	**$500** per occurrence.
94.	Failure to timely report information about offenses listed in s. 435.04, F.S., as described in this Contract.	**$500** per occurrence.
95.	Failure to comply with conflict of interest or lobbying requirements as described in this Contract.	**$10,000** per occurrence.

Liquidated Damages Issues and Amounts		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
96.	Failure to disclose lobbying activities and/or conflict of interest as required by this Contract.	**$1,000** per day that disclosure is late.
97.	Failure to meet plan readiness review deadlines set by the Agency	**$2,000** per day per occurrence
98.	Failure to comply with public records laws, in accordance with s. 119.0701, F.S.	**$5,000** per occurrence.
99.	Submission of inappropriate report certifications and/or failure to submit report attestations as described in this Contract.	**$250** per occurrence.
100.	Failure to file required reports timely as described in this Contract.	**$500** per occurrence.
101.	Failure to file accurate reports as described in this Contract.	**$1,000** per occurrence.
102.	Failure to respond to an Agency request or ad-hoc report for documentation within the time prescribed by the Agency as described in this Contract.	**$500** per day.
103.	Failure to comply with the enrollee records documentation requirements pursuant to the Contract.	**$1,000** per enrollee record that does not include all of the required elements.
104.	Failure to comply with the following preventive dental services rate requirements by year: · FFY 2018-19: 41% · FFY 2019-20: 44% · FFY 2020-21: 46% · FFY 2021-22: 48% · FFY 2022-23: 50%	**$50,000** per occurrence in addition to $10,000 for each percentage point less than the target.
105.	Failure to comply with the following dental treatment services rate requirements by year: · FFY 2018-19: 21% · FFY 2019-20: 23% · FFY 2020-21: 24% · FFY 2021-22: 24% · FFY 2022-23: 24%	**$50,000** per occurrence in addition to $10,000 for each percentage point less than the target.

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
106.	Failure to achieve the National Medicaid 50th percentile rate (as calculated and published by the National Committee for Quality Assurance) for the HEDIS Annual Dental Visit measure.	**$100** per eligible enrollee not receiving the service up to the 50th percentile rate for the measure.
107.	Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children (ages 0 - <21 years)	**$250** per occurrence.
108.	Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Adults (ages 21 years and up)	**$100** per occurrence.
109.	Failure to develop and document a treatment or service plan as described in the Contract for an enrollee with complex dental issues, high service utilization, intensive health care needs, or who consistently accesses services at the highest level of care.	**$500** per deficient/missing treatment or service plan.

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Section XV. Special Terms and Conditions

A. Applicable Laws and Regulations

1. The Prepaid Dental Health Plan shall comply with all applicable federal and State laws, rules and regulations including but not limited to:

   a. Title IX of the Education Amendments of 1972;

   b. Title IX of the Education Amendments of 1972 (regarding education programs and activities);

   c. Title 42 CFR 422.208 and 422.210 on Physician Incentive Plans;

   d. The Rehabilitation Act of 1973, as amended, 29 USC 794 (which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance);

   e. Medicare - Medicaid Anti-Fraud and Abuse Amendments of 1977;

   f. 42 CFR part 438;

   g. 42 CFR part 438, Subpart K and the Mental Health Parity and Addictions Equity Act;

   h. Section 1557 of the ACA;

   i. 2 CFR part 200; and 2 CFR 300.1; and 45 CFR part 75;

   j. Section 508 of the Federal Water Pollution Control Act as amended (33 U.S.C. 1251, et seq.);

   k. Executive Order 11738 as amended;

   l. Environmental Protection Agency regulations 40 CFR 30, as applicable;

   m. Title 2 CFR part 200 and Executive Order 11246, Equal Employment Opportunity, as amended by Executive Order 11375 and others, and as supplemented in Department of Labor regulation 41 CFR part 60, if applicable;

   n. The Pro-Children Act of 1994 (20 U.S.C. 7183);

   o. Title 2 CFR parts 180 and 376 and Executive Orders 12549 and 12689 “Debarment and Suspension;

   p. Title 2 CFR part 175 relating to trafficking in persons;

   q. Title 2 CFR part 170, relating to the Transparency Act, as applicable;

   r. Section 501.171, F.S., the Florida Information Protection Act of 2014;

s. Sections 1903(i)(16)-(17) and 1903(i)(2)(A)-(C) of the Social Security Act;

t. Chapter 409, F.S.;

u. Section 403.7065, F.S.;

v. Rule 62-730.160, F.A.C. pertaining to standards applicable to generators of hazardous waste;

w. All applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 USC 7401 et seq.;

x. 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin;

y. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended;

z. 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs;

aa. Other federal omnibus budget reconciliation acts; and

bb. All regulations, guidelines and standards as are now or may be lawfully adopted under the above statutes.

In addition to the above, the terms of the applicable federal waivers shall apply.

2. The Prepaid Dental Health Plan is subject to any changes in federal and State law, rules or regulations and federal CMS waivers applicable to this Contract and shall implement such changes in accordance with the required effective dates upon notice from the Agency without waiting for an amendment to this Contract. However, an amendment to this Contract shall be processed to incorporate the changes.

B. Entire Agreement

This Contract, including all Attachments, represents the entire agreement between the Prepaid Dental Health Plan and the Agency and supersedes all other contracts between the parties when it is executed by duly authorized signatures of the Prepaid Dental Health Plan and the Agency. Correspondence and memoranda of understanding do not constitute part of this Contract. In the event of a conflict of language between this Contract and the Attachments (which includes the ITN), the provisions of this Contract shall govern, unless otherwise noted. The Agency reserves the right to clarify any contractual relationship in writing and such clarification shall govern. Pending final determination of any dispute over any Agency decision, the Prepaid Dental Health Plan shall proceed diligently with the performance of its duties as specified under this Contract and in accordance with the direction of the Agency's Division of Medicaid. The Parties, notwithstanding any other term of this Contract, do not intend to create through this Contract, and hereby disclaim and reject, any rights enforceable by third-parties or non-parties to this Contract, through a third party beneficiary cause of action or under any other contractual claim in equity or in law.

C. Ownership and Management Disclosure

1. The Prepaid Dental Health Plan shall fully disclose any business relationships, ownership, management and control of disclosing entities in accordance with State and federal law. A Prepaid Dental Health Plan providing PDHP services shall not contract with the Agency to operate as a Prepaid Dental Health Plan that has a business relationship with another Prepaid Dental Health Plan providing Prepaid Dental Health Plan services and operating in the State. (s. 409.966(3)(b), F.S.)

2. If the Prepaid Dental Health Plan fails to disclose a business relationship or is considering a business relationship with a Prepaid Dental Health Plan that has a Contract with the Agency under the PDHP program, the Prepaid Dental Health Plan shall immediately disclose such business relationship to the Agency pursuant to s. 409.966(3)(b), F.S., within five (5) days after discovery. The disclosure shall include but not be limited to the identifying information for each Prepaid Dental Health Plan, the nature of the business relationship, and the signature of the authorized representative for each Prepaid Dental Health Plan.

3. The Prepaid Dental Health Plan shall submit the following for the areas of ownership and control interest:

   a. The name and address of any person (individual or corporation) with an ownership or control interest in the Prepaid Dental Health Plan and its subcontractors. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

   b. The date of birth and SSN of any individual with an ownership or control interest in the Prepaid Dental Health Plan and its subcontractors.

   c. Other tax identification number of any corporation with an ownership or control interest in the Prepaid Dental Health Plan and any subcontractors in which the Prepaid Dental Health Plan has a five (5) percent or more interest.

   d. Information on whether an individual or corporation with ownership or control interest in the Prepaid Dental Health Plan as a spouse, parent, child, or sibling.

   e. Information on whether a person or corporation with an ownership or control interest in any subcontractor in which the Prepaid Dental Health Plan has a five (5) percent or more interest is related to another person with ownership or control interest in the Prepaid Dental Health Plan as a spouse, parent, child, or sibling.

   f. The name of any other disclosing entity in which an owner of the Prepaid Dental Health Plan has an ownership or control interest.

   g. The name, address, date of birth, and SSN or any managing employee of the Prepaid Dental Health Plan.

   (42 CFR 438.604(a)(6); 42 CFR 455.104(b)(1)(i)-(iii); 42 CFR 455.104(b)(2)-(4); 42 CFR 438.230; 42 CFR 438.608(c)(2))

4. Disclosure shall be made on forms prescribed by the Agency for business transactions

(42 CFR 455.105); conviction of crimes (42 CFR 455.106); public entity crimes (s. 287.133(2)(a), F.S.); and disbarment and suspension (Executive Order No. 12549; 52 Fed. Reg., pages 20360-20369, and Section 4707 of the Balanced Budget Act of 1997). The forms are available through the Agency and are to be submitted to the Agency by September 1 of each Contract year. In addition, the Prepaid Dental Health Plan shall submit to the Agency for review, full disclosure of ownership and control of the Prepaid Dental Health Plan and any subcontractors as required in 42 CFR 438.608(c), and any changes in management within five (5) days of knowing the change shall occur and at least sixty (60) days before any change in the Prepaid Dental Health Plan's ownership or control takes effect.

5. The following definitions apply to ownership disclosure:

   a. A person with an ownership interest or control interest means a person or corporation that:

      (1) Owns, indirectly or directly, five percent (5%) or more of the Prepaid Dental Health Plan's capital or stock, or receives five percent (5%) or more of its profits;

      (2) Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the Prepaid Dental Health Plan or by its property or assets and that interest is equal to or exceeds five percent of the total property or assets;

      (3) Is an officer or director of the Prepaid Dental Health Plan, if organized as a corporation, or is a partner in the Prepaid Dental Health Plan, if organized as a partnership; or

   b. The percentage of direct ownership or control is calculated by multiplying the percent of interest that a person owns by the percent of the Prepaid Dental Health Plan's assets used to secure the obligation. Thus, if a person owns ten percent (10%) of a note secured by sixty percent (60%) of the Prepaid Dental Health Plan's assets, the person owns six percent (6%) of the Prepaid Dental Health Plan.

   c. The percent of indirect ownership or control is calculated by multiplying the percentage of ownership in each organization. Thus, if a person owns ten percent (10%) of the stock in a corporation, which owns eighty percent (80%) of the Prepaid Dental Health Plan's stock, the person owns eight percent (8%) of the Prepaid Dental Health Plan.

6. The following definitions apply to management disclosure:

   a. Changes in management are defined as any change in the management control of the Prepaid Dental Health Plan. Examples of such changes are those listed below and in Section X., Administration and Management, or equivalent positions by another title.

   b. Changes in the board of directors or officers of the Prepaid Dental Health Plan, medical director, CEO, administrator and CFO.

   c. Changes in the management of the Prepaid Dental Health Plan where the Prepaid Dental Health Plan has decided to contract out the operation of the Prepaid Dental Health Plan to a management corporation. The Prepaid Dental Health Plan shall disclose such changes in management control and provide a copy of the contract to

the Agency for approval at least sixty (60) days prior to the management contract start date.

7. The Prepaid Dental Health Plan shall conduct criminal history record check on all principals of the Prepaid Dental Health Plan, and all persons with five percent (5%) or more ownership interest in the Prepaid Dental Health Plan, or who have executive management responsibility for the Prepaid Dental Health Plan, or have the ability to exercise effective control of the Prepaid Dental Health Plan. (s. 435.04, F.S.)

   a. Principals of the Prepaid Dental Health Plan shall be as defined in s. 409.907, F.S.

   b. The Prepaid Dental Health Plan shall initiate the criminal history check on newly hired principals (officers, directors, agents, and managing employees) within thirty (30) days of the hire date, if the individual's fingerprints are not already retained in the Care Provider Background Screening Clearinghouse (Clearinghouse, see s. 435.12, F.S.).

   c. The Prepaid Dental Health Plan shall conduct this verification as follows:

      (1) By requesting screening results through the Agency's background screening system. (See the Agency's background screening website.) If the person's fingerprints are not retained in the Clearinghouse and/or eligibility results are not found, the Prepaid Dental Health Plan shall submit complete sets of the person's fingerprints electronically for Medicaid Level II screening following the process described on the Agency's Care Provider Background Screening Clearinghouse website.

      (2) The Prepaid Dental Health Plan shall complete and email a Background Screening (BGS) Managed Care User Registration Agreement to the Agency at BGSSCREEN@ahca.myflorida.com.

      (3) In accordance with s. 435.12(2)(c), F.S., the Prepaid Dental Health Plan shall register with the Clearinghouse and maintain the employment status of all employees within the Clearinghouse. The Prepaid Dental Health Plan shall report initial employment status and changes to the Clearinghouse within ten (10) business days after the initial employment or change.

      (4) The Prepaid Dental Health Plan shall comply with the employment screening regulations described in Chapter 435, F.S.

      (5) By the five (5) year expiration date of retained fingerprints for a Prepaid Dental Health Plan principal, the Prepaid Dental Health Plan shall initiate and complete a new background screening via the Agency's Care Provider Background Screening Clearinghouse website for that individual.

8. The Prepaid Dental Health Plan shall submit to the Agency, within five (5) business days, any information on any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the Prepaid Dental Health Plan who has been found guilty of, regardless of adjudication, or who entered a plea of *nolo contendere* or guilty to, any of the offenses listed in s. 435.04, F.S. The Prepaid Dental Health Plan shall submit information to the Agency for such persons who have a record of illegal conduct according to the background check. The Prepaid Dental Health Plan shall

keep a record of all background checks to be available for Agency review upon request.

9. The Prepaid Dental Health Plan that has an officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the Prepaid Dental Health Plan, who has committed any of the above listed offenses shall not contract with the Agency. (42 CFR 455.434 and s. 435.04, F.S.) In order to avoid termination, pursuant to a timeline as determined by the Agency, the Prepaid Dental Health Plan shall submit a CAP, acceptable to the Agency, which ensures that such person is divested of all interest and/or control and has no role in the operation and/or management of the Prepaid Dental Health Plan.

10. The Prepaid Dental Health Plan shall submit to the Agency reports regarding current administrative subcontractors and affiliates as specified in Section XVI., Reporting Requirements, and the Statewide Medicaid Prepaid Dental Health Plan Report Guide.

D. Conflict of Interest

This Contract is subject to the provisions of Chapter 112, F.S. Within ten (10) business days of discovery, the Prepaid Dental Health Plan shall disclose to the Agency the name of any officer, director or agent who is an employee of the State of Florida, or any of its agencies. Further, within this same timeframe, the Prepaid Dental Health Plan shall disclose the name of any State employee who owns, directly or indirectly, an interest of five percent (5%) or more in the Prepaid Dental Health Plan or any of its affiliates. The Prepaid Dental Health Plan shall disclose the name of any Agency or DOEA employee who owns, directly or indirectly, an interest of one percent (1%) or more in the Prepaid Dental Health Plan or any of its affiliates. The Prepaid Dental Health Plan covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of the services hereunder. The Prepaid Dental Health Plan further covenants that in the performance of this Contract, no person having any such known interest shall be employed. No official or employee of the Agency and no other public official of the State of Florida or the federal government who exercises any functions or responsibilities in the review or approval of the undertaking of carrying out this Contract shall, prior to completion of this Contract, voluntarily acquire any personal interest, direct or indirect, in this Contract or proposed Contract.

E. Readiness

1. Prior to enrolling recipients in the Prepaid Dental Health Plan, the Agency will conduct a plan-specific readiness review to assess the Prepaid Dental Health Plan's readiness and ability to provide services to recipients. The plan readiness review may include, but is not limited to, desk and onsite review of plan procedures and corresponding documents, the Prepaid Dental Health Plan's provider network and corresponding Contracts, a walk-through of the Prepaid Dental Health Plan's processes, system demonstrations, and interviews with Plan staff. The scope of the plan readiness review may include any and all Contract requirements, as determined by the Agency.

2. If the Prepaid Dental Health Plan does not meet the plan readiness review deadlines established by the Agency, the Agency may exercise the following options:

   a. The Agency may impose liquidated damages for failure to meet plan readiness review

deadlines and/or specific plan readiness goals set by the Agency.

F. Withdrawing Services

1. If the Prepaid Dental Health Plan intends to withdraw services, the Prepaid Dental Health Plan shall provide the Agency with one hundred eighty (180) days' notice. Once the Agency receives the request for withdrawal, the Prepaid Dental Health Plan shall not receive new voluntary enrollments, mandatory assignments, and reinstatements going forward.

2. The Prepaid Dental Health Plan shall work with the Agency to develop a transition plan for enrollees, particularly those under care coordination/case management and those with complex medical needs. The Prepaid Dental Health Plan withdrawing from the Contract shall perform as follows:

   a. Notice its enrollees, providers and subcontractors of the change at least sixty (60) days before the last day of service; and

   b. Provide to the Agency the data, including encounter data, needed by the Agency to maintain existing case relationships.

3. The notice to enrollees shall contain the same information as required for a notice of termination according to Section XV.G., Termination Procedures.

4. If the Prepaid Dental Health Plan withdraws from the Contract before the end of the term of this Contract, the Prepaid Dental Health Plan shall pay the costs and penalties specified in s. 409.967(2)(i)1, F.S., and Section XIII., Sanctions, and this Contract shall be terminated in accordance with the termination procedures in s. 409.967(2)(i)3, F.S., this Section and Section XIII., Sanctions.

5. As specified in s. 409.967(2)(i)1. F.S., if the Prepaid Dental Health Plan intends to withdraw services, the Prepaid Dental Health Plan shall provide the Agency with one hundred eighty (180) days' notice and work with the Agency to develop a transition plan for enrollees, particularly those under case management and those with complex medical needs, and provide data needed to maintain existing case relationships.

6. As specified in s. 409.967 (2)(i)1., F.S., Prepaid Dental Health Plans that limit enrollment levels or leave the Contract before the end of this Contract term must continue to provide services to the enrollee for ninety (90) days or until the enrollee is enrolled in another Prepaid Dental Health Plan, whichever occurs first.

G. Termination Procedures

1. In conjunction with the Standard Contract, Section III., Item A., Termination, all provider agreements and subcontracts shall contain termination procedures. The Prepaid Dental Health Plan agrees to extend the thirty (30)-day termination notice found in the Standard Contract, Section III., Item A.1., Termination at Will, to one hundred eighty (180) days' notice. Depending on the volume of Prepaid Dental Health Plan enrollees affected, the Agency may require an extension of the termination date. Once the Agency receives the request for termination, the Prepaid Dental Health Plan shall not receive new voluntary

enrollments, mandatory assignments, and reinstatements going forward.

2. The Prepaid Dental Health Plan shall work with the Agency to create a transition plan that shall ensure the orderly and reasonable transfer of enrollee care and progress whether or not the enrollees are under care coordination/case management and/or have complex medical needs. The Prepaid Dental Health Plan shall perform as follows:

    a. Notice its enrollees, providers, and subcontractors of the change in accordance with this Contract; and

    b. Provide to the Agency the data needed by the Agency to maintain existing case/care relationships.

3. The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery, or by facsimile letter followed by certified mail, return receipt requested. The notice of termination shall specify the nature of termination, the extent to which performance of work under this Contract is terminated, and the date on which such termination shall become effective. In accordance with s. 1932(e)(4), Social Security Act, the Prepaid Dental Health Plan shall be provided with an opportunity for a hearing prior to termination for cause. This does not preclude the Agency from terminating the Prepaid Dental Health Plan without cause.

4. Upon receipt of final notice of termination, on the date and to the extent specified in the notice of termination, the Prepaid Dental Health Plan shall:

    a. Continue work under this Contract until the termination date unless otherwise required by the Agency;

    b. Cease enrollment of new enrollees under this Contract;

    c. Terminate all marketing activities and subcontracts relating to marketing;

    d. Assign to the State those subcontracts as directed by the Agency's contracting officer including all the rights, title, and interest of the Prepaid Dental Health Plan for performance of those subcontracts;

    e. Take such action as may be necessary, or as the Agency's contracting officer may direct, for the protection of property related to this Contract that is in the possession of the Prepaid Dental Health Plan and in which the Agency has been granted or may acquire an interest;

    f. Not accept any payment after this Contract ends, unless the payment is for the time period covered under this Contract. Any payments due under the terms of this Contract may be withheld until the Agency receives from the Prepaid Dental Health Plan all written and properly executed documents as required by the written instructions of the Agency; and

    g. At least sixty (60) days before the termination effective date, provide written notification to all enrollees of the following information: the date on which the Prepaid Dental Health Plan shall no longer participate in the State's Medicaid program and instructions

on contacting the Agency's enrollment broker help line to obtain information on enrollment options and to request a change in Prepaid Dental Health Plans.

5. If the Prepaid Dental Health Plan fails to disclose any business relationship, as defined in s. 409.966(3)(b), F.S., with another Prepaid Dental Health Plan in the State during the procurement process, the Prepaid Dental Health Plan's Contract shall be terminated.

6. In the event the Agency terminates the Prepaid Dental Health Plan's participation due to non-compliance with Contract requirements, the Prepaid Dental Health Plan's entire Contract shall be terminated in accordance with s. 409.967(2)(i)3., F.S.

7. If the Prepaid Dental Health Plan fails to meet plan readiness criteria by the Agency's specified monthly enrollment calculation date prior to the becoming operational in SMPDHP, the Prepaid Dental Health Plan shall be terminated from participation. In addition, the following requirements apply to the Prepaid Dental Health Plan's entire Contract shall be terminated with thirty (30) days' notice, as specified in the Standard Contract, Section III., Item B., Termination at Will.

8. If the Prepaid Dental Health Plan Contract is terminated by either the Prepaid Dental Health Plan or the Agency (with cause) prior to the end of this Contract period, the Prepaid Dental Health Plan shall be assessed the performance bond required under this Contract to cover the costs of issuing a solicitation and selecting a new Prepaid Dental Health Plan. The Agency's damages in the event of termination shall be considered the full amount of the bond. The Agency need not prove the damage amount in exercising its right of recourse against the bond.

H. Agency Contract Management

1. The Agency will be responsible for management of this Contract. Contract management shall be conducted in good faith, with the best interest of the State and the Medicaid recipients it serves being the prime consideration. The Agency will make all statewide policy decisions via issuance of a Policy Transmittal or Contract Interpretation, which shall be included in the next amendment.

2. The Prepaid Dental Health Plan shall submit all procedures to the Agency as required by this Contract. Unless specified elsewhere in this Contract, procedures required by this Contract shall be submitted to the Agency at least seventy-five (75) days before the proposed effective date of the policy and procedure or change. Other procedures related to this Contract shall be submitted to the Agency upon request. If the Agency has requested procedures, the Prepaid Dental Health Plan shall notify the Agency of any subsequent changes in such materials.

3. The Prepaid Dental Health Plan may seek an interpretation from the Agency of any Contract requirement or Medicaid policy. When an interpretation of this Contract is sought, the Prepaid Dental Health Plan shall submit a written request to the Agency's Deputy Secretary for Medicaid in a format prescribed by the Agency.

4. The terms of this Contract do not limit or waive the ability, authority or obligation of the OIG, MPI, its contractors, DOEA, or other duly constituted government units (State or federal) to audit or investigate matters related to, or arising out of this Contract.

5. This Contract shall be amended only as follows (unless specified elsewhere in this Contract):

    a. The parties cannot amend or alter the terms of this Contract without a written amendment and/or change order to this Contract.

    b. The Agency and the Prepaid Dental Health Plan understand that any such written amendment to amend or alter the terms of this Contract shall be executed by an officer of each party, who is duly authorized to bind the Agency and the Prepaid Dental Health Plan.

    c. The Agency reserves the right to amend this Contract within the scope set forth in the procurement (to include original Contract and all Attachments) in order to clarify requirements or if it is determined by the Agency that modifications are necessary to better serve or provide covered services to the eligible population.

I. Disputes

1. To dispute an interpretation of this Contract, the Prepaid Dental Health Plan shall request that the Agency's Deputy Secretary for Medicaid hear and decide the dispute. The Prepaid Dental Health Plan shall submit a written dispute of this Contract interpretation directly to the Deputy Secretary; by U.S. mail and/or commercial courier service (hand delivery shall not be accepted); this submission must be received by the Agency within twenty-one (21) days after the interpretation of this Contract and shall include all arguments, materials, data, and information necessary to resolve the dispute (to include all evidence, documentation, and exhibits). A Prepaid Dental Health Plan submitting such written requests for appeal or dispute as allowed under this Contract by U.S. mail and/or commercial courier service, shall submit such appeal or dispute to the following mailing address:

    Deputy Secretary for Medicaid
    Agency for Health Care Administration
    Managed Care Appeals/Disputes, MS 70
    2727 Mahan Drive
    Tallahassee, FL 32308

    Regardless of whether delivered by U.S. mail or commercial courier service, appeals not delivered to the address shall be denied.

    The Prepaid Dental Health Plan waives any dispute not raised within twenty-one (21) days of receiving a notice of this Contract interpretation. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving a Contract interpretation, and waives the right to use any materials, data, and/or information not contained in or accompanying the Prepaid Dental Health Plan's submission submitted within the twenty-one (21) days following its receipt of the notice of this Contract interpretation in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).

2. The Deputy Secretary or his/her designee shall decide the dispute under the reasonableness standard, reduce the decision to writing and serve a copy to the Prepaid Dental Health Plan. This written decision shall be final.

3. The exclusive venue of any legal or equitable action that arises out of or relating to this Contract, including an appeal of the final decision of the Deputy Secretary or his/her designee, shall be Circuit Court in Leon County, Florida; in any such action, the Prepaid Dental Health Plan agrees to waive its rights to a jury trial, and that the Circuit Court can only review the final decision for reasonableness, and Florida law shall apply. In the event the Agency issues any action under Florida Statutes or Florida Administrative Code apart from this Contract, the Prepaid Dental Health Plan shall receive notice of the appropriate administrative remedy.

J. Indemnification

1. The Prepaid Dental Health Plan, agrees to indemnify, defend, and hold harmless the Agency, as provided in this Clause.

2. Scope. The Duty to Indemnify and the Duty to Defend, as described herein (collectively known as the "Duty to Indemnify and Defend"), extend to any completed, actual, pending, or threatened action, suit, claim, or proceeding, whether civil, criminal, administrative, or investigative (including any action by or in the right of the Prepaid Dental Health Plan), and whether formal or informal, in which the Agency is, was, or becomes involved and which in any way arises from, relates to, or concerns the Prepaid Dental Health Plan's acts or omissions related to this Contract (inclusive of all Attachments, etc.) (collectively "Proceeding").

   a. Duty to Indemnify. The Prepaid Dental Health Plan agrees to hold harmless and indemnify the Agency to the full extent permitted by law against any and all liability, claims, actions, suits, judgments, damages, and costs of whatsoever name and description, including attorneys' fees, arising from or relating to any Proceeding.

   b. Duty to Defend. With respect to any Proceeding, the Prepaid Dental Health Plan agrees to fully defend the Agency and shall timely reimburse all of the Agency's legal fees and costs; provided, however, that the amount of such payment for attorneys' fees and costs is reasonable pursuant to Rule 4-1.5, Rules Regulating the Florida Bar. The Agency retains the exclusive right to select, retain, and direct its defense through defense counsel funded by the Prepaid Dental Health Plan pursuant to the Duty to Indemnify and Defend the Agency.

3. Expense Advance. The presumptive right to indemnification of damages shall include the right to have the Prepaid Dental Health Plan pay the Agency's expenses in any Proceeding as such expenses are incurred and in advance of the final disposition of such Proceeding.

4. Enforcement Action. In the event that any claim for indemnity, whether an Expense Advance or otherwise, is made hereunder and is not paid in full within sixty (60) days after written notice of such claim is delivered to the Prepaid Dental Health Plan, the Agency may, but need not, at any time thereafter, bring suit against the Prepaid Dental Health Plan to recover the unpaid amount of the claim (hereinafter "Enforcement Action"). In the event the Agency brings an Enforcement Action, the Prepaid Dental Health Plan shall pay all of the Agency's attorneys' fees and expenses incurred in bringing and pursuing the Enforcement Action.

5. Contribution. In any Proceeding in which the Prepaid Dental Health Plan is held to be jointly liable with the Agency for payment of any claim of any kind (whether for damages, attorneys' fees, costs, or otherwise), if the Duty to Indemnify provision is for any reason deemed to be inapplicable, the Prepaid Dental Health Plan shall contribute toward satisfaction of the claim whatever portion is or would be payable by the Agency in addition to that portion which is or would be payable by the Prepaid Dental Health Plan, including payment of damages, attorneys' fees, and costs, without recourse against the Agency. No provision of this part, or of any other section of this Contract (inclusive of all Attachments, etc.), whether read separately or in conjunction with any other provision, shall be construed to: (i) waive the State or the Agency's immunity to suit or limitations on liability; (ii) obligate the State or the Agency to indemnify the Prepaid Dental Health Plan for the Prepaid Dental Health Plan's own negligence, or otherwise assume any liability for the Prepaid Dental Health Plan's own negligence; or (iii) create any rights enforceable by third parties, as third party beneficiaries or otherwise, in law or in equity.

K. Public Records Requests

In accordance with s.119.0701, F.S., and notwithstanding Standard Contract, Section I., Item M., Requirements of Section 287.058, F.S., in addition to other Contract requirements provided by law, the Prepaid Dental Health Plan shall comply with public records laws, as follows:

1. The Prepaid Dental Health Plan shall keep and maintain public records that ordinarily and necessarily would be required in order to perform services under this Contract;

2. The Prepaid Dental Health Plan shall provide the public with access to public records on the same terms and conditions that the Agency would provide the records and at a cost that does not exceed the cost provided in s. 119.0701, F.S., or as otherwise provided by law;

3. The Prepaid Dental Health Plan agrees that it is the custodian of any and all recordings for purposes of the Public Records Act, Chapter 119, F.S., and is solely responsible for responding to any public records requests for recordings. This responsibility includes gathering, redacting, duplication, and provision of the recordings, as well as defense of any actions for enforcement brought pursuant to Section 119.11, F.S.;

4. The Prepaid Dental Health Plan shall ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law;

5. The Prepaid Dental Health Plan shall meet all requirements for retaining public records and transfer, at no cost, to the Agency all public records in possession of the Prepaid Dental Health Plan upon termination of this Contract and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. All records stored electronically must be provided to the Agency in a format that is compatible with the IT systems of the Agency; and

6. If the Prepaid Dental Health Plan does not comply with a public records request, the Prepaid Dental Health Plan shall be subject to enforcement of this Contract provisions in accordance with this Contract.

L. Communications

1. Notwithstanding any term or condition of this Contract to the contrary, the Prepaid Dental Health Plan bears sole responsibility for ensuring that its performance of this Contract (and that of its subcontractors related to this Contract) fully complies with all State and federal law governing the monitoring, interception, recording, use or disclosure of wire, oral or electronic communications, including but not limited to the Florida Security of Communications Act, Sections 934.01, et seq., F.S., and the Electronic Communications Privacy Act, 18 U.S.C. 2510 et seq. (hereafter, collectively, "Communication Privacy Laws").

2. Prior to intercepting, recording or monitoring any communications which are subject to Communication Privacy Laws, the Prepaid Dental Health Plan shall:

   a. Submit a plan which specifies in detail the manner in which the Prepaid Dental Health Plan (and its subcontractors related to this Contract) shall ensure that such actions are in full compliance with Communication Privacy Laws (the "Privacy Compliance Plan"); and

   b. Obtain written approval, signed and stamped by the Agency Contract Manager, of the Privacy Compliance Plan.

3. No modifications to an approved Privacy Compliance Plan may be implemented by the Prepaid Dental Health Plan unless an amended Privacy Compliance Plan is submitted to the Agency, and written approval of the amended Plan is signed and stamped by the Agency Contract Manager. Agency approval of the Prepaid Dental Health Plan's Privacy Compliance Plan in no way constitutes a representation by the Agency that the Privacy Compliance Plan is in full compliance with applicable Communication Privacy Laws, or otherwise shifts or diminishes the Prepaid Dental Health Plan's sole burden to ensure full compliance with applicable Communication Privacy Laws in all aspects of the Prepaid Dental Health Plan's performance of this Contract. Violation of this term may result in sanctions to include termination of this Contract and/or liquidated damages.

M. Audits and Monitoring

1. The Agency may conduct, or have conducted, performance and/or compliance reviews, reviews of specific records or other data as determined by the Agency. The Agency may conduct a review of a sample of analyses performed by the Prepaid Dental Health Plan to verify the quality of the Prepaid Dental Health Plan's analyses. Reasonable notice shall be provided for reviews conducted at the Prepaid Dental Health Plan's place of business.

2. Reviews may include, but shall not be limited to, reviews of procedures, computer systems, recipient records, accounting records, and internal quality control reviews. The Prepaid Dental Health Plan shall work with any reviewing entity selected by the Agency.

3. During this Contract period, these records shall be available at the Prepaid Dental Health Plan's office at all reasonable times. After this Contract period and for ten (10) years following, the records shall be available at the Prepaid Dental Health Plan's chosen location subject to the approval of the Agency. If the records need to be sent to the Agency, the Prepaid Dental Health Plan shall bear the expense of delivery. Prior approval of the disposition of the Prepaid Dental Health Plan and subcontractor records must be

requested and approved by the Agency. This obligation survives termination of this Contract.

4. The Prepaid Dental Health Plan shall comply with all applicable federal requirements pertaining to procurement, including but not limited to Chapter 2 of the CFR and any other final or interim rules with respect to audit requirements of federal contracts administered through State and local public agencies.

5. The Prepaid Dental Health Plan shall ensure an annual SOC 2 Type II audit is performed on the application hosting center. The Prepaid Dental Health Plan shall provide a copy of the most recent audit report to the Agency.

N. Inspection of Records and Work Performed

1. The Agency and its authorized representatives shall have the right to enter the Prepaid Dental Health Plan's premises, or other places where duties under this Contract are performed, at all reasonable times. All inspections and evaluations shall be performed in such a manner as not to unduly delay work.

2. The Prepaid Dental Health Plan shall retain all financial records, enrollee records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to performance under this Contract for a period of ten (10) years after termination of this Contract, or if an audit has been initiated and audit findings have not been resolved at the end of ten (10) years, the records shall be retained until resolution of the audit findings.

3. Refusal by the Prepaid Dental Health Plan to allow access to all records, documents, papers, letters, other materials or on-site activities related to this Contract performance shall constitute a breach of this Contract.

4. The right of the Agency and its authorized representatives to perform inspections shall continue for as long as the Prepaid Dental Health Plan is required to maintain records.

5. The Prepaid Dental Health Plan shall be responsible for all storage fees associated with all records maintained under this Contract. The Prepaid Dental Health Plan is also responsible for the destruction of all records that meet the retention schedule noted above.

6. Failure to retain all records as required may result in cancellation of this Contract. The Agency will give the Prepaid Dental Health Plan advance notice of cancellation pursuant to this provision and shall pay the Prepaid Dental Health Plan only those amounts that are earned prior to the date of cancellation in accordance with the terms and conditions of this Contract. Performance by the Agency of any of its obligations under this Contract shall be subject to the Prepaid Dental Health Plan's compliance with this provision.

7. In accordance with Section 20.055, F.S., the Prepaid Dental Health Plan and its subcontractors shall cooperate with the OIG in any investigation, audit, inspection, review or hearing; and shall grant access to any records, data or other information the OIG deems necessary to carry out its official duties.

O. Employment

The Prepaid Dental Health Plan shall comply with Section 274A of the Immigration and Nationality Act. The Agency will consider the employment by any Prepaid Dental Health Plan of unauthorized aliens a violation of this Act. If the Prepaid Dental Health Plan knowingly employs unauthorized aliens, such violation shall be cause for unilateral cancellation of this Contract. The Prepaid Dental Health Plan shall be responsible for including this provision in all subcontracts with private organizations issued as a result of this Contract.

P. Work Authorization Program

The Immigration Reform and Control Act of 1986 prohibits employers from knowingly hiring illegal workers. The Prepaid Dental Health Plan shall only employ individuals who may legally work in the U.S. – either U.S. citizens or foreign citizens who are authorized to work in the U.S. The Prepaid Dental Health Plan shall use the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system, https://e-verify.uscis.gov/emp, to verify the employment eligibility of all new employees hired by the Prepaid Dental Health Plan during the term of this Contract and shall also include a requirement in its subcontracts that the subcontractor utilize the E-Verify system to verify the employment eligibility of all new employees hired by the subcontractor performing work or providing services pursuant to this Contract.

Q. Equal Employment Opportunity (EEO) Compliance

The Prepaid Dental Health Plan awarded a Contract shall not discriminate in its employment practices with respect to race, color, religion, age, sex, marital status, political affiliation, national origin, or handicap.

R. Discrimination

Pursuant to s. 287.134(2)(a), F.S., an entity or affiliate who has been placed on the discriminatory vendor list may not submit a Bid, Proposal, or Reply on a contract to provide any goods or services to a public entity; may not submit a Bid, Proposal, or Reply on a contract with a public entity for the construction or repair of a public building or public work; may not submit Bids, Proposals, or Replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and may not transact business with any public entity. The Florida Department of Management Services is responsible for maintaining the discriminatory vendor list. Questions regarding the discriminatory vendor list may be directed to the Florida Department of Management Services, Office of Supplier Diversity at (850) 487-0915.

S. Patents, Royalties, Copyrights, Right to Data, and Sponsorship Statement

1. The Prepaid Dental Health Plan, without exception, shall indemnify and hold harmless the Agency and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or unattended invention, process, or article manufactured or supplied by the Prepaid Dental Health Plan. The Prepaid Dental Health Plan has no liability when such claim is solely and exclusively due to the combination, operation or use of any article supplied hereunder with equipment or data not supplied by

the Prepaid Dental Health Plan or is based solely and exclusively upon the Agency's alteration of the article.

2. The Agency will provide prompt written notification of a claim of copyright or patent infringement and shall afford the Prepaid Dental Health Plan full opportunity to defend the action and control the defense. Further, if such a claim is made or is pending, the Prepaid Dental Health Plan may, at its option and expense procure for the Agency the right to continue the use of, replace, or modify the article to render it non-infringing (if none of the alternatives is reasonably available, the Agency agrees to return the article on request to the Prepaid Dental Health Plan and receive reimbursement, if any, as may be determined by a court of competent jurisdiction).

3. If the Prepaid Dental Health Plan brings to the performance of this Contract a pre-existing patent, patent pending, and/or copyright, the Prepaid Dental Health Plan shall retain all rights and entitlements to that pre-existing patent, patent pending and/or copyright, unless this Contract provides otherwise.

4. If the Prepaid Dental Health Plan uses any design, device, or materials covered by letter, patent, or copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or cost arising from the use of such design, device, or materials in any way involved in the work. Prior to the initiation of services under this Contract, the Prepaid Dental Health Plan shall disclose, in writing, all intellectual properties relevant to the performance of this Contract which the Prepaid Dental Health Plan knows, or should know, could give rise to a patent or copyright. The Prepaid Dental Health Plan shall retain all rights and entitlements to any pre-existing intellectual property that is so disclosed. Failure to disclose shall indicate that no such property exists. The Agency will then have the right to all patents and copyrights that arise as a result of performance under this Contract as provided in this Sub-Section.

5. If any discovery or invention arises or is developed in the course of, or as a result of, work or services performed under this Contract, or in any way connected herewith, the Prepaid Dental Health Plan shall refer the discovery or invention to the Agency for a determination whether patent protection shall be sought in the name of the State of Florida. Any and all patent rights accruing under or in connection with the performance of this Contract are hereby reserved to the State of Florida. All materials to which the Agency is to have patent rights or copyrights shall be marked and dated by the Prepaid Dental Health Plan in such a manner as to preserve and protect the legal rights of the Agency.

6. Where activities supported by this Contract produce original writing, sound recordings, pictorial reproductions, drawings or other graphic representation, and works of any similar nature, the Agency has the right to use, duplicate, and disclose such materials in whole or in part, in any manner, for any purpose whatsoever and to have others acting on behalf of the Agency to do so. If the materials so developed are subject to copyright, trademark, or patent, legal title and every right, interest, claim, or demand of any kind in and to any patent, trademark or copyright, or application for the same, shall vest in the State of Florida, Department of State for the exclusive use and benefit of the State. Pursuant to s. 286.021, F.S., no person, firm, corporation, including parties to this Contract shall be entitled to use the copyright, patent, or trademark without the prior written consent of the Florida Department of State.

7. The Agency will have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Prepaid Dental Health Plan under any Contract.

8. Pursuant to s. 286.25, F.S., all non-governmental vendors must assure that all notices, information pamphlets, press releases, advertisements, descriptions of the sponsorship of the program, research reports, and similar public notices prepared and released by the Prepaid Dental Health Plan shall include the statement: “Sponsored by (name of Prepaid Dental Health Plan) and the State of Florida, Agency for Health Care Administration.” If the sponsorship reference is in written material, the words, “State of Florida, Agency for Health Care Administration” shall appear in the same size letters or type as the name of the organization.

9. All rights and title to works for hire under this Contract, whether patentable or copyrightable or not, shall belong to the Agency and shall be subject to the terms and conditions of this Contract.

10. The computer programs, data, materials and other information furnished by the Agency to the Prepaid Dental Health Plan hereunder shall be and remain the sole and exclusive property of the Agency, free from any claim or right of retention by or on behalf of the Prepaid Dental Health Plan. The services and products listed in this Contract shall become the property of the Agency upon the Prepaid Dental Health Plan’s performance and delivery thereof. The Prepaid Dental Health Plan hereby acknowledges that said computer programs, materials and other information provided by the Agency to the Prepaid Dental Health Plan hereunder, together with the products delivered and services performed by the Prepaid Dental Health Plan hereunder, shall be and remain confidential and proprietary in nature to the extent provided by Chapter 119, F.S., and that the Prepaid Dental Health Plan shall not disclose, publish, or use same for any purpose other than the purposes provided in this Contract; however, upon the Prepaid Dental Health Plan first demonstrating to the Agency’s satisfaction that such information, in part or in whole, (1) was already known to the Prepaid Dental Health Plan prior to its receipt from the Agency; (2) became known to the Prepaid Dental Health Plan from a source other than the Agency; or (3) has been disclosed by the Agency to third parties without restriction, the Prepaid Dental Health Plan shall be free to use and disclose same without restriction. Upon completion of the Prepaid Dental Health Plan’s performance or otherwise cancellation or termination of this Contract, the Prepaid Dental Health Plan shall surrender and deliver to the Agency, freely and voluntarily, all of the above-described information remaining in the Prepaid Dental Health Plan's possession.

11. The Prepaid Dental Health Plan warrants that all materials produced hereunder shall be of original development by the Prepaid Dental Health Plan and shall be specifically developed for the fulfillment of this Contract and shall not knowingly infringe upon or violate any patent, copyright, trade secret, or other property right of any third party, and the Prepaid Dental Health Plan shall indemnify and hold the Agency harmless from and against any loss, cost, liability, or expense arising out of any breach or claimed breach of this warranty.

12. The terms and conditions specified in this Sub-Section shall also apply to any subcontract made under this Contract. The Prepaid Dental Health Plan shall be responsible for informing the subcontractor of the provisions of this Sub-Section and obtaining disclosures.

T. Confidentiality of Information

1. The Prepaid Dental Health Plan shall not use or disclose any information, that is confidential by State or federal law, including but not limited to Social Security numbers that may be supplied under this Contract pursuant to law, and also including the identity or identifying information concerning a Medicaid recipient or services under this Contract for any purpose not in conformity with State and federal laws, except upon written consent of the recipient or his/her guardian.

2. Confidential information, including Medicaid information, shall be used only as authorized for purposes directly related to the administration of this Contract. The Prepaid Dental Health Plan shall have a process that specifies that patient-specific information remains confidential, is used solely for the purposes of data analysis or other Prepaid Dental Health Plan responsibilities under this Contract, and is exchanged in a manner compliant with HIPAA/HITECH and only for the purpose of conducting a review or other duties outlined in this Contract.

3. Any patient-specific information and/or data constituting protected health care information received by the Prepaid Dental Health Plan may be shared only with those agencies that have legal authority to receive such information and cannot be otherwise transmitted for any purpose other than those for which the Prepaid Dental Health Plan is retained by the Agency. The Prepaid Dental Health Plan shall have in place written confidentiality procedures to ensure confidentiality and to comply with all federal and State laws (including the HIPAA and HITECH Acts) governing confidentiality, including electronic treatment records, facsimile mail, and electronic mail).

4. The Prepaid Dental Health Plan’s subcontracts must explicitly State expectations about the confidentiality of information, and the subcontractor is held to the same confidentiality requirements as the Prepaid Dental Health Plan. If provider-specific data are released to the public, the Prepaid Dental Health Plan shall have procedures for exercising due care in compiling and releasing such data that address statutory protections of quality assurance and confidentiality while assuring that open records requirements of Chapter 119, F.S., are met.

5. Any releases of information to the media, the public, or other entities require prior approval from the Agency.

U. Legal Action Notification

The Prepaid Dental Health Plan shall give the Agency, by certified mail, immediate written notification (no later than thirty (30) calendar days after service of process) of any action or suit filed or of any claim made against the Prepaid Dental Health Plan by any subcontractor, vendor, or other party that results in litigation related to this Contract for disputes or damages exceeding the amount of **$50,000.00**.

V. Venue

1. In the event of any legal challenges to this Contract, the Prepaid Dental Health Plan shall agree and shall consent that hearings and depositions for any administrative or other

litigation related to this procurement shall be held in Leon County, Florida. The Agency, in its sole discretion, may waive this venue for depositions.

2. The Prepaid Dental Health Plan (and their successors, including but not limited to their parent(s), affiliates, subsidiaries, subcontractors, assigns, heirs, administrators, representatives, and trustees) acknowledges that this Contract and its Attachments or amendments are not rules nor subject to rulemaking under Chapter 120 (or its successor) of the Florida Statutes and are not subject to challenge as a rule or non-rule policy under any provision of Chapter 120, F.S.

3. This Contract shall be delivered in the State of Florida and shall be construed in accordance with the laws of Florida. Wherever possible, each provision of this Contract shall be interpreted in such a manner as to be effective and valid under applicable law, but if any provision shall be found ineffective, then to the extent of such prohibition or invalidity, that provision shall be severed without invalidating the remainder of such provision or the remaining provisions of this Contract.

4. The exclusive venue and jurisdiction for any action in law or in equity to adjudicate rights or obligations arising pursuant to or out of this Contract for which there is no administrative remedy shall be the Second Judicial Circuit Court in and for Leon County, Florida, or, on appeal, the First District Court of Appeal (and, if applicable, the Florida Supreme Court). Any administrative hearings hereon or in connection herewith shall be held in Leon County, Florida.

W. Performance Bond

1. A performance bond in the amount of **$1,000,000** shall be furnished to the Agency for each contract awarded to a Prepaid Dental Health Plan. The bond shall be furnished to the Issuing Officer identified in Attachment A, Section A.5 within thirty (30) calendar days after execution of the resulting Contract and prior to commencement of any work under this Contract.

2. The bond must be furnished to the Issuing Officer identified in Attachment A, Section A., Overview, Item 5., Issuing Officer, within thirty (30) calendar days after execution of the resulting Contract and prior to commencement of any work under the resulting Contract. Thereafter, the bond shall be furnished on an annual basis, thirty (30) calendar days prior to the new Contract year for the same amount as required for the initial performance bond. A copy of all performance bonds shall be submitted to the Agency's Contract Manager. The performance bond must not contain any provisions that shorten the time for bringing an action to a time less than that provided by the applicable Florida Statute of Limitations. See Section 95.03, F.S. No payments shall be made to the Prepaid Dental Health Plan until an acceptable performance bond is furnished to the Agency.

3. The Prepaid Dental Health Plan shall maintain an effective performance bond for the full term of this Contract, including any renewal period. The Prepaid Dental Health Plan shall name the Agency as the beneficiary of the Prepaid Dental Health Plan's bond. The bond shall provide that the insurer or bonding company(s) pay losses suffered by the Agency directly to the Agency.

4. The Prepaid Dental Health Plan shall bear cost of the performance bond.

5. Should the Prepaid Dental Health Plan terminate the resulting Contract prior to the end of the resulting Contract period, an assessment against the bond shall be made by the Agency to cover the costs of issuing a new solicitation and selecting a new Prepaid Dental Health Plan. The Prepaid Dental Health Plan agrees that the Agency's damages in the event of termination by the Prepaid Dental Health Plan shall be considered to be for the full amount of the bond. The Agency need not prove the damage amount in exercising its right of recourse against the bond.

X. Fidelity Bond

The Prepaid Dental Health Plan shall secure and maintain during the life of the resulting Contract and any Contract extension(s), a blanket fidelity bond from a company doing business in the State of Florida on all personnel in its employment. The bond shall be issued in the amount of at least **$250,000** per occurrence. Said bond shall protect the Agency from any losses sustained through any fraudulent or dishonest act or acts committed by any employees of the Prepaid Dental Health Plan and subcontractors, if any. Proof of coverage shall be submitted to the Agency within sixty (60) calendar days after execution of this Contract and prior to the delivery of health care. To be acceptable to the Agency for fidelity bonds, a surety company shall comply with the provisions of Chapter 624, F.S.

Y. Insurance

1. To the extent required by law, the Prepaid Dental Health Plan shall be self-insured against, or shall secure and maintain during the life of the resulting Contract, Worker's Compensation Insurance for all its employees connected with the work of the resulting Contract and, in case any work is subcontracted, the Prepaid Dental Health Plan shall require the subcontractor similarly to provide Worker's Compensation Insurance for all of the latter's employees unless such employees engaged in work under the resulting Contract are covered by the Prepaid Dental Health Plan's self-insurance program. Such self-insurance or insurance coverage shall comply with the Florida Worker's Compensation law. In the event hazardous work is being performed by the Prepaid Dental Health Plan under the resulting Contract and any class of employees performing the hazardous work is not protected under Worker's Compensation statutes, the Prepaid Dental Health Plan shall provide, and cause each subcontractor to provide, adequate insurance satisfactory to the Agency, for the protection of its employees not otherwise protected.

2. The Prepaid Dental Health Plan shall secure and maintain Commercial General Liability insurance including bodily injury, property damage, personal and advertising injury, and products and completed operations. This insurance shall provide coverage for all claims that may arise from the services and/or activities completed under the resulting Contract, whether such services and/or activities are by the Prepaid Dental Health Plan or anyone directly, or indirectly employed by it. Such insurance shall include a Hold Harmless Agreement in favor of the State of Florida and also include the State of Florida as an Additional Named Insured for the entire length of the resulting Contract and hold the State of Florida harmless from subrogation. The Prepaid Dental Health Plan shall set the limits of liability necessary to provide reasonable financial protections to the Prepaid Dental Health Plan and the State of Florida under the resulting Contract.

3. All insurance policies shall be with insurers licensed or eligible to transact business in the State of Florida. The Prepaid Dental Health Plan's current insurance policy(ies) shall contain a provision that the insurance shall not be canceled for any reason except after thirty (30) calendar days' written notice. The Prepaid Dental Health Plan shall provide thirty (30) calendar days written notice of cancellation to the Agency's Contract Manager.

4. The Prepaid Dental Health Plan shall submit insurance certificates evidencing such insurance coverage prior to execution of a Contract with the Agency.

Z. MyFloridaMarketPlace Vendor Registration and Transaction Fee

1. MyFloridaMarketPlace Vendor Registration**.** Each vendor doing business with the State of Florida for the sale of commodities or contractual services as defined in Section 287.012, F.S., shall register in MyFloridaMarketPlace, in compliance with Rule 60A-1.033, F.A.C., unless exempt under Rule 60A-1.033(3), F.A.C.

2. MyFloridaMarketPlace Transaction Fee. This Contract has been exempted by the Florida Department of Management Services from paying the transaction fee per Rule 60A-1.031(4)(a and b), F.A.C.

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Section XVI. Reporting Requirements

A. Prepaid Dental Health Plan Reporting Requirements

1. General Provisions

a. The Prepaid Dental Health Plan shall comply with all reporting requirements set forth in this Contract.

b. The Prepaid Dental Health Plan may be required to provide to the Agency or its agents any other information, documentation, or data relative to this Contract in accordance with 42 CFR 438.604(b). In such instances, and at the direction of the Agency, the Prepaid Dental Health Plan shall fully cooperate with such requests and furnish all data or information in a timely manner, in the format in which it is requested. The Prepaid Dental Health Plan shall have at least thirty (30) days to fulfill such ad hoc requests, unless the Agency directs the Prepaid Dental Health Plan to provide data or information in less than thirty (30) days. The Prepaid Dental Health Plan shall certify that data and information it submits to the Agency is accurate, truthful, and complete in accordance with 42 CFR 438.606.

c. The Prepaid Dental Health Plan shall comply with the Statewide Medicaid Prepaid Dental Health Plan Report Guide in submitting required reports, including the report formats, templates, instructions, data specifications, submission timetables and locations, and other materials contained in the guide. The Statewide Medicaid Prepaid Dental Health Plan Report Guide shall be posted on the Agency's website. The Prepaid Dental Health Plan shall be furnished with appropriate technical assistance in using the Statewide Medicaid Prepaid Dental Health Plan Report Guide.

d. Unless otherwise specified, all reports shall be submitted electronically, as prescribed in the reporting guidelines. Materials including PHI shall be submitted to the Agency SFTP sites.

2. Submission Deadlines

a. Deadlines for report submission referred to in this Contract specify the actual time of receipt at the Agency bureau or location, not the date the file was postmarked or transmitted.

b. If a reporting due date falls on a weekend or State holiday, the report shall be due to the Agency on the following business day.

c. All reports filed on a quarterly basis shall be filed on a calendar year quarter.

3. Required Reports

a. The Prepaid Dental Health Plan shall comply with reports required by the Agency as specified in the Prepaid Dental Health Plan Statewide Medicaid Report Guide. All reports shall be submitted to the Agency Contract Manager unless otherwise indicated in the Statewide Medicaid Prepaid Dental Health Plan Report Guide.

Summary of Reporting Requirements	
Report Name	**Frequency**
Administrative Subcontractors and Affiliates Report	Quarterly
Adverse Incident Summary Report	Monthly
Annual Fraud and Abuse Activity Report	Annually
ASR Financial Reports	Annually Quarterly
Audited Financial Statements	Annually
Adverse Incident Summary Report	Monthly
Customized Benefit Notification	Monthly
Enrollee Complaints, Grievance, and Plan Appeals Report	Monthly
ER Visits for Enrollees without PDP appointment	Annually
Healthy Behaviors	Quarterly
Marketing Agent Status Report	Quarterly
Marketing/Public/Educational Events Report	Monthly
NAIC Health Statements	Annually Quarterly
PDP Appointment Report	Annually
Performance Measure Report	Annually
Provider Complaint Report	Monthly
Provider Network File	Weekly
Quarterly Fraud and Abuse Activity Report	Quarterly
Suspected/ Confirmed Fraud & Abuse Activity Report	Within fifteen (15) days of detection
Quarterly Fraud and Abuse Activity Report	Quarterly
Timely Access/PDP Wait Times Report	Annually
Well-child Visit (CMS-416) and FL 80% Screening	Annually

4. Modifications to Reporting Requirements

a. The Agency reserves the right to modify the reporting requirements and to provide technical assistance to the Prepaid Dental Health Plan for up to ninety (90) day notice, to allow the Prepaid Dental Health Plan to complete implementation, unless otherwise required by law.

b. The Prepaid Dental Health Plan shall be provided with written notification of any modifications to the reporting requirements.

5. Certification of Timely, Complete and Accurate Submission

a. The Prepaid Dental Health Plan shall assure the accuracy, completeness and timely submission of each report.

b. The Prepaid Dental Health Plan’s CEO, CFO or an individual who reports to the CEO or CFO and who has delegated authority to certify the Prepaid Dental Health Plan’s reports, shall attest, based on his/her best knowledge, information and belief, that all

data submitted in conjunction with the reports and all documents requested by the Agency are accurate, truthful and complete. (42 CFR 438.606(a) and (b).)

c. The Prepaid Dental Health Plan shall submit its certification at the same time it submits the certified data reports. (42 CFR 438.606(c).) The certification page shall be scanned and submitted electronically.

d. If the Prepaid Dental Health Plan fails to submit the required reports accurately or within the timeframes specified, the Prepaid Dental Health Plan shall be subject to fines or otherwise sanctioned in accordance with Section XIII., Sanctions.

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ATTACHMENT C
DATA BOOK, COST PROPOSAL INSTRUCTIONS, AND RATE METHODOLOGY NARRATIVE

Attachment C, Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, is available for respondents to download at:

http://ahca.myflorida.com/procurements/index.shtml

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ATTACHMENT C
APPENDIX I – PREPAID DENTAL HEALTH PROGRAM DATA BOOK DATABASE

Attachment C, Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, **Appendix I –** Prepaid Dental Health Program Data Book Database**,** is available for respondents to download at:

http://ahca.myflorida.com/procurements/index.shtml

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ATTACHMENT C
APPENDIX II – PREPAID DENTAL HEALTH PROGRAM DATA BOOK SUMMARY EXHIBITS
EXHIBIT 1: MMA CAPITATED PLAN DENTAL ENCOUNTER DATA BOOK SUMMARIES

Attachment C, Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, **Appendix II –** Prepaid Dental Health Program Data Book Summary Exhibits, **Exhibit 1:** MMA Capitated Plan Dental Encounter Data Book Summaries, is available for respondents to download at:

http://ahca.myflorida.com/procurements/index.shtml

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ATTACHMENT C
APPENDIX II – PREPAID DENTAL HEALTH PROGRAM DATA BOOK SUMMARY EXHIBITS
EXHIBIT 2: CMSN DENTAL ENCOUNTER DATA BOOK SUMMARIES

Attachment C, Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, **Appendix II –** Prepaid Dental Health Program Data Book Summary Exhibits, **Exhibit 2:** CMSN Dental Encounter Data Book Summaries, is available for respondents to download at:

http://ahca.myflorida.com/procurements/index.shtml

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ATTACHMENT C
APPENDIX II – PREPAID DENTAL HEALTH PROGRAM DATA BOOK SUMMARY EXHIBITS
EXHIBIT 3: FFS DENTAL DATA BOOK SUMMARIES

Attachment C, Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, **Appendix II –** Prepaid Dental Health Program Data Book Summary Exhibits, **Exhibit 3:** FFS Dental Data Book Summaries, is available for respondents to download at:

http://ahca.myflorida.com/procurements/index.shtml

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ATTACHMENT C
APPENDIX II – PREPAID DENTAL HEALTH PROGRAM DATA BOOK SUMMARY EXHIBITS
EXHIBIT 4: AGENCY ELIGIBILITY DATA BOOK SUMMARIES

Attachment C, Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, **Appendix II –** Prepaid Dental Health Program Data Book Summary Exhibits, **Exhibit 4:** Agency Eligibility Data Book Summaries, is available for respondents to download at:

http://ahca.myflorida.com/procurements/index.shtml

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APPENDIX III – PREPAID DENTAL HEALTH PROGRAM DATA BOOK SUPPLEMENTAL INFORMATION
EXHIBIT 5: MMA CAPITATED PLAN SUBCAPITATED DENTAL ENCOUNTER AND ASR DATA COMPARISON

Attachment C, Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, **Appendix III –** Prepaid Dental Health Program Data Book Supplemental Information, **Exhibit 5:** MMA Capitated Plan Subcapitated Dental Encounter and ASR Data Comparison**,** is available for respondents to download at:

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APPENDIX III – PREPAID DENTAL HEALTH PROGRAM DATA BOOK SUPPLEMENTAL INFORMATION
EXHIBIT 6: SUBCAPITATED MMA CAPITATED PLAN DENTAL ENCOUNTER CLAIMS AS A PERCENTAGE OF TOTAL SUBCAPITATED ENCOUNTER CLAIMS IN DATA BOOK

Attachment C, Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, **Appendix III –** Prepaid Dental Health Program Data Book Supplemental Information, **Exhibit 6:** Subcapitated MMA Capitated Plan Dental Encounter Claims as a Percentage of Total Subcapitated Encounter Claims in Data Book**,** is available for respondents to download at:

http://ahca.myflorida.com/procurements/index.shtml

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APPENDIX III – PREPAID DENTAL HEALTH PROGRAM DATA BOOK SUPPLEMENTAL INFORMATION
EXHIBIT 7: IBNR FACTORS USED IN COST PROPOSAL DATA BOOK TEMPLATE

Attachment C, Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, **Appendix III –** Prepaid Dental Health Program Data Book Supplemental Information, **Exhibit 7:** IBNR Factors Used in Cost Proposal Data Book Template**,** is available for respondents to download at:

http://ahca.myflorida.com/procurements/index.shtml

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ATTACHMENT C
APPENDIX IV – PREPAID DENTAL HEALTH PROGRAM COST PROPOSAL TEMPLATE

Attachment C, Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, **Appendix IV –** Prepaid Dental Health Program Cost Proposal Template, is available for respondents to download at:

http://ahca.myflorida.com/procurements/index.shtml

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