

# The Oklahoma Health Care Authority

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## *SoonerSelect Dental Program*

### *Request for Proposals*

**Solicitation Number 8070001235**

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## **1 Section 1: Introduction and Solicitation Overview**

### **1.1 RFP Overview**

#### **1.1.1 The Oklahoma Central Purchasing Act (74 O.S. §85.1 *et seq.*) and accompanying OAC provisions**

The Oklahoma Central Purchasing Act (the Central Purchasing Act) establishes policies that an Oklahoma state agency must follow to procure products or services from a third-party vendor, including the requirement that, absent an exemption, such contracts must be competitively bid. The Central Purchasing Act provides that all purchasing activities of a state agency shall be under the direction of the Central Purchasing Division of the Office of Management and Enterprise Services (OMES) unless otherwise delegated to the state agency. The Central Purchasing Division has delegated the right to procure needed products and services for the Oklahoma Health Care Authority (OHCA) to OHCA's CEO and other OHCA officers and personnel, subject to certain prior approval requirements from the Oklahoma Health Care Authority Board. In accordance with Oklahoma Administrative Code (OAC) 317:10-1-1, when an acquisition is made by the OHCA, the OHCA's rules, located at OAC 317:10, must be read in conjunction with the OMES Purchasing rules at OAC 260:115. For purposes of the application of the Central Purchasing Act and related OAC provisions to acquisitions by the OHCA, OAC 317:10-1-3 provides that where "State Purchasing Director" is specified, it means the OHCA certified procurement officer and the OHCA CEO and where "Purchasing Division" is specified, it means the OHCA.

#### **1.1.2 The Oklahoma Privatization of State Functions Act (74 O.S. §586 *et seq.*) and accompanying OAC provisions**

The Oklahoma Privatization of State Functions Act (Privatization Act) establishes guidelines for the privatization of state services to ensure that such privatization is cost effective and in the best interest of the state. Due to the size of the Contract(s) to be awarded pursuant this RFP and because of the possibility that the Privatization Act may be found to apply to this RFP and the resulting Contract(s), the OHCA has elected to voluntarily comply with the provisions of Privatization Act. The OHCA has submitted a cost analysis to OMES and OMES has found that the analysis fulfills the content requirements of the Privatization Act. The OHCA has also provided the notices required under Section 589 of the Privatization Act. To the extent that the OHCA receives a response to those notices that requires it to modify or amend this solicitation, those updates or amendments will be posted in accordance with Section 1.8.9: "Changes in Solicitation Specifications or Contract Terms".

Bidders will be required to provide in their Proposal all the information and certifications required by the Privatization Act as more fully discussed in Section 2.5.2.5: "Privatization Act Mandated Representations and Certifications". Failure to provide this information and certifications could result in a Proposal being considered non-responsive and not considered for further evaluation. Failure to abide by the Privatization Act may also result in a Bidder's disqualification.

#### **1.1.3 The RFP**

Through this RFP, OHCA intends to contract on a statewide basis with prepaid ambulatory health plans (PAHPs) to deliver risk-based dental benefits to SoonerCare Children, Pregnant Women, Deemed Newborns, Parent and Caretaker Relatives, and Expansion Adults. OHCA seeks Proposals from qualified Bidders to improve dental health outcomes, increase access to care, and increase accountability in the State's Medicaid program, referred to as SoonerCare. Successful Bidders will be responsible for coordinating and delivering SoonerCare dental benefits to the covered SoonerCare populations.

The Contracts resulting from this RFP process will be for an initial one year term (through June 30, 2021), with five optional one year extensions at the discretion of OHCA. Enrollment of SoonerCare Eligibles into the SoonerSelect Dental program will be effective October 1, 2021.

## 1.2 SoonerSelect Dental Goals

The SoonerSelect Dental program has been designed to advance Governor Stitt’s plan to transform Oklahoma into a Top Ten state in health outcomes, including oral health. OHCA is pursuing a dental managed care approach that will allow the state to improve the oral health of Oklahomans by:

- Improve health outcomes for Oklahomans;
  - Improving access to oral healthcare including preventive and restorative services;
  - Developing high-quality outreach and education materials and regularly scheduled outreach activities for Dental Health Plan Enrollees;
  - Building collaborations between medical and dental professionals;
- Transform payment and delivery system reform statewide by moving toward value-based payment and away from payment based on volume;
- Improve SoonerCare Eligibles’ access to and satisfaction with necessary services;
- Contain costs through better coordinating services; and
- Increase cost predictability to the State.

## 1.3 SoonerCare Program Background

SoonerCare is the State of Oklahoma’s Medicaid program. The OHCA is the single state agency responsible for administration of SoonerCare. Since 1995, SoonerCare has operated under Section 1115 demonstration authority granted by the Centers for Medicare and Medicaid Services (CMS). SoonerCare services are currently delivered through coordinated care models including patient centered medical homes (PCMH), Health Access Networks (HANs) and the SoonerCare Health Management Program (HMP). All SoonerCare Eligibles currently qualify to receive services through these models, with the exception of the following:

- Dual Eligible Individuals;
- Individuals residing in an institution or nursing home;
- §1915(c) Waiver enrollees;
- Individuals infected with tuberculosis covered under §§ 1902(a)(10)(A)(ii)(XII) and 1902(z)(1) of the Act;
- Individuals eligible as a Former Foster Care Child under 42 C.F.R. § 435.150;
- Pregnant women with incomes between 134% and 185% FPL; and
- Individuals with other creditable coverage.

On June 30, 2020, the Oklahoma Medicaid Expansion Initiative, State Question 802, passed by a majority vote to expand Medicaid eligibility to adults ages 19-64 whose income is at or below 138% FPL<sup>1</sup> (Expansion Adults). Medicaid expansion will go into effect on July 1, 2021.

## 1.4 SoonerSelect Dental Enrollment

The enrollment table presented below is for informational purposes only. The enrollment data used in Capitation Rate setting is presented separately in the SoonerSelect Dental Capitation Rate data book. Data

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<sup>1</sup> Includes the MAGI five percent FPL disregard

presented below reflects average monthly enrollment from September 2019 through August 2020, with the exception of Expansion Adults which reflects projected monthly enrollment. This data includes enrollment increases that were attributed to COVID-19, including requirements to maintain eligibility for otherwise ineligible individuals in accordance with Section 6008 of the Families First Coronavirus Response Act (FFCRA).

SoonerSelect Dental DBM Populations

Eligibility Group	Enrollment
Children	512,292
Pregnant Women	21,015
Deemed Newborns	1,959
Parent and Caretaker Relatives	62,199
Expansion Adults (projected – enrollment to begin 7/1/21)	175,623
Former Foster Children	706
<b>TOTAL</b>	<b>773,794</b>

**1.5 Future Reform**

OHCA may consider enrollment of additional SoonerCare eligibility groups into the SoonerSelect Dental program in future years. Expansion of enrolled populations would be implemented through the procurement or Contract amendment process.

OHCA is considering an expansion to a limited adult dental benefit as outlined in Section 1.6.1 “Dental Benefits.” This expansion is contingent upon the availability of funds and receipt of federal authority.

**1.6 General Solicitation Information**

**1.6.1 Solicitation Scope**

The purpose of this solicitation is to secure Contracts with qualified organizations that have the necessary experience and demonstrated quality to perform all of the duties outlined in Appendix 1A: Model Contract (hereinafter referred to as “Model Contract”).OHCA adheres to the concept of best-value contracting, which takes into consideration both past performance and proposed methods when determining a Bidder’s capacity to meet Contract standards.

**1.6.2 OHCA Sole Point of Contact**

OHCA is the issuing agency for this competitive bid RFP. The sole point of contact for the RFP is listed below. All RFP-related inquiries must be directed to this individual. The sole point of contact is the only individual the Bidder should contact, or communicate with, regarding any questions or issues with the RFP or a Bid, and in no instance should a Bidder contact the OHCA Chief Executive Officer, the Oklahoma Health Care Authority Board, or any other official in Oklahoma about the RFP or a Bid. Failure to comply with this requirement may result in the Bid being considered non-responsive or not considered for further evaluation. Failure to abide by this provision may result in a Bidder’s disqualification.

Sheila Killingsworth

Email: [procurement@okhca.org](mailto:procurement@okhca.org)

All emails shall include the solicitation name and number in the subject line of the email.

### **1.6.3 Definitions**

Appendices 1A and 1B to the RFP contains acronyms and definitions of key words used in the solicitation and Model Contract.

### **1.6.4 Effect of the Federal Waiver or State Plan Authority**

OHCA shall seek federal authority from CMS to operate the SoonerSelect Dental program. The Contractor shall comply with any modifications to this RFP and the subsequent Contract resulting from the approval process. In the event CMS denies the request prior to Contract award or signature, OHCA shall be under no obligation to award a Contract as a result of this RFP. In the event CMS denies the request following Contract award and signature, OHCA may terminate the Contract immediately in writing to the Contractor without penalty. OHCA shall not be liable or required to compensate the Contractor for any work performed or expenses incurred prior to termination.

### **1.6.5 Geographic Scope and Number of Contracts**

OHCA intends to award statewide Contracts to multiple Contractors. At its sole discretion, OHCA may issue a future solicitation to procure additional SoonerSelect DBMs in future Contract years.

### **1.6.6 Cost of Preparation**

The Bidder is liable for all costs incurred in preparing its Proposal and participating in any related activities, including oral presentations and Readiness Reviews, if required by OHCA as a condition of award and/or initiation of enrollment.

### **1.6.7 Certifications**

For the purposes of a competitive bid, in accordance with 74 O.S. § 85.22, the person whose signature appears on the Proposal affirms that:

- He or she is an authorized Agent for the purpose of certifying facts pertaining to the existence of collusion among and between Bidders and suppliers and State officials or employees, as well as facts pertaining to the giving or offering of things of value to government personnel in return for special consideration in connection with the prospective acquisition.
- Is fully aware of the facts and circumstances surrounding the acquisition or making of the bid to which this statement relates and has been personally and directly involved in events leading to the acquisition or submission of such bid;
- Neither the business entity that is represented in this certification nor anyone subject to the business entity's direction or control has been a party:
  - To any collusion among Bidders or suppliers in restraint of freedom of competition by agreement to bid or contract at a fixed price or to refrain from bidding or contracting;
  - To any collusion with any State official or employee as to quantity, quality or price in the prospective Contract or as to any other terms of such prospective Contract, nor
  - To any discussions between Bidders or suppliers and any State official concerning exchange of money or other thing of value for special consideration in connection with the prospective Contract; and

- If awarded the Contract, neither the business entity represented nor anyone subject to the business entity's direction or control has paid, given or donated or agreed to pay, give or donate to any officer or employee of this State any money or other thing of value, either directly or indirectly, in procuring the Contract to which this statement relate.

By submitting a response to this solicitation, the Bidder and any proposed Subcontractor(s), Subsidiaries, Affiliates and employees to the best of their knowledge and belief also certify that:

- In accordance with 74 O.S. § 85.42 and amendments or revisions thereto, no person who has been involved in any manner in the development of this Model Contract while employed by the State of Oklahoma shall be employed by the Contractor to fulfill any of the services provided under the Contract relating from this solicitation;
- No such person or entity is presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded by any federal, State or local department or agency;
- No such person or entity has, within a three-year period preceding this Proposal, been convicted of or had a civil judgment rendered against it for commission of Fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) contract; or for violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property;
- No such person or entity is presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses enumerated in the previous paragraph;
- No such person or entity has, within a three-year period preceding this application/Proposal, had one or more public (federal, state or local) contracts terminated for cause or default; and
- It will disclose any activity or interest that conflicts or may conflict with the best interest of the State, including, but not limited to, any person or entity currently under contract with or seeking to do business with the State or one of its agencies, its employees or any other third-party individual or entity awarded a contract with the State or one of its agencies. Any conflict of interest shall, in the sole discretion of OHCA, be grounds for rejection of the bid or partial or whole termination of the Contract.

Pursuant to 74 O.S. §582(B), Bidder certifies that it is not currently engaged in a boycott of goods or services from Israel that constitutes an integral part of business conducted or sought to be conducted with the State.

If the Bidder or a Subcontractor is unable to certify any of the statements in this certification, an explanation must be attached to the solicitation response.

#### **1.6.8 Bids Subject to Public Disclosure/Proprietary Information**

Unless otherwise specified in the Oklahoma Open Records Act (51 O.S. §24A.1 *et seq.*), the Central Purchasing Act, or other applicable law, documents and information a Bidder submits as part of or in connection with a solicitation, including any materials provided at an in-person meeting, are public records and subject disclosure after a contract is awarded or the solicitation is cancelled. No portion of a bid shall be considered confidential after award of the contract or cancellation of the solicitation except, pursuant to 74 O.S. § 85.10, information in a bid determined to be confidential by OHCA. This practice

protects the integrity of the competitive bid process and prevents excessive disruption to the procurement process under 51 O.S. § 24A.5(6).

Bidders claiming any portion of their bid as proprietary or confidential must specifically identify what documents or portions of documents they consider confidential and submit an additional copy of the bid with this information redacted, in accordance with instructions provided in Section 2.4.2 "Proprietary Information." OHCA shall make the final determination as to whether the documentation or information is confidential.

**1.6.9 Changes in Solicitation Specifications or Contract Terms**

Any solicitation amendment shall be set forth at the same online link as the solicitation. If one or more amendments to this solicitation are issued, the Bidder shall acknowledge receipt of any/all such amendment(s) by signing and returning the amendment cover page in accordance with instructions provided in Section 2.5.2 "Technical Proposal Contents". OHCA must receive the amendment acknowledgement(s) by the response due date and time specified for receipt of bids for the bid to be deemed responsive. Failure to acknowledge solicitation amendment(s) may be grounds for rejection.

No oral statement of any person shall modify or otherwise affect the terms, conditions or specifications stated in the solicitation. All amendments to the solicitation shall be made in writing by OHCA.

It is the Bidder’s responsibility to check the Bidder’s Library frequently for any amendments that may be issued. OHCA is not responsible for a Bidder’s failure to acquire any amendment documents required to complete a solicitation.

**1.6.10 Waiver of Objections**

The Bidder is responsible for reviewing all materials associated with this solicitation and submitting questions and comments in advance of the deadline specified in Section 1.7: "Solicitation Timeline." Protests based on any matter that could have been raised prior to the deadline, but was not, will be considered waived by OHCA.

**1.6.11 Accommodations for Bidders with Disabilities**

OHCA will make appropriate accommodations for Bidders with disabilities. Bidders seeking accommodations must notify the sole point of contact for the solicitation.

**1.7 Solicitation Timeline**

Key milestone dates for the solicitation and SoonerSelect Dental program implementation are presented in the table below. Dates are subject to change through RFP amendment. All times are Central Time.

Milestone	Day and Time
RFP available on OHCA website/email Bidders	October 15, 2020
RFP Technical Questions Due	October 29, 2020 3:00 p.m.
RFP answers available on website	November 6, 2020
Release of Capitation Rates	December 7, 2020
Actuarial Bidder’s Conference	December 14, 2020
Proposals Due to OHCA	December 15, 2020 3:00 p.m.



Milestone	Day and Time
Oral Presentations	January 25, 2021 – January 29, 2021
Award of Contract	February 1, 2021
Readiness Review	February 1, 2021 – September 30, 2021
Operations Begin	October 1, 2021

OHCA reserves the right to adjust the award announcement date. Initiation of enrollment with a Contractor will be subject to successful completion of Readiness Review activities, in accordance with 42 C.F.R. § 438.66(d). If no time of day is specified for a “Milestone” in this Section 1.7, the deadline for each is 11:59 p.m.

**1.8 Bidder’s Library**

OHCA has established an on-line Bidder’s Library for this solicitation at <http://www.okhca.org/about.aspx?id=74>. New content will be added to the Bidder’s Library as appropriate throughout the solicitation. It is the Bidder’s responsibility to check the library frequently for updated information. OHCA will not routinely notify Bidders when new material has been posted to the library.

## **2 Section 2: Solicitation Guidelines**

### **2.1 Overview**

This section presents Proposal submission requirements for Solicitation Number 8070001235. The submission requirements have been developed to identify organizations with the necessary experience, demonstrated outcomes, capacity and processes to deliver high quality, cost effective services to SoonerSelect Dental Health Plan Enrollees.

As discussed in more detail below, in conducting this solicitation, OHCA reserves the right to:

- Reject any bids that do not comply with the requirements and specifications of the solicitation. A bid may be rejected when the Bidder imposes terms or conditions that would modify the requirements of the solicitation, require indemnification by OHCA, or limit the Bidder's liability to the State;
- Waive minor irregularities in Proposals if determined to be in the best interest of the State. If granted, the waivers will in no way modify the requirements of the solicitation or the obligations of Bidders awarded Contracts;
- Award a Contract based on this solicitation and the Proposals of selected Bidder(s);
- Award the Contract to more than one Bidder, or reject any or all Proposals received, if deemed to be in the best interest of the State of Oklahoma;
- Request clarification or correction of Proposals;
- Amend this solicitation, or any segment hereof;
- Cancel this solicitation, if determined to be in the best interest of the State; or
- Discontinue the contracting process at any time.

#### **2.1.1 Submission of Bid**

Submitted bids shall be in strict conformity with the instructions to bidders and shall be submitted with a completed Responding Bidder Information, [Form 80700012408070001235-C-Proposal Cover Page](#), and any other forms required by the solicitation.

As discussed in Section 2.4.1: "Electronic Proposals", all Proposals must be submitted electronically.

The required certification statement, "Certification for Competitive Bid and/or Contract (Non-Collusion Certification)", OMES-Form-CP-004, must be made out in the name of the bidder and must be properly executed by an authorized person, with full knowledge and acceptance of all of its provisions.

The technical requirements of a properly submitted bid are discussed in Section 2.5: "Technical Proposal Requirements". A bid submitted in any other format may not be accepted.

Each bid is required to include relevant information for a designated contact to receive notice, approvals and requests allowed or required by the terms of the Contract.

Proposal shall remain firm for a minimum of one hundred eighty (180) days from the RFP closing date. Bidders guarantee unit prices to be correct. In accordance with 74 O.S 85.40, ALL travel expenses to be incurred by the supplier in performance of the Contract shall be included in the total proposal price/contract amount.

In accordance with 74 O.S. §85.40, all travel expenses to be incurred by a winning Bidder in performance of the Contract shall be included in the total bid price/contract amount. Travel expenses include, but are not limited to, transportation, lodging and meals. Examples of other miscellaneous travel expenses are referenced in Section 10.14 of the Statewide Accounting Manual.

Pursuant to Oklahoma Attorney General Opinion No. 96-7, OHCA is prohibited from indemnifying a Bidder, any subcontractor or any other party to the Contract. Any Contract between the selected Bidder and OHCA will not contain any terms limiting the liability of the Bidder or providing indemnification by OHCA in favor of the Bidder or any third parties. By submitting a Proposal, the Bidder will be deemed to acknowledge and agree that the State of Oklahoma and its agencies are prohibited from holding an individual or a private entity harmless from liability or providing indemnity to a private entity or individual. Any attempt by the Bidder to add indemnification or limitation of liability provisions in favor of the Bidder (or third parties) to the definitive Contract may render the Bidder's Proposal non-responsive and subject to rejection.

After review of a Bidder's submitted Bid, OHCA may require additional terms related to a solicitation in which consumer data will be accessed, processed or stored by the Contractor.

All bids submitted shall be subject to the Central Purchasing Act, Central Purchasing Rules, and other statutory regulations as applicable.

For the avoidance of doubt, and subject to OHCA protest process discussed in Section 2.9: "Protests", by submitting a Proposal to this RFP, the Bidder stipulates that the courts of the State of Oklahoma sitting in Oklahoma County, Oklahoma shall have personal jurisdiction over its person, and it hereby irrevocably (i) submits to the personal jurisdiction of said courts and (ii) consents to the service of process, pleadings and notices in connection with any and all actions initiated in said courts and waives any objection to venue. The Bidder agrees that a final judgment in any such action or proceeding shall be conclusive and binding and may be enforced in any other jurisdiction. Any disputes will be governed by Oklahoma law, without regard to the principals of conflict of laws of such state.

### **2.1.2 One Proposal**

Except as requested by OHCA, a bid may not be changed after the response due date and time. Bidders may submit only one Proposal in response to this solicitation. If the Bidder needs to change a submitted bid prior to the response due date and time, the Bidder shall withdraw the originally submitted bid and a new bid shall be submitted to OHCA by the response date and time. Bidders may withdraw and resubmit a Proposal at any time prior to the submission deadline. As part of the resubmission process, Bidders must acknowledge in writing that the resubmitted Proposal supersedes all previously submitted Proposals by including the following statement on the superseding bid cover page "THIS BID SUPERSEDES THE BID PREVIOUSLY SUBMITTED". The resubmitted bid should contain the solicitation number and solicitation response due date and time [in the body of the submission email].

### **2.1.3 Strict Due Date and Time**

Bids received by OHCA after the response due date and time shall be deemed non-responsive and shall NOT be considered for any resultant award.

#### **2.1.4 Property of the State**

Unless otherwise specified in the Oklahoma Open Records Act, Central Purchasing Act, or other applicable law, documents and information a Bidder submits as part of or in connection with a Bid are public records and subject to disclosure. All material submitted by Bidders becomes the property of the State of Oklahoma and will be a matter of public record, subject to the procedures for treatment of proprietary information, as described in Section 2.4.2: "Proprietary Information." OHCA shall have the right to use all concepts described in Proposals, whether or not such Proposals are accepted.

#### **2.1.5 Withdrawal from Solicitation**

Bidders may withdraw Proposals and remove themselves from consideration by providing written notification, in the form specified in OAC 260:115-3-13, to the OHCA sole point of contact at any time prior to the submission deadline. The OHCA sole point of contact is provided in Section 1.6.2: "OHCA Sole Point of Contact." A bid may not be withdrawn after the response due date and time except as authorized by the OHCA CEO after proof by the Bidder that a significant error by the Bidder exists in the bid.

Unless properly withdrawn, the submitted Proposal is deemed to be a binding offer on the part of the Bidder.

#### **2.1.6 Binding Proposals**

All bids shall be firm representations that the responding Bidder has carefully investigated and will comply with all OHCA and State terms and conditions relating to the Solicitation. Bidders whose Proposals are accepted for evaluation will be bound by the terms of the solicitation and the contents of the Proposals for the duration of the solicitation. Bidders awarded a Contract will be governed by the terms outlined in Appendix 1: Model Contract.

#### **2.1.7 Bid Rejection**

The Bidder's failure to submit required information may cause its bid to be rejected. In addition, a bid received after the bid response date and time shall be deemed non-responsive and shall not be considered unless, in accordance with OAC 260:115-3-11, OHCA has authorized acceptance of bids due to a significant error or incident that occurred which affected the receipt of a bid.

Additionally, failure to comply with these Bidder instructions or solicitation requirements may result in the bid being disqualified from evaluation. Whenever the terms "shall", "must", "will" or "is required" are used in the solicitation, the specification being referred to is a mandatory specification of the solicitation. Failure to meet any mandatory specification may cause rejection of a bid. Whenever the terms "can", "may" or "should" are used in the solicitation, the specification being referred to is a desirable item and failure to provide any item so termed shall not be the cause for rejection of a bid.

A bid may be rejected when the Bidder imposes terms or conditions that would modify the requirements of the solicitation, requires OHCA to indemnify the Bidder or a third party or limits the Bidder's liability. Other possible reasons for rejection are listed in OAC 260:115-7-32(h).

#### **2.1.8 Deficiencies**

In accordance with the OAC 260:115-7-32.J, OHCA has the right but is not required to waive minor deficiencies or informalities if OHCA determines the deficiencies or informalities do not prejudice the other Bidders. OHCA may also permit Bidders to cure certain non-substantive deficiencies if there is sufficient time prior to the award of the Contract.

## **2.2 Submission of Questions**

Bidders may submit written questions by email only to OHCA sole point of contact. Questions must be submitted using Form 8070001235-A-Questions included in the Bidder's Library. The form must be submitted in original Excel format.

OHCA will provide written answers to all technical Proposal and price questions received on or before the dates specified in Section 1.7 "Solicitation Timeline". Answers will be made publicly available in the form of one or more solicitation amendments posted to the Bidder's Library. Only posted answers will be considered official and valid by the State. No Bidder shall rely upon, take any action, or make any decision based upon any verbal communication with any State employee.

## **2.3 Actuarial Bidders' Conference; Evaluation**

### **2.3.1 Bid Public Opening**

OHCA will hold an actuarial Bidder's conference at the OHCA offices on the date and time specified in Section 1.7 "Solicitation Timeline." Additional information about the Bidder's conference will be provided in advance of the session.

### **2.3.2 Evaluation**

A responsive bid will proceed to the evaluation process. The evaluation process will be conducted in accordance with Section 2.7: "Proposal Evaluation". Bids will be evaluated on a "best value" criteria. Bidder's past performance may be considered when evaluating a Bid.

## **2.4 Proposal Structure & Submission Requirements**

### **2.4.1 Electronic Proposals**

All proposals shall be submitted electronically. Bidders will e-mail [procurement@okhca.org](mailto:procurement@okhca.org) to set up their large file upload for Bidder submissions. Bidder submissions shall include the solicitation name and number (# 8070001235) in the subject line of the email. The body of the email shall state:

1. Large file request for [Your Company Name]
2. Name of requestor
3. E-mail address of requestor

The OHCA procurement officer for this solicitation will send an email to the Bidders specified email address that states, "You've been invited to share large files."

1. The Bidder will click on the "Upload Files" button on the e-mail and will be directed to get an access key;
2. The access key will be sent in a separate email and will need to be copied and pasted into the email requesting the access key;
3. The Bidder will receive a secure e-mail to send their large files;
4. The Bidder will add the files and send their proposal; and
5. The Bidder will receive a message that the email was sent.

OHCA encourages Bidders to request a test submission to make sure they understand the process and are comfortable using the large file submission software. Once you have uploaded files from a request you can no longer upload files (i.e. you cannot upload a test file and then use the same access key to upload your solicitation response). If you need to upload more files or make corrections, a new large file request will have to be submitted.

All request to submit large files for this solicitations should be requested seven days in advance.

#### **2.4.2 Proprietary Information**

Documents and information a Bidder submits as part of or in connection with a solicitation are public records and subject to disclosure, unless otherwise specified in applicable law. Bidders claiming any portion of their bid as proprietary or confidential must conspicuously mark on the first page that its bid contains information considered confidential, specifically identify what documents or portions of documents they consider confidential, enumerate the specific grounds, based on applicable laws, which support treatment of the marked information as exempt from disclosure, explain why disclosure is not in the best interest of the public and submit an additional electronic copy of the bid with this information redacted (marked out to be illegible). The additional copies should be clearly labeled "Redacted Copy." OHCA shall make the final decision as to whether the documentation or information is confidential.

A bid marked in total as proprietary and/or confidential (versus specific documents or portions of documents within a bid) shall not be considered confidential. Likewise, unless specifically referenced otherwise in a solicitation, resumes, pricing, marketing materials, business references, additional terms proposed by a Bidder, and subcontractor information are not confidential and are not exempt from disclosure under the Oklahoma Open Records Act. The foregoing list is intended to address information often marked confidential that is not exempt from disclosure and is not an exhaustive list.

OHCA has no responsibility to independently review an entire bid for a confidentiality claim. Likewise, confidentiality claims of a Bidder will not be considered if a bid does not comply with the requirements of this Section 2.4.2 and applicable law, including OAC 260:115-3-9, and the information will be subject to disclosure pursuant to State law.

If the Bidder provides a copy of this Proposal with proprietary and confidential information redacted and OHCA appropriately supplies the redacted Proposal to another party under the Oklahoma Open Records Act or other statutory or regulatory requirements, the Bidder agrees to indemnify OHCA and step in to defend its interest in protecting the referenced redacted material.

For the avoidance of doubt, if a Bidder wishes to seek an exemption from disclosure under the Oklahoma Open Records Act or other statutory or regulatory requirements, it is the responsibility of the Bidder to assert any right of confidentiality that may exist. OHCA will not make that assertion on behalf of a Bidder.

### **2.5 Technical Proposal Requirements**

#### **2.5.1 Format**

Technical Proposals must conform to the following formatting requirements:

- Proposal header must include the solicitation number and the Bidder's legal name.
- Proposal footer must include a page number. Pages must be numbered sequentially, beginning with the transmittal letter and continuing to the end of the technical Proposal. Pages must run 1, 2, 3 etc., without starting over and with no section or question prefixes. It is not necessary to erase page numbers on pre-printed documents, such as solicitation amendments, as long as the sequential page numbering is visible. The original worksheet files included in Proposal Forms folder do not require page numbers that align with the consolidated ~~hard-copy-and~~ PDF versions.
- Narrative submission responses must be in 12-point or greater Calibri or Times New Roman font, with a minimum of one-inch margins and 1.15 line spacing.

- Wording in any exhibits included or attached to Proposal narrative must be in 8-point or greater font.
- Narrative submission responses should begin by restating the submission requirement number (i.e., Item Number) and bold-faced title. It is not necessary to restate the question.
- Page limits, where applicable, are noted at the end of a submission requirement. Page limits include headers, footers and titles. Page limits also apply to exhibits and attachments, unless otherwise specified. OHCA will not review material outside of page limits.
- The Proposal and each form and document submitted as part of the Proposal must have the Bidder’s legal name and complete address, the solicitation number and the closing date of the RFP.

**2.5.2 Technical Proposal Contents**

The Technical Proposal must contain the elements listed below, in the order shown. Mandated forms/templates are included in the Bidder’s library.

In preparing technical Proposals, Bidders are encouraged to:

- Be as specific as possible when documenting past performance (i.e., outcomes) and when describing actions or initiatives to be undertaken on behalf of SoonerSelect Dental Health Plan Enrollees;
- Use flow charts and other exhibits to help illustrate processes, where applicable;
- Address diversity within the state when describing challenges to, and strategies for, meeting program requirements, including but not limited to differences between urban and rural areas;
- Discuss innovative programs and best practices implemented in other states or for other Oklahoma populations that also will be offered to the SoonerSelect Dental Health Plan Enrollees;
- Avoid use of tentative language such as “may undertake” or “will explore doing,” as this may result in the proposed activity or initiative being given reduced or no weight in the evaluation; and
- Reference publically available data and reports, including but not limited to, Dashboards, Fast Facts, and the OHCA Annual Report, online at [www.okhca.org/data](http://www.okhca.org/data).

ITEM	INSTRUCTIONS
1	<p><b>Bidder Proposal Submission Checklist</b></p> <p>Complete and include a copy of <b>Form 8070001235-B Bidder Proposal Submission Checklist</b>. Indicate whether each submission item is included by checking “Yes” or “No.” If “No” is checked for an item, explain the reason, which is to be submitted with Bidder's Proposal.</p> <p>Note that failure to submit a required submission item may result in rejection of the Bidder’s proposal as non-responsive.</p> <p>(Page Limit: N/A)</p>
2	<p><b>Transmittal Letter</b></p> <p>Include a dated proposal Transmittal Letter signed by an individual authorized to bind the Bidder’s organization to the terms of the solicitation.</p> <p>The contents of the letter must include:</p> <ul style="list-style-type: none"> <li>• Solicitation number, Bidder’s full legal name and mailing address and FEIN.</li> </ul>

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> <li>• Name and contact information for a point-of-contact for ongoing communication.</li> <li>• A statement attesting to the accuracy and truthfulness of all information contained in the Proposal.</li> <li>• A statement that a true and correct List of Authorized Signatories of the Bidder is attached to the Proposal Transmittal Letter as an exhibit.</li> <li>• A statement that the Bidder is willing to enroll and serve all Eligibles for enrollment in the SoonerSelect Dental program as identified in Model Contract Section 1.4 “Mandatory, Voluntary and Excluded Populations.”</li> <li>• A statement that the entity proposing to contract with OHCA is located inside the United States.</li> <li>• A statement that the Bidder has reviewed and accepts the SoonerSelect Dental Capitation Rates as calculated, the Capitation Rate methodology and methodology for updating the rates.</li> </ul> <p>The letter also must include either:</p> <ul style="list-style-type: none"> <li>• A statement that the Bidder has read, understands and is able and willing to comply with all terms of the Model Contract and standards and participation requirements described in the solicitation; or</li> <li>• A statement specifying any objections the Bidder has to one or more solicitation terms or conditions. Each objection to a solicitation term or condition shall identify (i) the document and section reference of the specific affected term or condition and (ii) either that the term is inapplicable and should be intentionally omitted or offer alternative language. OHCA has no responsibility to independently review an entire bid for objections and any objection embodied in a section of the bid but not listed in the Proposal Transmittal Letter will not be considered.</li> <li>• Any additional terms that the Bidder requests be applicable to the Contract shall also be included in the Proposal Transmittal Letter and shall also be provided in a separate Word format document. OHCA has no responsibility to independently review an entire bid for additional terms and any such terms not listed in the Proposal Transmittal Letter shall not be considered.</li> </ul> <p>OHCA reserves the right to disqualify a Proposal with objections or additional Bidder terms on the grounds of non-responsiveness. Even if OHCA does not disqualify a Proposal, it makes no commitment to modifying terms and conditions based on the Bidder’s objections.</p> <p>If a bid includes an offer of value-added products and/or services, such offer shall be included in the Proposal Transmittal Letter and include associated pricing and any other information relevant to such value-added offer. However, OHCA is not obligated to purchase value-added products or services.</p> <p>(Page Limit: N/A)</p>
3	<b>Solicitation Amendments</b>



ITEM	INSTRUCTIONS
	<p>RFP amendment(s), if any, will be located at the same online link as the RFP. The Bidder shall acknowledge agreement with each RFP amendment, if any, by including a cover page from each RFP amendment, signed by an authorized signatory of the Bidder, in its bid.</p> <p>(Page Limit: N/A)</p>
4	<p><b>OMES- and OHCA-Mandated Representations and Certifications</b></p> <p>Include completed <u>Form 8070001235 - C Cover Page and Form 8070001235-D-Bidder Representations and Certifications</u>. Note that Form 8070001235-D consists of both a Word document and Excel File (“companion templates”). Include <del>a hard-an</del> <b>electronic</b> copy of the Excel file content immediately behind Form 8070001235-D. If a template within the Excel file does not contain data, enter “N/A” in the first row of the template and include in the proposal.</p> <p>Form 8070001235-C and Form 8070001235-D include signature requirements. The forms should be signed by the same individual signing the Bidder’s Transmittal Letter.</p> <p>(Page Limit: N/A)</p>
5	<p><b>Privatization Act Mandated Representations and Certifications</b></p> <p>Include a section in the Bidder’s Proposal which addresses the following items:</p> <ul style="list-style-type: none"> <li>• A description of any past (within the past <del>ten</del> <b>five</b> years) or present litigation involving the Bidder. <del>Include the case name, court, case number, and a brief description of the case and any judgments, settlements or decisions.</del></li> <li>• The financial stability of the Bidder, including its ability to fund its operations during the term of the Contract.</li> <li>• At least three references related to the Bidder’s performance of a contract with a governmental entity or agency.</li> <li>• A detailed description of how the Bidder will perform the Contract, including anticipated staffing and equipment information.</li> </ul> <p><del>To the extent that Bidder has addressed these items elsewhere in the proposal, Bidder may attest that all requested information has been provided. Any such attestation must clearly identify where the requested information is located in the proposal. Bidders must ensure that all requests for information are answered completely.</del></p> <p>Include a certification, in accordance with 74 O.S. § 589, certifying that the Bidder:</p> <ul style="list-style-type: none"> <li>• Will offer available employee positions pursuant to the Contract to qualified employees of OHCA who meet the hiring criteria of the Bidder (or any applicable Subcontractor) and whose State employment is terminated because of the awarding of the Contract to the Bidder.</li> <li>• Agrees that the Contract shall provide that the dollar amount agreed upon in the Contract may be reduced if the agency experiences a budget shortfall, <del>but such adjustment shall ensure capitation rates remain actuarially sound and are approved by CMS.</del></li> <li>• Is financially stable as of the date of its Proposal and shall maintain a financially stable operation in accordance with all State and federal laws, regulations and guidance during the term of the Contract, including any extensions thereof.</li> </ul> <p>(Page Limit: N/A)</p>

6	<p><b>Executive Summary</b></p> <p>Include an Executive Summary of your proposal to serve SoonerSelect Dental Health Plan Enrollees. The Executive Summary should describe your approach to improve oral health outcomes, increase access to care and increase accountability in the SoonerCare program. Information included in the Executive Summary may be used by OHCA when preparing public announcements concerning solicitation awards.</p> <p>(Page Limit: Six pages)</p>
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ITEM	INSTRUCTIONS
7	<p><b>Oklahoma Experience</b></p> <p>Describe your organization’s experience in the State of Oklahoma serving publicly- and privately-funded populations. Limit your response to the years 2015 and later.</p> <p>Provide examples of innovative programs and initiatives implemented for Oklahoma populations, results achieved and how these programs and initiatives will be integrated into your strategy for serving SoonerSelect Dental Health Plan Enrollees.</p> <p>Also include <b><u>Form 8070001235-E-Oklahoma Experience</u></b>.</p> <p>(Page Limit: Five pages, excluding Form 8070001235-E)</p>
8	<p><b>Medicaid Experience</b></p> <p>Describe your organization’s experience serving the Medicaid populations covered under the SoonerSelect Dental program in other states. Limit your response to the years 2015 and later.</p> <p>As part of your response, provide examples of innovative programs and initiatives implemented in other states, results achieved, and data collected to document and measure those results. Describe their relevance to the SoonerSelect Dental program, potential barriers to implementation in Oklahoma and how you intend to overcome these barriers.</p> <p>Also include <b><u>Form 8070001235 – F- Other State Medicaid Experience</u></b>.</p> <p>(Page Limit: Six pages, excluding Form 8070001235 – F)</p>
9	<p><b>References</b></p> <p>References shall be submitted using <b>Form 8070001235 – G - References</b> in accordance with the instructions on the front page of the form. It is the responsibility of the Bidder to collect references from their customers. All references should be signed and clearly list the contact information of the responding customer. Bidder will submit three to five references where the proposed solution is currently in use. <b>At least three references must relate to the Bidder’s performance of a contract with a governmental entity or agency.</b></p> <p>(Page Limit: N/A)</p>
10	<p><b>Litigation</b></p> <p>Describe whether a contracting party found you to be in breach of any of your dental services contracts within the past five years. The response should include parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.</p>

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> <li>• Provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond your control.</li> <li>• If a corrective action plan was imposed, describe the steps and timeframes in the corrective action plan and whether the corrective action plan was completed.</li> <li>• If a sanction was imposed, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage).</li> <li>• If the breach was the subject of an administrative proceeding or litigation, indicate the result of the proceeding/litigation.</li> </ul> <p>Responses should also include:</p> <ul style="list-style-type: none"> <li>• A statement of whether there is any pending or recent (within the past five years) litigation against the Bidder. This shall include, but not be limited to, litigation involving failure to provide timely, adequate, or quality dental services. <b>Disclose the case name, court, case number, and a brief description of the case and any judgments, settlements or decisions.</b> The Bidder does not need to report workers’ compensation cases. <del>If there is pending or recent litigation against the Bidder,</del> Describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include an opinion of counsel as to the degree of risk presented by any pending litigation and whether pending or recent litigation will impair the Bidder’s performance in a contract. The Bidder shall also include any Securities and Exchange Commission (SEC) filings discussing any pending or recent litigation. The Bidder shall also address the Bidder’s parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.</li> <li>• The Bidder shall specify whether there is any pending or recent (within the past five years) litigation against a <b>Major</b> health care service Subcontractor. This shall include, but not be limited to, litigation involving failure to provide timely, adequate, or quality physical or behavioral health services. <b>Disclose the case name, court, case number, and a brief description of the case and any judgments, settlements or decisions.</b> The Bidder does not need to report workers’ compensation cases. <del>If there is pending or recent litigation against a health care service Subcontractor,</del> Describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Also, the Bidder shall include any SEC filings discussing any pending or recent <b>Major</b> health care service Subcontractor litigation. The Bidder shall address the <b>Major</b> Subcontractors’ parent organization, affiliates, and subsidiaries.</li> </ul> <p><b>Form 8070001235-D-B.12 Legal Actions must be completed in addition to, and may not serve as a substitute for, Items 5 and 10</b></p> <p>(Page Limit: N/A)</p>

11	<p><b>Company Financial Information</b></p> <p>Provide a copy of the Bidder’s audited financial statements for each of the last three years, including at least a balance sheet, profit and loss statement, or other appropriate documentation, and the auditor’s report. This information must also be submitted with respect to the Bidder’s corporate parent organization and any Major Subcontractors, as applicable.</p> <p>Also, describe how the Bidder can assist the state with cash flow for start-up costs such as Fee-For-Service claims run out, if the need arises. <b>OHCA is requesting ideas from Bidders for offsetting initial costs to the State and assisting with potential cash flow issues. Please use experience in other states to provide response.</b></p> <p>(Page Limit: N/A)</p>
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ITEM	INSTRUCTIONS
12	<p><b>General Terms and Conditions: Reinsurance</b></p> <p>Describe how you intend to meet the reinsurance requirements outlined in the Model Contract Section 1.1.18.7 “Reinsurance.”</p> <p>(Page Limit: One page)</p>
13	<p><b>Payments to Contractor: Capitation Reconciliation and Overpayment</b></p> <p>Describe your process for completing a monthly reconciliation of enrollment roster data against Capitation Payments in accordance with Model Contract Section 1.2.2: “Capitation Reconciliation.”</p> <p>(Page Limit: One page)</p>
14	<p><b>Administrative Requirements: Licensure</b></p> <p>The Contractor shall be licensed and authorized to transact dental business in the state of Oklahoma in accordance with Model Contract Section 1.3.1: “Licensure.” Include a copy of your license, or if not currently licensed in Oklahoma, your plan for obtaining licensure and the date by which this is anticipated to occur.</p> <p>(Page Limit: Two pages, excluding license. If already licensed statewide, do not submit a narrative.)</p>
15	<p><b>Administrative Requirements: Accreditation</b></p> <p>Indicate whether you are currently accredited in accordance with Model Contract Section 1.3.2: “Accreditation.” If not currently accredited, describe your plan to achieve accreditation within the required timeframe. Identify the entity from which you will be seeking accreditation.</p> <p>(Page Limit: One page)</p>
16	<p><b>Administrative Requirements: Major Subcontractors</b></p> <p>Identify the services to be furnished by Major Subcontractors, as defined in Model Contract Section 1.3.3: “Subcontracting” As part of your response, discuss:</p> <ul style="list-style-type: none"> <li>• Roles and locations of each Major Subcontractor, Subsidiary and Affiliate;</li> <li>• Relevant experience of each Subsidiary, Major Subcontractor and Affiliate;</li> <li>• Metrics used to evaluate prospective Major Subcontractors’, Subsidiaries’ and Affiliates’ abilities to perform delegated activities prior to delegation;</li> <li>• Policies and procedures for monitoring Major Subcontractor activity;</li> <li>• Enforcement policies used for Major Subcontractor non-performance, including examples;</li> </ul>

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> <li>• How you will ensure ongoing collaboration with Major Subcontractors for a streamlined and coordinated approach to serving Dental Health Plan Enrollees and Providers; and</li> <li>• Quality goals and performance oversight activities for Major Subcontractors providing health services.</li> </ul> <p>Also include <b>Form 8070001235-H-Major Subcontractors</b> for each applicable Subcontractor.</p> <p>(Page Limit: Six pages, excluding Form 8070001235-H)</p>
17	<p><b>Administrative Requirements: Oklahoma Presence, Business Relationships &amp; Organizational Structure</b></p> <p>Describe your organizational structure for the SoonerSelect Dental Plan, in accordance with Model Contract Section 1.3.5: “Oklahoma Presence.” Include a description of the relationship to other Oklahoma lines-of-business and entities described in Model Contract Section 1.3.4: “Business Relationship Disclosure,” as applicable. For any functions to be performed outside of Oklahoma, describe how you will ensure a streamlined and coordinated approach to serving Dental Health Plan Enrollees and Providers and how you will ensure the remote location does not hinder OHCA’s ability to monitor performance.</p> <p>Also provide:</p> <ul style="list-style-type: none"> <li>• Organizational chart of SoonerSelect Dental Plan showing functions, staff types including number of full time employees and their reporting relationships. Identify functions located within and outside of Oklahoma and functions performed by Subcontractors.</li> <li>• Chart depicting SoonerSelect Dental Plan’s relationship to parent and affiliate plans, as applicable.</li> </ul> <p>(Page Limit: Four pages, excluding charts)</p>
18	<p><b>Administrative Requirements: Key Staff</b></p> <p>Describe your management structure and include a copy of <b>Form 8070001235-I-Key Staff</b> identifying the individuals who will serve in the Key Staff positions described in Model Contract Section 1.3.6.2: “Key Staff,” if known. Also:</p> <ul style="list-style-type: none"> <li>• Include a job description for each position denoted on Form 8070001235-H that includes at least the following information: position responsibilities; reporting relationship; educational and experience requirements; and license/credential requirements, if applicable.</li> <li>• Include a current resume for each of the individuals identified on <b>Form 8070001235-I</b>. Resumes must include at least the following information: Summary of relevant experience; work history up to the present time; educational history; and licenses/credentials, if applicable, and history of exclusion, debarment or other</li> </ul>

ITEM	INSTRUCTIONS
	<p>sanction; and history of audit or investigation by any federal, State authority or entity or Subcontractor thereof related to managed care activities in any state.</p> <ul style="list-style-type: none"> <li>• Provide a summary of recruitment timelines and activities for Key Staff positions for which individuals have not been identified. Describe contingency plans should these positions continue to remain open after Contract award.</li> </ul> <p>(Page Limit: Three pages, excluding Form 8070001235-I, job descriptions, resumes, recruitment timelines and contingency plans)</p>
19	<p><b>Administrative Requirements: Board of Directors</b></p> <p>Describe your Board of Director’s constituted for purposes of the SoonerSelect Dental Plan. Include in your response:</p> <ul style="list-style-type: none"> <li>• Description of how Board members are selected.</li> <li>• If the Board will be local.</li> <li>• A biographical description for each Board member.</li> </ul> <p>(Page Limit: Three pages)</p>
20	<p><b>Administrative Requirements: Staffing</b></p> <p>Describe your staffing plan for the SoonerSelect Dental Plan that meets the requirements of Model Contract Section 1.3.6: “Staffing.” Include the basis utilized for determining required numbers of staff by position type. Also include a copy of <b>Form 8070001235-J-Plan Staffing</b> denoting the estimated number of staff, by position, along with a job description for each position denoted on Form 8070001235-J that includes at least the following information: position responsibilities; reporting relationship; educational and experience requirements; and license/credential requirements, if applicable.</p> <p>(Page Limit: Three pages, excluding Form 8070001235-J and job descriptions)</p>
21	<p><b>Location of Staff within Oklahoma</b></p> <p>Identify your existing and proposed office locations within Oklahoma and any other office locations outside of Oklahoma. Describe your basis for selecting these locations, including a service area-level map denoting the locations.</p> <p>Also describe how staff located outside of Oklahoma will be structured to ensure compliance with Contract requirements and how Oklahoma-based staff will maintain a full understanding of the operations conducted out-of-state.</p> <p>(Page Limit: Three pages, excluding map)</p>
22	<p><b>Economic Impact</b></p> <p>Describe how your organization will contribute to the Oklahoma economy, in terms of jobs created specifically for this Model Contract.</p>



ITEM	INSTRUCTIONS
	<p>Also include a copy of <b>Form 8070001235-K-Economic Impact</b> documenting the estimated economic impact of your proposed Oklahoma-based staff.</p> <p>(Page Limit: Two pages, excluding Form 8070001235-K)</p>
23	<p><b>Administrative Requirements: Staff Training</b></p> <p>Describe your approach to staff training that meets the requirements of Model Contract Section 1.3.6.6: “Staff Training.” Also include a description of your approach to monitoring Subcontractor training.</p> <p>(Page Limit: Two pages)</p>
24	<p><b>Administrative Requirements: Policies and Procedures</b></p> <p>Describe your process and timeline for development and internal approval of policies and procedures in accordance with SoonerSelect Dental Program requirements outlined in Model Contract Section 1.3.9: “Policies and Procedures.”</p> <p>(Page Limit: Three pages)</p>
25	<p><b>Implementation Plan</b></p> <p>Address your plan for implementation through all of the following:</p> <ul style="list-style-type: none"> <li>• Identify key implementation activities and describe your approach for ensuring these activities will be completed prior to the onsite Readiness Review scheduled to occur approximately 120 days prior to initial enrollment of SoonerSelect Dental Eligibles;</li> <li>• Required OHCA resources to ensure Bidder readiness;</li> <li>• Discuss potential barriers or risks to timely implementation and your process for addressing;</li> <li>• Discuss the results of Readiness Reviews conducted in other Medicaid managed care programs. Limit examples to 2015 or later. Identify all examples of functions that failed at the time of the review and any corrective action plans issued as a result; and</li> <li>• Include an implementation work plan created in Microsoft Project or equivalent format that presents major implementation milestones and associated tasks by functional area between Proposal submission and 90 days post-go live. (The format specification is for presentation purposes only; the implementation plan should be submitted as part of the larger PDF Proposal.) The work plan should be in sufficient detail to serve as a management tool for tracking implementation progress in the event of Contract award.</li> </ul> <p>(Page Limit: Seven pages, excluding work plan)</p>
26	<p><b>Mandatory, Voluntary and Excluded Populations</b></p> <p>Identify any populations mandatorily or voluntarily enrolled in the SoonerSelect Dental, as identified in Model Contract Section 1.4: “Mandatory, Voluntary and Excluded Populations” that you do not have experience covering under a risk-based Medicaid managed care contract.</p>

ITEM	INSTRUCTIONS
	<p>Describe how you will prepare as an organization to deliver services to these population(s) in accordance with Model Contract requirements.</p> <p>(Page Limit: Three pages)</p>
27	<p><b>Covered Benefits</b></p> <p>Describe how you will prepare as an organization to deliver the benefits in accordance with Model Contract requirements. Identify any covered benefits specified in Model Contract Section 1.6: “Covered Benefits” that you do not have experience offering on a risk basis.</p> <p>(Page Limit: Three pages)</p>
28	<p><b>Covered Benefits: Value-Added Benefits</b></p> <p>Identify any Value-Added Benefits you propose to offer to SoonerSelect Dental Health Plan Enrollees and the basis for their selection. Complete <b>Form 8070001235-L-Value-Added Benefits</b> specifying expected utilization and cost of each benefit, as well as any limits in terms of eligible populations, service caps and/or Prior Authorization requirements. <del>Note that Form 8070001235-J must be signed by the actuary attesting to the actuarial value estimate.</del></p> <p>(Page Limit: Two pages, excluding Form 8070001235-L)</p>
29	<p><b>Covered Benefits: EPSDT</b></p> <p>Describe your strategies for increasing EPSDT screening visit rates.</p> <p>Provide an example of an innovative approach you took to address EPSDT, the results achieved, and how you will apply this experience to SoonerSelect Dental. Limit your examples to 2015 or later.</p> <p>(Page Limit: Three pages)</p>
30	<p><b>Covered Benefits: School-Based Services</b></p> <p>Describe your approach for reimbursing school-based services in accordance with Model Contract Section 1.6.6: “School-Based Services.” Include in your response how you will ensure compliance with the requirements of OAC317:30-5-1020 through 317:30-5-1027.</p> <p>(Page Limit: Three pages)</p>
31	<p><b>Dental Management: Evidence-Based Guidelines</b></p> <p>Describe your relevant experience and approach to developing an evidence-based dental management strategy. As part of your response, describe:</p> <ul style="list-style-type: none"> <li>• How evidence-based guidelines are developed and employed in medical management decision making;</li> <li>• How Providers are educated about guidelines, including updates;</li> <li>• How service utilization and other operational data are used to evaluate the effectiveness of guidelines; and</li> </ul>

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> <li>• How guidelines are updated based on outcomes and to remain current with national trends.</li> </ul> <p>In addition, provide two examples of dental management guidelines that were updated in response to evaluation of utilization/operational data or national trends and the impact of the changes. Limit your examples to 2015 or later.</p> <p>(Page Limit: Five pages)</p>
32	<p><b>Dental Management: Prior Authorization</b></p> <p>Describe your relevant experience and proposed approach for performing Prior Authorizations (PA) in accordance with the requirements outlined in Model Contract Section 1.7: “Dental Services Utilization Management.” Include a flow chart depicting the proposed workflow for processing PA requests from initial request to final disposition, including the process for expedited authorizations.</p> <p>As part of your response, discuss:</p> <ul style="list-style-type: none"> <li>• External guidelines to be used, if applicable;</li> <li>• How you will identify services that should require PA, beyond those currently required by OHCA;</li> <li>• Methods of PA submission available to Providers;</li> <li>• Processes to ensure timely processing;</li> <li>• Qualifications of prior authorization personnel;</li> <li>• Who will have authority to deny services;</li> <li>• Your peer-to-peer review process; and</li> <li>• How you will ensure consistent application of review criteria.</li> </ul> <p>(Page Limit: Five pages)</p>
33	<p><b>Dental Management: High Utilizers</b></p> <p>Describe your strategy for defining, identifying and improving quality of care and outcomes among high utilizers within the SoonerSelect Dental program.</p> <p>In addition, provide an example of an initiative undertaken to improve quality of care and outcomes for a high utilization population. Discuss the identified problem, intervention and results achieved. Limit your example to 2015 or later.</p> <p>(Page Limit: Four pages)</p>

ITEM	INSTRUCTIONS
34	<p><b>Coordination with Other SoonerCare Programs and Other State Agencies</b></p> <p>Describe your procedures to coordinate services delivered under the Contract with services Dental Health Plan Enrollees receive from the Medical MCO and community and social support providers in accordance with Model Contract Section 1.7.5: “Coordination with Other SoonerCare Programs.”</p> <p>Also describe your procedures to coordinate services delivered under the Contract with other state agencies in accordance with Model Contract Section 1.3.8: “Coordination with Other State Agencies.” Provide examples of successful collaborations with other state agencies that have been implemented in other state Medicaid programs.</p> <p>(Page Limit: Three pages)</p>
35	<p><b>Coordination with Other SoonerCare Programs: Case Study (Sarah)</b></p> <p>Sarah is a 17-year-old with a diagnosis of depression, as well as previous meth use. Sarah is in need of extensive dental work, and will continue to be at a high risk of oral disease as long as her behavioral health and substance abuse is not controlled. Describe the policies and procedures the DBM will have in place to coordinate oral health care with the appropriate behavioral health professionals.</p> <p>(Page Limit: Three pages)</p>
36	<p><b>Coordination with Other SoonerCare Programs: Case Study (Billy)</b></p> <p>Billy is a middle aged adult. He hasn’t had his teeth cleaned and has several loose teeth. He sees a dentist a few times a year when these loose teeth start to bother him. When Billy does have a tooth removed, he is very slow to heal. He is overweight and has a family history of diabetes. How will the DBM coordinate regular health screenings for members with theMCO?</p> <p>(Page Limit: Three pages)</p>
37	<p><b>Coordination with Other SoonerCare Programs: Case Study (Billy, ctd.)</b></p> <p>Billy has now been diagnosed with Type II Diabetes. He is not always compliant with his medications and does not always eat well. He comes in for another extraction. Dr. Williams asks Billy if he has had any medical changes. Billy states that he is as good as ever. After the extraction Billy has complications. Billy’s last HbHA1c was 8.1. How can the DBM encourage effective communication between the Primary Care Dentist (PCD) and PCP providers?</p> <p>(Page Limit: Three pages)</p>

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38	<p><b>Coordination with Other SoonerCare Programs: Case Study (Kyle)</b></p> <p>Due to a rare disease, Kyle, an 11 year old boy, is in need a liver transplant. He is on the waiting list, but to be eligible he must be free of any oral disease prior to the procedure. He has not seen a dental provider since he was 6 and has extensive dental treatment needs. Describe the contractor’s policies to ensure expedited care prior to the procedure, and to ensure effective communication takes place between the PCD and the health care providers both before and after the procedure.</p> <p>(Page Limit: Three pages)</p>
39	<p><b>Coordination with Other SoonerCare Programs: Case Study (Mark and Denise)</b></p> <p>Mark and Denise have an 8 month old baby. Dental care has not been a priority to them. They only see a dentist when ‘it really hurts’. They are not aware of oral health care needs for infants and toddlers. They do however, bring their child in for well-child visits as they want their child to stay healthy. Describe how the DBM will coordinate early oral preventive care interventions and referrals for care through the PCP? How does the DBM coordinate with both the PCP and the PCD to ensure kids start out with good oral health?</p> <p>(Page Limit: Three pages)</p>
40	<p><b>Transition of Care</b></p> <p>Describe your relevant experience and proposed approach for completing transition of care activities in accordance with requirements outlined in Model Contract Section 1.8: “Transition of Care.” As part of your response, discuss how you will:</p> <ul style="list-style-type: none"> <li>• Capture existing Prior Authorizations in your medical management system and ensure they are honored during the Continuity of Care period;</li> <li>• Identify Dental Health Plan Enrollees with continuity of care needs beyond the 90 day Continuity of Care Period as described in Model Contract Section 2.9.3: “Transition of Prior Authorizations;”</li> <li>• Ensure Dental Plan Enrollee services are not interrupted during the transition period; and</li> <li>• How you will share data and coordinate with other MCOs, OHCA or SoonerCare, and Non-Participating Providers.</li> </ul> <p>(Page Limit: Four pages)</p>
41	<p><b>Transition of Care: Case Study (Janet)</b></p> <p>Two years ago, Janet had a dental examination. She was told that she needed extensive dental treatment including several root canals and crowns. She was not able to complete the work due to transportation issues. Her grandfather recently gave her a car and she is ready to complete her dental work. Janet called to make an appointment with her dental provider. When the provider’s office called the Plan to verify eligibility, the Plan provider services representative noticed that Janet’s 21<sup>st</sup> birthday is in seven days and some of the services she needs are not covered under the adult benefit plan. Describe how the plan will ensure that</p>

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	<p>Janet receives the services she needs prior to aging out of the children’s benefit while also making sure the member successfully transitions into the adult dental benefit. What programs are in place to ensure members are not denied access to care due to lack of dependable transportation?</p> <p>(Page Limit: Three pages)</p>
42	<p><b>Access to Care</b></p> <p>Describe your relevant experience and approach to improving access to oral health care. As part of your response discuss:</p> <ul style="list-style-type: none"> <li>• Improving access to providers for Health Care Plan Enrollees living in rural areas and more specifically Dental Health Professional Shortage Areas.</li> <li>• Including screening, fluoride treatments, and sealants for Health Care Plan Enrollees within other alternative environments within the community.</li> <li>• Increasing oral health awareness and literacy among Health Care Plan Enrollees.</li> <li>• Diminishing language and cultural barriers to care.</li> <li>• Collaborating with community stakeholders to barriers to accessing oral health care.</li> </ul> <p>(Page Limit: 20 pages)</p>
43	<p><b>Access to Care: Case Study (Roger)</b></p> <p>Roger is a 49 year old male with extensive dental needs. He cannot afford treatment. Medicaid will only pay for medically necessary extractions. He does not want his teeth pulled. He manages a small store and believes that his customers will lose confidence in him if he does not have teeth. How will the Plan assist Roger in obtaining the treatment he needs to prevent extraction?</p> <p>(Page Limit: Three pages)</p>
44	<p><b>Access to Care: Case Study (Mya)</b></p> <p>Mya plays basketball at her high school girls’ varsity team. Dr. Jones placed braces on her teeth almost two years ago. She often knocks her brackets off while playing. Dr. Jones is now charging a \$50 fee to replace the brackets. Mya is raised by her grandmother who is on social security and cannot pay for the bracket replacement. Describe what policies and procedures are in place to handle this situation.</p> <p>(Page Limit: Three pages)</p>
45	<p><b>Quality: Quality Assurance and Performance Improvement (QAPI) Program</b></p> <p>Describe your relevant experience and proposed approach for implementing and administering QAPI programs in accordance with the requirements specified in Model Contract Section 1.9.3: “Quality Assessment and Performance Improvement (QAPI) Program.” In your description, address all of the following:</p> <ul style="list-style-type: none"> <li>• The QAPI governance and committee structure, responsibilities and functions;</li> </ul>

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	<ul style="list-style-type: none"> <li>• Provider representation on the QIC and other quality committees, including the total number and types of specialties represented;</li> <li>• How the larger organization, including plan leadership, is committed to quality improvement;</li> <li>• How you will ensure that Providers actively participate in the QAPI program; and</li> <li>• How you will make information about the QAPI program available to Providers and Dental Health Plan Enrollees.</li> </ul> <p>In addition, provide two examples of quality improvement initiatives undertaken in collaboration with Participating Providers. Discuss the basis for their selection, the involvement of Participating Providers in their design and implementation and results achieved. Limit your examples to 2015 or later.</p> <p>Also provide a sample QAPI program description, work plan and program evaluation utilized in another program. Include the materials after your narrative.</p> <p>(Page Limit: Eight pages, excluding sample QAPI program description, work plan and program evaluation; there is no page limit for the sample materials.)</p>
46	<p><b>Quality Improvement: Dental Health Plan Enrollee Satisfaction</b></p> <p>Provide the two most recent years of CAHPS data available for up to three Medicaid managed care programs. If you do not have CAHPS data but have other Dental Health Plan Enrollee satisfaction data, provide the substitute data along with a description of the methodology employed in its collection and analysis.</p> <p>(Page Limit: N/A)</p>
47	<p><b>Quality Improvement: Provider Satisfaction</b></p> <p>Provide results of Provider satisfaction surveys for up to three of Bidder’s Medicaid managed care programs. Limit examples to 2015 or later.</p> <p>If you do not have data for a program that meets the above specifications, indicate such in your response.</p> <p>(Page Limit: N/A)</p>
48	<p><b>Quality Improvement: Quality Performance Measures</b></p> <p>Select two (2) measures from Model Contract Section 1.9.5.1: “Oral Health Performance Measures” and describe strategies you employed in one or more Medicaid managed care programs to improve performance on the measure(s). As part of your response, discuss:</p> <ul style="list-style-type: none"> <li>• Why the measure(s) were selected for improvement;</li> <li>• Populations targeted;</li> <li>• Specific interventions undertaken;</li> </ul>

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	<ul style="list-style-type: none"> <li>• Intervention time period; and</li> <li>• Results achieved.</li> </ul> <p>(Page Limit: Eight pages)</p>
49	<p><b>Quality Improvement: HEDIS Measures</b></p> <p>Provide the two most recent years of audited HEDIS reports available for up to three of Bidder’s Medicaid managed care programs. The reported results must have undergone a HEDIS compliance audit conducted by an NCQA-certified HEDIS compliance auditor. The reports must be the final, auditor-locked version reported to the NCQA’s interactive database. Provide reference to the population(s) for which you are reporting, including geographic location and Dental Health Plan Enrollee demographics. If you do not have data for a program that meets the above specifications, indicate such in your response.</p> <p>(Page Limit: N/A)</p>
50	<p><b>Quality improvement: Addressing Health Disparities</b></p> <p>Describe your relevant experience and proposed approach for reducing health disparities in health care access, services and outcomes in accordance with the requirements of Model Contract Section 1.9.7 “Addressing Health Disparities..”</p> <p>In addition, provide an example of an innovative approach you took to address health disparities, the results achieved, and how you will apply this experience to SoonerSelect Dental.</p> <p>Limit your examples to 2015 or later. (Page Limit: Three pages)</p>
51	<p><b>Quality Improvement: Performance Improvement Projects (PIPs)</b></p> <p>Describe your proposed approach to ensure PIPs, as required under Model Contract Section 1.9.6: “Performance Improvement Projects (PIPs),” are effective in addressing identified focus areas and improving outcomes and quality of care for Dental Health Plan Enrollees. Include the following in your response:</p> <ul style="list-style-type: none"> <li>• Lessons learned, challenges and successes you have experienced while conducting PIPs, and how you will consider those experiences in implementing SoonerSelect Dental PIPs;</li> <li>• Proposed PIP focus areas for the first two Contract years;</li> <li>• Rationale for proposed PIPs; and</li> <li>• Methods for monitoring and ongoing evaluation of PIP progress and effectiveness.</li> </ul> <p>(Page Limit: Four pages)</p>
52	<p><b>Quality Improvement: Provider Profiling</b></p> <p>Describe your relevant experience and proposed approach to conducting provider profiling, in accordance with the requirements outlined in Model Contract Section 1.9.8: “Provider Profiling.” Include the following in your response:</p>



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	<ul style="list-style-type: none"> <li>• Methodology for determining which and how many Providers will be profiled;</li> <li>• Proposed performance measures;</li> <li>• Rationale for selecting proposed measures;</li> <li>• The proposed frequency with which profiles will be distributed.</li> </ul> <p>Also include a sample profile report or a representative sample used in another program.</p> <p>(Page Limit: Three pages; there is no page limit for the sample profile)</p>
53	<p><b>Dental Health Plan Enrollee Services: Accessibility</b></p> <p>Describe your relevant experience and proposed approach to ensuring that information is accessible to all Dental Health Plan Enrollees, in accordance with requirements outlined in Model Contract Section 1.10: “Dental Health Plan Enrollee Services.” As part of your response, discuss:</p> <ul style="list-style-type: none"> <li>• Your proposed auxiliary aids and alternative formats;</li> <li>• How you will meet in-office interpreter requirements; and</li> <li>• How you will ensure compliance with SoonerSelect Dental cultural competency requirements.</li> </ul> <p>In addition, provide an example of an innovative approach you took to make Dental Health Plan Enrollee services accessible to Dental Health Plan Enrollees with disabilities, the results achieved and how you will apply this experience to SoonerSelect Dental. Limit your example to 2015 or later.</p> <p>(Page Limit: Five pages)</p>
54	<p><b>Dental Health Plan Enrollee Services: New Dental Health Plan Enrollee Outreach</b></p> <p>Describe your relevant experience and proposed approaches for conducting outreach to new Dental Health Plan Enrollees and making initial contact in accordance with requirements outlined in Model Contract Section 1.10.5: “New Dental Health Plan Enrollee Materials and Outreach.” As part of your response discuss:</p> <ul style="list-style-type: none"> <li>• How you will undertake and track initial contact efforts;</li> <li>• SoonerSelect Dental population segments most likely to be “hard-to-contact” and steps you will take to reach hard-to-contact Dental Health Plan Enrollees;</li> <li>• How you will ensure distribution of Dental Health Plan Enrollee materials in compliance with timeliness standards; and</li> <li>• Initial Dental Health Plan Enrollee education activities.</li> </ul> <p>In addition, provide an example of an innovative approach you took to improve contact rates among hard-to-contact Dental Health Plan Enrollees, the results achieved and how you will apply this experience to SoonerSelect Dental. Limit your example to 2015 or later.</p>

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	<p>Also include a copy of <b>Form 8070001235 –T– New Dental Health Plan Enrollee Contact Rates</b>.</p> <p>(Page Limit: Five pages, excluding Form 8070001235-T)</p>
55	<p><b>Dental Health Plan Enrollee Services: New Dental Health Plan Enrollee Outreach Case Study (Rebecca)</b></p> <p>Rebecca is a 24-year old SoonerSelect Dental Health Plan Enrollee enrolled effective June 1. Rebecca was auto-assigned to your plan. Her enrollment information did not include a phone number and listed an Oklahoma City area homeless shelter as her last place of residence. Rebecca left the shelter on May 25 and the shelter does not know her current whereabouts. Describe how you will attempt to contact Rebecca by June 10.</p> <p>(Page Limit: Three pages)</p>
56	<p><b>Dental Health Plan Enrollee Services: Website &amp; Social Media</b></p> <p>Describe your relevant experience and proposed approach to using the Dental Health Plan Enrollee website, social media and mobile applications to enhance communications with Dental Health Plan Enrollees. As part of your response, discuss:</p> <ul style="list-style-type: none"> <li>• The types of social media applications and platforms you will employ;</li> <li>• How social media, the Dental Health Plan Enrollee website and mobile applications will be tailored to the different SoonerSelect Dental populations;</li> <li>• How you will monitor Dental Health Plan Enrollee use and responsiveness to social media, mobile applications and the Dental Health Plan Enrollee website; and</li> <li>• How you will ensure compliance with all State and federal privacy requirements, including but not limited to HIPAA, 42 U.S.C. § 290dd-2; 42 C.F.R. §§ 2.1 – 2.67, and 43A O.S. § 1-109.</li> </ul> <p>In addition, provide an example of an innovative approach you took to improve Dental Health Plan Enrollee health outcomes through social media, mobile applications or website, the results achieved and how you will apply this experience to the SoonerSelect Dental program. Limit your example to 2015 or later.</p> <p>(Page Limit: Five pages)</p>
57	<p><b>Dental Health Plan Enrollee Services: Call Center</b></p> <p>Describe your relevant experience and proposed approach to operating a call center, in accordance with the requirements outlined in Model Contract Section 1.10.7: “Dental Health Plan Enrollee Services Call Center.” As part of your response, discuss:</p> <ul style="list-style-type: none"> <li>• Call center location(s) and hours of operation;</li> <li>• How you will train call center staff;</li> <li>• How you will monitor compliance with performance standards and address staffing needs during unanticipated spikes in volume;</li> </ul>

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	<ul style="list-style-type: none"> <li>• How you will handle calls received from non-English speakers; and</li> <li>• Whether you will operate a combined call center for Dental Health Plan Enrollee and Provider services. If not, describe your proposed Provider Service call center structure in accordance with the requirements of Model Contract Section 1.12.2: “Provider Services Call Center.”</li> </ul> <p>Also include a copy of <b><u>Form 8070001235-M-Call Center Performance</u></b>.</p> <p>(Page Limit: Five pages, excluding Form 8070001235-M)</p>
58	<p><b>Dental Health Plan Enrollee Services: Call Center Scenarios</b></p> <p>Describe your procedures to address the following calls received at the Dental Health Plan Enrollee Services Call Center:</p> <ul style="list-style-type: none"> <li>• A Dental Health Plan Enrollee has received a bill from a Participating or Non-Participating Provider for a covered benefit.</li> <li>• A Dental Health Plan Enrollee is unable to reach his PCD Provider during non-business hours.</li> <li>• A Dental Health Plan Enrollee needs urgent dental care while traveling outside of Oklahoma.</li> <li>• A Dental Health Plan Enrollee is unable to find a specialist.</li> <li>• A Dental Health Plan Enrollee poses a clinical question to a Dental Health Plan Enrollee Services Call Center staff.</li> <li>• A Dental Health Plan Enrollee requests to see a Non-Participating Provider.</li> <li>• A Dental Health Plan Enrollee calls to file a Grievance.</li> <li>• A Dental Health Plan Enrollee calls to file an Appeal.</li> <li>• A Dental Health Plan Enrollee is requesting disenrollment.</li> <li>• A Dental Health Plan Enrollee calls to report a change in income or mailing address.</li> </ul> <p>(Page Limit: 11 pages)</p>
59	<p><b>Dental Health Plan Enrollee Services: Advisory Board</b></p> <p>Describe your relevant experience establishing Dental Health Plan Enrollee and Provider advisory boards and the proposed structure and composition of the SoonerSelect Dental Advisory Board described in Model Contract Section 1.10.9: “Advisory Board”. Discuss the steps you will take to identify, recruit and encourage participation by Dental Health Plan Enrollees.</p> <p>Also, provide two examples of issues brought before your Dental Health Plan Enrollee or Provider advisory board(s) operating in other Medicaid programs, actions taken based on recommendations from the board(s) and results achieved.</p> <p>In addition, as part of the response, you may include a letter of reference from an advisory board member in another program. The letter, if included, should discuss the board member’s</p>

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	<p>experience in terms of having meaningful input into plan decision making and the board member’s opinion of the plan’s level of inclusiveness with respect to soliciting and acting on the recommendations of stakeholders.</p> <p>(Page Limit: Four pages, excluding letter of reference)</p>
60	<p><b>Dental Health Plan Enrollee Services: PCD Selection and Assignment</b></p> <p>Describe your relevant experience and proposed approach for assigning Dental Health Plan Enrollees to PCD Providers in accordance with requirements outlined in Model Contract Section 1.10.10: “PCD Selection and Assignment.” As part of your response discuss:</p> <ul style="list-style-type: none"> <li>• Strategies you will implement to achieve high rates of Dental Health Plan Enrollee self-selection of a PCD Provider;</li> <li>• How you will educate Dental Health Plan Enrollees about their PCD Provider options, as well as their ability to change their PCD;</li> <li>• Processes you will implement to ensure Contractor-initiated PCD Provider assignments meet the criteria outlined in Model Contract Section: 1.10.10.2.: “Assignment Requirements;” and</li> <li>• How you will monitor trends with regard to PCD Provider changes and use the data as part of network management activities.</li> </ul> <p>(Page Limit: Four pages)</p>
61	<p><b>Dental Health Plan Enrollee Services: Marketing</b></p> <p>Describe your approach for meeting the requirements outlined in Model Contract section 1.10.14: “Marketing and Outreach” As part of your response, describe the types of Marketing you intend to undertake. Also discuss how you will ensure compliance with State and federal Marketing standards within your organization, including through training and monitoring activities.</p> <p>(Page Limit: Three pages)</p>
62	<p><b>Provider Network Development</b></p> <p>Describe your provider network development strategy to ensure compliance with access standards outlined in Model Contract Section 1.11.4: “Time and Distance and Appointment Access Standards” at the time of Readiness Review. Also discuss:</p> <ul style="list-style-type: none"> <li>• What you consider to be the most significant challenges to developing a complete statewide Provider network;</li> <li>• Innovative network development strategies you have employed in other programs and how you will implement these strategies for your SoonerSelect Dental network to overcome identified challenges; and</li> <li>• How you will address gaps and barriers-to-care where there are no Providers in a geographic area.</li> </ul>

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	(Page Limit: Five pages)
63	<p><b>Provider Network Development: Monitoring Compliance with Access Standards</b></p> <p>Describe your relevant experience and proposed approach for monitoring compliance with access standards as described in Model Contract Section 1.11.4: “Time and Distance and Appointment Access Standards” and how you will respond to gaps identified through monitoring activities.</p> <p>In addition, provide an example of an innovative approach you took to close a network gap, the results achieved and how you will apply this experience to the SoonerSelect Dental. Limit your example to 2015 or later.</p> <p>(Page Limit: Four pages)</p>
64	<p><b>Provider Network Development: Provider Agreements</b></p> <p>Provide sample provider agreements in accordance with the requirements of Model Contract Section 1.11.2: “Provider Agreement Requirements.”</p> <p>(Page Limit: N/A)</p>
65	<p><b>Provider Network Development: Credentialing</b></p> <p>Describe your relevant experience and proposed approach for meeting the credentialing requirements outlined in Model Contract Section 1.11.3: “Credentialing.” Include in your response:</p> <ul style="list-style-type: none"> <li>• How you will ensure all Participating Providers hold appropriate licensure or certification and are enrolled with SoonerCare;</li> <li>• Description of your credentialing process and timelines, including ways to reduce Participating Providers’ burden and loading Participating Providers into your claims processing system; and</li> <li>• Your experience with utilizing a centralized credentialing agency.</li> </ul> <p>(Page Limit: Three pages)</p>
66	<p><b>Provider Network: Primary Care Dentist Model</b></p> <p>Describe your proposed approach for contracting with PCD Providers in accordance with requirements outlined in Model Contract Section 1.11.2.4: “Provider Agreement Requirements for Specific Provider Types.”</p> <p>In addition, provide an example of an innovative approach you took to supporting PCD activities and quality of care through use of health information technology, the results achieved and how you will apply this experience to SoonerSelect Dental. Limit your example to 2015 or later.</p> <p>(Page Limit: Five pages)</p>
67	<p><b>Provider Network: Ongoing Monitoring</b></p> <p>Describe your approach for conducting ongoing monitoring as outlined in Model Contract Section 1.11.3.2 “Ongoing Monitoring.”</p>

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	<p>As a part of your response, discuss:</p> <ul style="list-style-type: none"> <li>• How you collect data for ongoing monitoring;</li> <li>• Your internal review and validation process for the data; and</li> <li>• Your process for reviewing and addressing poor quality performance by Participating Providers.</li> </ul> <p>(Page Limit: Four Pages)</p>
68	<p><b>Provider Services</b></p> <p>Describe your relevant experience and proposed approach to preparing Participating Providers to serve SoonerSelect Dental Health Plan Enrollees and for ongoing network management in accordance with Model Contract section 1.12: “Provider Services.”</p> <p>As part of your response, discuss:</p> <ul style="list-style-type: none"> <li>• Network education and training activities prior to go live;</li> <li>• Assessment of Provider readiness prior to go live;</li> <li>• Collaboration with Providers to meet performance-based contracting targets; and</li> <li>• Methods for ongoing monitoring of network compliance with program requirements.</li> </ul> <p>In addition, provide an example of an innovative approach you took to educating Providers without managed care experience on managed care principles and procedures, the results achieved and how you will apply this experience to SoonerSelect Dental. Limit your example to 2015 or later.</p> <p>(Page Limit: Five pages)</p>
69	<p><b>Provider Services: Provider Education, Training and Technical Assistance</b></p> <p>Describe your relevant experience and proposed approach for providing ongoing Provider training, education and technical assistance. Also, include your approach to assisting Providers to comply with requirements concerning Prior Authorization, claims payment and quality-related data reporting. Include in your response methods for identifying Providers which require targeted outreach.</p> <p>(Page Limit: Three pages)</p>
70	<p><b>Provider Services: Provider Complaint System</b></p> <p>Describe your relevant experience and proposed approach for operating a Provider Complaint system in accordance with Model Contract Section 1.12.6: “Provider Complaint System.”</p> <p>(Page Limit: Three pages)</p>
71	<p><b>Provider Payment: Performance-Based Provider Payments</b></p> <p>Describe your relevant experience and proposed approach for meeting the performance-based provider payment thresholds outlined in Model Contract Section 1.13.1.7: “Performance-Based Provider Payments.” As part of your response:</p>

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	<ul style="list-style-type: none"> <li>• Separately discuss PCD and dental specialist;</li> <li>• Outline the specific reimbursement methodology, or methodologies, to be implemented, including payment structure, performance incentives and metrics; and</li> <li>• Describe how data sharing and reporting will be used to promote transparency, collaboration and accountability with provider partners of all types.</li> </ul> <p>Also provide an example of an innovative performance-based purchasing initiative you have undertaken, including objectives for the initiative, month/year of implementation, barriers encountered, how these barriers were overcome and the results achieved. Limit your example to 2015 or later.</p> <p>(Page Limit: Five pages)</p>
72	<p><b>Provider Payment: Claims Processing</b></p> <p>Describe your claims system and proposed processes for meeting the requirements outlined in Model Contract Section 1.13.4: “Claims Processing.” As part of your response, describe:</p> <ul style="list-style-type: none"> <li>• Procedures for receipt and adjudication of electronic and paper claims;</li> <li>• Process for identification and resolution of Provider- or system-level issues; and</li> <li>• Processes for ensuring compliance with timely payment requirements.</li> <li>• Process for ensuring claims accuracy.</li> </ul> <p>Also include a copy of <b>Form 8070001235-N-Claims Processing</b>.</p> <p>(Page Limit: Ten pages, excluding Form 8070001235-N)</p>
73	<p><b>American Indian/Alaska Native Population and IHCPs: Tribal Government Liaison</b></p> <p>Describe your relevant experience and proposed approach for undertaking an outreach strategy for American Indian/Alaska Native Dental Health Plan Enrollees and how you will use the Tribal Government Liaison position to support American Indian/Alaska Native Dental Health Plan Enrollees and IHCPs in accordance with the requirements outlined in Model Contract section 1.14.1: “Tribal Government Liaison.”</p> <p>(Page Limit: Three pages)</p>
74	<p><b>American Indian/Alaska Native: Indian Health Care Providers</b></p> <p>Describe how you will meet the network requirements outlined in Model Contract section 1.14.4: “Indian Healthcare Providers (IHCPs).”</p> <p>(Page Limit: Three pages)</p>
75	<p><b>Dental Health Plan Enrollee Grievances and Appeals</b></p> <p>Describe your proposed structure and process for meeting the requirements outlined in Model Contract Section 1.15: “Dental Health Plan Enrollee Grievances and Appeals.” As part of your response discuss:</p>

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> <li>• How you will provide assistance to Dental Health Plan Enrollees in filing Grievances or Appeals;</li> <li>• How you determine if a Grievance or Appeal will undergo an expedited review;</li> <li>• Who in your organization will serve as decision makers when reviewing Grievances and Appeals;</li> <li>• How you will ensure compliance with timeliness requirements;</li> <li>• Processes for continuing or reinstating benefits;</li> <li>• How you will incorporate Grievance and Appeals data into your quality improvement process; and</li> <li>• Your process for remediation as required by certain grievance and appeals outcomes.</li> </ul> <p>In addition, provide an example of a trend you identified through analysis of Grievances data, the steps you took to address and the results achieved. Provide a separate example for a trend identified through analysis of Appeals data. Limit your examples to 2015 or later.</p> <p>Also include a copy of <b><u>Form 8070001235-O-Dental Health Plan Enrollee Grievances and Appeals Resolution</u></b>.</p> <p>(Page Limit: Seven pages, excluding Form 8070001235-O)</p>
76	<p><b>Cost Sharing</b></p> <p>Describe your methodology, in accordance with the requirements of Model Contract Section 1.16: “Cost Sharing,” for the following:</p> <ul style="list-style-type: none"> <li>• Systematically identifying Cost Sharing exempt Dental Health Plan Enrollees;</li> <li>• Ensuring Cost Sharing is not imposed on Cost Sharing exempt services;</li> <li>• Reducing claims payment to Providers by the amount of a Dental Health Plan Enrollee’s Cost Sharing obligation;</li> <li>• Notifying Providers when a Dental Health Plan Enrollee is exempt from Cost Sharing; and</li> <li>• Tracking and responding to the five percent Cost Sharing limit.</li> </ul> <p>(Page Limit: Four pages)</p>
77	<p><b>Program Integrity</b></p> <p>Describe your structure and proposed processes for meeting the requirements outlined in Model Contract Section 1.17: “Program Integrity.” As part of your response, provide an overview of your Compliance Program and discuss:</p> <ul style="list-style-type: none"> <li>• Your procedures for educating and training both employees and Subcontractors in accordance with Model Contract Section: “1.17.2.2: “Compliance Education and Training;”</li> </ul>



ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> <li>• Your internally-focused and externally-focused Fraud and abuse detection methodologies, including but not limited to, analytics, referral processes, audit techniques (or practices), and reporting;</li> <li>• Your procedures for reporting changes in Dental Health Plan Enrollee or Provider circumstances;</li> <li>• Your procedures for suspending payments for credible allegations of Fraud; and</li> <li>• Your procedures for verifying delivery of services to Dental Health Plan Enrollees.</li> </ul> <p>(Page Limit: Five pages)</p>
78	<p><b>Information Technology: General Requirements</b></p> <p>Describe your capacity and proposed approach for meeting the requirements outlined in Model Contract Section 1.18.1: “General Requirements.” Include in your response the following:</p> <ul style="list-style-type: none"> <li>• A description and system diagram of the proposed Management Information System (MIS) solution that will support the SoonerSelect Dental program. Ensure at a minimum the response covers all systems that support the required functional areas that you will provide as a part of your solution.</li> <li>• Provide a narrative and diagram that demonstrates an understanding of all required interfaces.</li> <li>• Describe and discuss your data analytics and reporting tools capabilities. How do your tools and processes provide you with the capability to prepare timely and accurate reports for submission to OHCA as required? Describe internal reports you can create to monitor internal operations and system performance. Describe your standard (out of the box) reporting as well as your ability to provide as hoc reporting based on the changing CMS environment.</li> <li>• Describe and discuss your current status of readiness for implementation of the features and functions required in the 21<sup>st</sup> Century CURES act – specifically the support application programming interface (API), easy access to Eligibles data in real time, Interoperability and application authentication and Anti-blocking provisions. If not currently operational, indicate when the compliance systems will be in place. Describe your standard (out of the box) reporting as well as your ability to provide ad hoc reporting based on the changing CMS environment.</li> <li>• Describe your IT infrastructure regarding the MIS DBM platform; explain your IT Roadmap for continued development and improvements in the care management enterprise.</li> <li>• Discuss your System Development Lifecycle (SDLC) for new development and correcting defects and how you will notify and keep OHCA, Dental Health Plan Enrollees and Providers informed of any updates or releases to your systems.</li> <li>• Confirm your ability to utilize all batch and online HIPAA transactions listed in Model Contract Section: 1.18.1 “General Requirements.”</li> <li>• Confirm your ability and experience in providing T-MSIS data to State Medicaid agencies for submission to CMS.</li> </ul>

ITEM	INSTRUCTIONS
	(Page Limit: Ten pages; page limit does not include IT Roadmap or MIS Diagram)
79	<p><b>Information Technology: Operations Support and Integration of IT Systems</b></p> <p>Describe your approach to meeting the requirements of Model Contract Section 1.18.2: “Operations.” Include in your response:</p> <ul style="list-style-type: none"> <li>• How your IT solution integrates and makes available in real time, all data captured by your various functional operational units.</li> <li>• A description and explanation of your systems capabilities for detecting duplicate Dental Health Plan Enrollee records. What tools are in place to merge duplicate records or unmerge records that were incorrectly merged?</li> <li>• A description of how you will ensure complete and accurate data, including from any Subcontractors prior to submitting any required reports to OHCA and including provisions for responding to requests by Eligibles to a change in or amendment to a dental record.</li> </ul> <p>(Page Limit: Four pages)</p>
80	<p><b>Information Technology: Communications with OHCA</b></p> <p>Describe your approach to meeting the requirements of Model Contract Section 1.18.3: “Communications with OHCA.” Include in your response an explanation of how you will communicate with OHCA, including how you will meet the OHCA security standards for encryption of confidential information.</p> <p>(Page Limit: Three pages)</p>
81	<p><b>Information Technology: Dental Health Plan Enrollee Encounter Data</b></p> <p>Describe your approach to meeting the requirements of Model Contract Section 1.18.4: “Dental Health Plan Enrollee Encounter Data.” Include in your response:</p> <ul style="list-style-type: none"> <li>• A detailed diagram and narrative that specifically discusses and demonstrates how your system collects data from your claims system and Subcontractors to create the required encounters file in the required format as specified in the Contract.</li> <li>• A description of your ability to meet the format requirements specified in the Contract.</li> <li>• A description of your internal quality assurance (QA) and validation process to analyze the weekly encounter file prior to sending to OHCA. If encounters are handled at the national level, describe how you will work with the local Oklahoma office/staff to coordinate submission of the encounter file and/or to resolve any errors detected.</li> <li>• In the event that errors are found, whether during your internal QA or by rejected transactions from the State’s MMIS, describe your process for reconciliation, resolving, and resubmitting any errors.</li> <li>• Confirm and describe how you will ensure that all claims data, including not only paid claims but denied claims, voided claims, zero dollar paid and claim adjustments will be included in your Encounter Data submissions to both the State MMIS and State HIE.</li> </ul>

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> <li>• Statistics from at least two other states that demonstrate your ability to submit timely, accurate and complete encounters.</li> </ul> <p>(Page Limit: Five pages)</p>
82	<p><b>Information Technology: Health Information Exchange</b></p> <p>Describe your approach to meeting the requirements of Model Contract Section 1.18.4.4: “Health Information Exchange.” In addition to the items outlined in the aforementioned section, submitter shall specifically, address the following items in your response:</p> <ul style="list-style-type: none"> <li>• Your proposed plan to integrate with the State’s HIE. What additional data will you share and what data do you expect to pull from the HIE?</li> <li>• As it relates to your implementation of CURES Act, specifically interoperability and anti-information blocking, explain your system capabilities and processes to share the core data (required in the CURES Act) set with other MCOs and OHCA as Dental Health Plan Enrollees move or transition to another plan.</li> <li>• Discuss your experience submitting Encounter Data to a State HIE as well as a State Medicaid MMIS system.</li> <li>• Discuss how you will train and monitor Participating Provider’s compliance with the requirement to connect to the State HIE and submit Admission, Discharge and Transfer (ADT) orders.</li> <li>• Discuss how you will train and monitor Provider’s use of their Electronic Health Records (EHRs) connected to the State HIE. What actions will you take upon discovering that a Participating Provider connected to the State HIE is not submitting or receiving clinical health information?</li> <li>• Discuss how you will train and monitor Provider’s use of the State HIE Provider portal to query patient data when the Provider does not have an EHR. What actions will you take upon discovering that a Participating Provider does not use the State HIE provider portal?</li> <li>• Discuss your approach and processes for converting incoming paper claims to HIPAA standard formats for claims processing and Encounter Data generation.</li> </ul> <p>(Page Limit: Five pages)</p>
83	<p><b>Information Technology: Enrollment Data</b></p> <p>Describe your approach to meeting the requirements of Model Contract Section 1.18.5: “Enrollment Data.” Include in your response:</p> <ul style="list-style-type: none"> <li>• Description of your experience and process for receiving daily 834 transactions and reconciling them to both your capitation payment file and your internal Dental Health Plan Enrollee system.</li> <li>• Discussion of your current abilities to make use of a statewide e-Master Person Index (e-MPI) as a unique statewide identifier.</li> </ul> <p>(Page Limit: Two pages)</p>
84	<p><b>Information Technology: System Security</b></p>

ITEM	INSTRUCTIONS
	<p>Describe your approach to meeting the requirements of Model Contract Sections 1.18.6: “System Security.” Include responses to the following questions:</p> <ul style="list-style-type: none"> <li>• Description of your overall cybersecurity methodology, with an emphasis on which best practices your organization follows to manage its cybersecurity risks. Clarify whether your methodology adheres to any cybersecurity frameworks, including but not limited to, National Institute of Standards and Technology (NIST), or ISO/IEC 27001. If so, provide documentation on how your practices align.</li> <li>• Description of what auditing capabilities exist in the system. What are your processes around security audits to include frequency, results reporting, and corrective actions?</li> <li>• How you will manage security authorizations to the system. At a minimum, include content regarding processes for role-based security, fine-grained controls for authorization, and your processes for identification and authentication.</li> <li>• What encryption level does your system support and what type of encryption do you recommend and upon what bases?</li> <li>• What type of security controls and measures will you implement? Include both system and physical security controls at national offices and any proposed local Oklahoma offices.</li> <li>• What is your process for handling security incidents? “Security Incident” refers to attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with the hosted environment used to perform the services.</li> <li>• Describe your process for corrective action should a system error or penetration test reveal that PHI/PII could have been or was compromised.</li> <li>• Describe how you perform data masking in test environments and/or production.</li> <li>• Describe data management techniques and processes as they relate to security.</li> <li>• Describe your security monitoring and evaluation activities. Include both system monitoring and operational monitoring and evaluation activities.</li> <li>• What type of security and privacy training do you provide? How often and to whom?</li> <li>• Describe the extent of your latest SOC Type II, HiTrust, or equivalent audit and did you have any findings? If so, what corrective actions were done or will be done to address the findings?</li> <li>• If you are utilizing a cloud hosting service, describe a breakdown of security shared responsibility model, with supportive roles, processes, policies, and procedures defining how those security responsibilities are being maintained.</li> <li>• Describe any third-party security assessments performed on your cloud providers.</li> <li>• Do you classify assets by risk and criticality and if so, describe your methodology and approach to classifying your IT assets?</li> <li>• If you upgrade your system(s), what kind of security testing is done prior to implementing the new solution or fix?</li> </ul> <p>Include a copy of <b>Form 8070001235-P-MCO Security Specifications</b> and <b>Form 8070001235-Q-OMES Cloud Computing Certification</b>. Please note that in Form 8070001235-Q, the maturity levels for each control are based on NIST 800-53 Rev 5 guidance.</p>

ITEM	INSTRUCTIONS
	(Page Limit: Ten pages; does not include Forms 8070001235-P and -Q or security audit)
85	<p><b>Information Technology: Business Continuity and Disaster Recovery</b></p> <p>Describe your approach to meeting the requirements of Model Contract Sections 1.18.7: “Disaster Preparation and Data Recovery” and Section 1.18.8: “Back-up Plan.” Include in your response:</p> <ul style="list-style-type: none"> <li>• A high level narrative of your BCDR plan.</li> <li>• Description of your testing procedures for the BCDR Plan. Include description of frequency of testing and where your offsite recovery centers are located.</li> <li>• Discussion of the last time you invoked your BCDR plan and how you ensured services to Dental Health Plan Enrollees were not disrupted.</li> </ul> <p>Also submit a copy of your current BCDR plan.</p> <p>(Page Limit: Four pages; does not include BCDR plan)</p>
86	<p><b>Information Technology: Accessibility</b></p> <p>Describe your approach to meeting the requirements of Model Contract Section 1.18.9: “Accessibility.” Include in your response:</p> <ul style="list-style-type: none"> <li>• Description of functionality for your proposed Web Portals (Dental Health Plan Enrollee and Provider). Discuss compliance with section 508 requirements.</li> <li>• Describe any development efforts required either on the proposed IT system infrastructure to comply with Contract requirements or the required reporting capabilities to meet the Contract requirements in this section.</li> <li>• Discussion of your ability to meet the requirements listed in Model Contract Section 1.18.9.1 “System Performance Requirements.”</li> </ul> <p>(Page Limit: Three pages)</p>
87	<p><b>Third Party Liability</b></p> <p>Describe your relevant experience and proposed approach for identification and management of TPL in accordance with the requirements outlined in Model Contract Section 1.19.3: “Third Party Liability.”</p> <p>(Page Limit: Three pages)</p>
88	<p><b>Reporting</b></p> <p>Describe your relevant experience and proposed approach for meeting the requirements outlined in Model Contract Section 1.20: “Reporting.” As part of your response, discuss:</p> <ul style="list-style-type: none"> <li>• Your monitoring and evaluation procedures for ensuring reports are accurate and submitted timely;</li> <li>• Your ability to generate ad hoc reports if requested by OHCA;</li> <li>• How changes to reporting requirements will be addressed, including testing and quality assurance procedures;</li> </ul>

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> <li>• How reports are continually analyzed and incorporated into quality improvement initiatives;</li> <li>• Your process for monitoring, tracking and validating data from Subcontractors; and</li> <li>• Your capability to produce system-generated reports versus manual.</li> </ul> <p>(Page Limit: Five pages)</p>
89	<p><b>Contractor Performance Standards</b></p> <p>Describe your relevant experience and proposed approach for monitoring performance against program standards and identifying and correcting deficiencies proactively. As part of your response, discuss:</p> <ul style="list-style-type: none"> <li>• The role individual departments will play in monitoring performance;</li> <li>• Whether there will be a centralized function within the plan responsible for monitoring performance; and</li> <li>• Process for identifying, reporting and remediating performance issues.</li> </ul> <p>Also include a copy of <b><u>Form 8070001235-R- Contractor Performance History</u></b>.</p> <p>(Page Limit: Four pages, excluding Form 8070001235-R)</p>
90	<p><b>Contract Termination</b></p> <p>Describe whether your organization has had a contract terminated or not renewed for any reason within the past ten years. The response should include parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business. Include a description of the issues and the parties involved and provide the name, title, email address and direct telephone number of the primary contact for the party with whom the contract was held.</p> <p>(Page Limit: N/A)</p>
91	<p><b>Customizations</b></p> <p>Describe the level of customization to your current programming and operations your organization will need to implement to comply with the terms of the SoonerSelect Dental Model Contract.</p> <p>(Page Limit: Ten pages)</p>
92	<p><b>Contract Compliance</b></p> <p>Describe the processes you have in place to achieve compliance with the terms of the SoonerSelect Dental Model Contract.</p> <p>(Page Limit: Four pages)</p>

ITEM	INSTRUCTIONS
93	<p data-bbox="316 237 560 268"><b>Strategic Alignment</b></p> <p data-bbox="316 317 1409 390">Provide a detailed description of your success in “moving the needle” on each payment and delivery system reform goal articulated in Section 1.2: “SoonerSelect Dental Goals.”</p> <p data-bbox="316 432 581 464">(Page Limit: 15 pages)</p>

**SoonerSelect Dental Solicitation Forms – Summary Listing (Forms are located in Bidder’s Library)**

Form Number	Form Title
Form 8070001235 - A	SoonerSelect Dental Solicitation Questions
Form 8070001235 - B	Bidder Proposal Submission Checklist
Form 8070001235 - C	Cover Page
Form 8070001235 - D	Bidder Representations and Certifications
Form 8070001235 - E	Oklahoma Experience
Form 8070001235 – F	Other State Medicaid Experience
Form 8070001235 – G	References
Form 8070001235 – H	Identification of Major Subcontractors
Form 8070001235 – I	Key Staff
Form 8070001235 - J	Plan Staffing
Form 8070001235 - K	Economic Impact
Form 8070001235 – L	Value-Added Benefit
Form 8070001235 – M	Call Center Performance
Form 8070001235 – N	Claims Processing
Form 8070001235 – O	Dental Health Plan Enrollee Grievances and Appeals Resolution
Form 8070001235 – P	DBM Security Specifications
Form 8070001235 – Q	OMES Cloud Computing Certification
Form 8070001235 – R	Contractor Performance History
Form 8070001235 – S	OMES Hosting Agreement
Form 8070001235 – T	New Dental Health Plan Enrollee Contact Rates

**2.6 Written Clarification and Oral Presentations**

OHCA reserves the right, at its sole discretion, to request clarifications of bid information or to conduct discussions for the purposes of clarification with any or all Bidders. The purpose of any such discussion shall be to ensure full understanding of the bid. If clarifications are made because of such discussion, the Bidder(s) shall put such clarifications in writing. Bidder answers that are outside the scope of the clarification questions shall be disregarded. Oral explanations or instructions provided to a potential Bidder is not binding.

If a bidder fails to notify OHCA of an error, ambiguity, conflict, discrepancy, omission or other error in the Solicitation, known to the Bidder, or that reasonably should have been known by the Bidder, the Bidder shall submit a bid at its own risk; and if awarded the contract, the Bidder shall not be entitled to additional compensation, relief or time, by reason of the error or its later correction. If a Bidder takes exception to any requirement or specification contained in the Solicitation, these exceptions must be clearly and prominently stated in their Proposal.

OHCA also may schedule oral presentations as part of Proposal evaluation activities. OHCA may invite some or all Bidders to participate in oral presentations. Further information on oral presentation schedule and content requirements will be provided after the Proposal submission deadline.



**2.7 Proposal Evaluation**

Following the closing of the RFP, an administrative review and evaluation process will be conducted to determine the responsiveness and quality of each Proposal.

Proposals will be evaluated based upon the ability of the Bidder to satisfy the requirements of the RFP in best serving the interests of the citizens of Oklahoma. Each of the evaluation steps is described below with a brief explanation of the evaluation criteria in that step. The points associated with each evaluation area are indicated following the category name.

**2.7.1 Step One – Administrative Review (Pass/Fail)**

OHCA will review the Bidder’s Proposal for timely submission, completeness, and compliance with general submission guidelines outlined in this RFP. The Administrative Review will also determine compliance with mandated forms and ability to meet risk-based capital requirements. Inability to meet any Mandatory Requirements will be grounds to disqualify a response from further consideration.

**2.7.2 Step Two – Technical Proposal Evaluation (1,550 points)**

OHCA will review each Proposal passing the Administrative Review and use the Evaluation Areas and points below to determine a Technical Proposal score for each Bidder.

Evaluation Area	Points Possible
Executive Summary	25
Staffing and Organizational Structure	75
References and Past Performance Information	50
Corporate Information and Experience in Improving Outcomes includes: <ul style="list-style-type: none"> <li>• Oklahoma Experience</li> <li>• Medicaid Experience</li> <li>• Proposed Oklahoma Economic Impact</li> </ul>	100
Implementation Plan	50
Provider Network	75
Covered Benefits	100
Rural Health Strategy	75
American Indian/Alaska Native Health Understanding and Strategy	50
Care Coordination	150
Dental Utilization Management	100
Quality Improvement	100
Dental Health Plan Enrollee Services including:	75

Evaluation Area	Points Possible
<ul style="list-style-type: none"> <li>Dental Health Plan Enrollee Grievance and Appeals</li> <li>Call Center</li> </ul>	
Provider Services including: <ul style="list-style-type: none"> <li>Claims Payment Processing</li> <li>Call Center</li> </ul>	75
Program Integrity	75
Information Technology Including: <ul style="list-style-type: none"> <li>General Requirements Response</li> <li>Encounter Processing</li> <li>Interoperability Rule Readiness</li> <li>HIE Response</li> <li>System Security and Privacy</li> <li>Business Continuity and Disaster Recovery Plan</li> </ul>	100
Financial Standards and Third Party Liability	75
Reporting	50
Value-Based Payment Strategy	50
Case Studies	75
Contractor Performance/Compliance Strategy	25

The CEO of OHCA or such CEO’s designee(s) will, in the exercise of their sole discretion, determine which Proposal(s) offer the best means of serving the interests of the State based on overall RFP scores. The exercise of this discretion will be final.

**2.7.3 Step Three – Oral Presentation Evaluation (50 points)**

As stated in Section 2.6, OHCA may invite some or all Bidders to participate in Oral Presentations. OHCA may “short-list” some Bidders as a result of their Technical Proposal scores from Steps 2 & 3 and invite only those Bidders “short-listed” to participate in oral presentations.

If Bidders are invited to provide Oral Presentations, the Oral Presentations will be evaluated and eligible to be awarded points based on the possible point values below:

	Points Possible
SoonerSelect Dental	50

Oral Presentation scores would be added to Technical Proposal scores to result in final proposal scores. Bidders may have little notice as to whether they will be invited or not invited to provide oral presentations January 18-22, 2021, so all Bidders should be prepared to provide oral presentations that follow the instructions for oral presentations that will be distributed after the Proposal submission deadline as stated previously in Section 2.6.

#### **2.7.4 Step ~~Three~~ Four – Final Negotiations**

In accordance with the Oklahoma Central Purchasing Act and Oklahoma Administrative Code (OAC) 260:115, OHCA reserves the right to negotiate with one, selected, all or none of the Bidders responding to this RFP to obtain the best value for OHCA. OHCA reserves the right to limit negotiations to those Proposals that received the highest rankings during the initial evaluation phase. Negotiations will be conducted in accordance with OAC 260:115-7-34, and may be conducted in person, in writing or by electronic means. Negotiations could entail discussions on products, services, pricing, Contract terminology or any other issue that mitigate OHCA's risks. OHCA will consider all issues negotiable and not artificially constrained by internal corporate policies. Negotiation may be with one or more Bidders, for any and all items in the Bidder's Proposal. Bidders that contend a lack of flexibility because of corporate policy on a particular negotiation item shall face a significant disadvantage and may not be considered.

### **2.7.5 Step ~~Four~~ Five – Award of Contract**

Contract awards shall be made in accordance with OAC 260:115-7-36. OHCA may award the Contract to more than one Bidder by awarding the Contract(s) by item or groups of items or may award the Contract on an all or none basis, whichever is deemed to be in the best interest of OHCA.

Pursuant to Oklahoma Attorney General Opinion No. 06-23, any Bidder that has assisted in preparing the solicitation or developing the procurement terms, either directly or indirectly, is precluded from being awarded the Contract or from securing a sub-contractor that has provided such services.

Prior to award, OHCA may choose to request information from the Bidder to demonstrate its (and/or its parent's or subsidiary's) financial status and performance.

### **2.7.6 Step ~~Five~~ Six – Notice of Award**

1. The successful Bidder(s) shall be notified they have been selected for award, and before the official award, the following shall be requested to be completed:
  - a. In order to receive an award or payments from the State of Oklahoma, Bidder must be a registered vendor. The Bidder registration process can be completed electronically through the website at the following link: <https://www.ok.gov/dcs/vendors/index.php>.
  - b. The successful Bidder shall register with the Oklahoma Secretary of State or shall attach a signed statement that provides specific details supporting the exemption the supplier is claiming. The Oklahoma Secretary of State Office's contact information is as follows: [www.sos.ok.gov](http://www.sos.ok.gov) or 405-521-3911.
  - c. Bidder is required to provide a certificate of liability insurance showing proof of compliance with Model Contract Section 1.1.18: "Insurance".
2. A notice of award in the form of a purchase order or other Contract documents resulting from this RFP shall be furnished to the successful Bidder(s) and shall result in a binding Contract.
3. Notification of award shall also be posted on OHCA website.

## **2.8 Debriefings**

Bidders may request copies of proposals and evaluation and award materials after the Contract has been awarded. Due to limited staff time, OHCA is unable to provide formal debriefings for any Bidder.

## **2.9 Protests**

Protest of awards under this solicitation will be addressed by OHCA in accordance with administrative rules found at OAC 317:2-1-14. In summary, a Bidder who wishes to protest the award of a contract under the solicitation must submit a written notice to the OHCA Legal Division within ten Business Days of the contract award. The protest must state the relevant facts and the Bidder's grounds for protest. The OHCA Legal Division will respond to the Bidder's protest within ten Business Days of its receipt of the Bidder's properly submitted written notice of protest. OHCA will determine, in its sole discretion, if a written notice of protest was properly submitted in accordance with OAC 317:2-1-14. The OHCA Legal Division reserves the right to decline to consider any protests that are not submitted in conformity with OAC 317:2-1-14.

Notwithstanding anything in OAC 317:2-1-14 or OAC 317:2-1-2 to the contrary, by submitting a Proposal, the Bidder agrees that if it wishes to appeal the OHCA Legal Division's decision, the Bidder may request an administrative hearing before an administrative law judge (ALJ) by filing a Form LD-3 with the OHCA's

docket clerk within 30 calendar days of its receipt of the written denial from the OHCA Legal Division. The ALJ's decision will constitute the final administrative decision of OHCA.

Any claims, disputes or litigation relating to the solicitation shall be governed by the laws of the State of Oklahoma. Venue for any action, claim, dispute or litigation relating in any way to the solicitation shall be in Oklahoma County, Oklahoma.

**1 Appendix 1: Model Contract**

**OKLAHOMA HEALTH CARE AUTHORITY**

**AND**

**[CONTRACTOR NAME]**

The purpose of this Model Contract is for the Oklahoma Health Care Authority (OHCA) and **[CONTRACTOR NAME] (Contractor)** to provide oral healthcare services to certain Eligibles in the Oklahoma Medicaid program known as SoonerCare.

## **1.1 General Terms and Conditions**

### **1.1.1 Parties**

#### **1.1.1.1 Oklahoma Health Care Authority**

OHCA is the single State agency designated by the Oklahoma Legislature through 63 O.S. § 5009(B) to administer Oklahoma's Medicaid program, known as SoonerCare. OHCA has the authority to enter into this Model Contract pursuant to 63 O.S. § 5006(A)(2) and 74 O.S. § 85.1. OHCA's Chief Executive Officer has authority to execute this Model Contract on OHCA's behalf pursuant to 63 O.S. § 5008(B)(4) and (5).

#### **1.1.1.2 Contractor:**

Contractor's Full Legal Name:

Point of Contact:

Address:

Phone Number:

Fax Number:

Email Address:

Web Address:

FEI/SSN:

PeopleSoft Vendor Number:

The Contractor states that it has the experience and expertise to perform the services required under the Contract. The Contractor has the authority to enter into the resulting Contract pursuant to its organizational documents, bylaws or properly enacted resolution of its governing authority. The person executing the Contract for the Contractor has authority to execute the Contract on the Contractor's behalf pursuant to the Contractor's organizational documents, bylaws or properly enacted resolution of the Contractor's governing authority.

### **1.1.2 Contract Administration**

#### **1.1.2.1 OHCA**

OHCA has appointed a contracts designee responsible for all matters related to the Contract. The designee shall be the Contractor's primary liaison in working with other OHCA staff. The contracts designee is Sheila Killingsworth.

Once a contract has been awarded, the Contractor shall not refer any matter to OHCA Chief Executive Officer, the Oklahoma Health Care Authority Board, or any other official in Oklahoma unless initial contact regarding the matter has been presented to the contracts designee both orally and in writing.

#### **1.1.2.2 Contractor**

The Contractor shall designate a Contract Officer. Such designation may be changed during the period of the Contract only by written notice. The Contract Officer shall be listed on the Contractor's List of Authorized Signatories provided to OHCA, as the same may be amended from time to time, and shall be

authorized and empowered to represent the Contractor with respect to all matters within such area of authority related to implementation of the Contract.

### **1.1.3 Legal Contract**

Submitted bids are rendered as a legal offer and any bid, upon acceptance by OHCA, shall constitute a contract. The Contract resulting from this solicitation will consist of the following documents in order of preference:

- Contract award documents, including but not limited to the Model Contract, purchase orders, any addendum to the Contract, Contract modifications or amendments, negotiated statements of work, required certifications, affidavits, and change orders;
- Approved corrective action plans submitted by the Contractor in response to deficiencies documented by OHCA through Readiness Reviews, operational/financial audits, routine reporting and/or other oversight activities as described in Section 1.21 “Contractor Performance Standards” of this Model Contract;
- The RFP in its entirety, including any amendments or attachments such as drawings, attachments, schedules, diagrams, illustrations, OHCA answers to Bidder’s questions that lead to a change in the project scope, and the like; and
- The Bidder’s accepted Proposal, including Bidder’s responses to OHCA questions.

This Contract constitutes and defines the entire agreement between the Contractor and OHCA. No documentation shall be omitted which in any way bears upon the terms of that agreement.

In the event of a conflict between any of the provisions of this Model Contract, precedence shall be given in the following order:

- Betterments: Any portions of the accepted Proposal (including, but not limited to, Bidder’s answers to OHCA questions asked in response to a Proposal) which both conform to and exceed the requirements of the RFP;
- Contract award documents, including but not limited to this Model Contract, the Purchase Order, Contract modifications, negotiated Statements of Work, required certifications, affidavits, and change orders;
- The RFP in its entirety, including any amendments or attachments; and,
- All other provisions of the accepted Proposal to the extent that the Proposal does not conflict with the requirements of this Model Contract award documents, this RFP, or applicable law.

In the event that an issue is addressed in the accepted Proposal that is not addressed in this RFP or Contract award documents, no conflict in language shall be deemed to occur. However, OHCA reserves the right to clarify, in writing, any contractual relationship with the concurrence of Contractor(s), and such written clarification shall govern in case of conflict with the applicable requirements stated in the RFP. Such clarifications shall be issued solely by OHCA’s Chief Executive Officer or designee for this Model Contract.

The State may award the Contract, in accordance with the State Health Plan and in compliance with federal law, to more than one Bidder by awarding the Contract(s) by item or groups of items, or may award the Contract on an all or none basis, whichever is deemed to be in the best interest of OHCA and the State of Oklahoma.



Either OHCA or the Bidder(s) may discontinue the contracting process at any time.

**1.1.4 Approval of the Contract**

Award of this Contract is contingent approval by OHCA Board and the Centers for Medicare and Medicaid Services (CMS) approval. In accordance with 42 C.F.R. § 438.3, the CMS has final authority to approve this Model Contract. If the CMS does not approve the Contract entered into under the terms and conditions described herein, it will be considered null and void.

**1.1.5 Notices**

Whenever a notice is required to be given to the other party, it shall be made in writing and delivered to that party personally, by reputable courier service such as Federal Express (signature required), or by registered or certified mail, return receipt requested, to the addresses below or to such other address as may be designated by a party. Delivery shall be deemed to have occurred if a signed receipt is obtained, either when delivered by hand, by courier or return receipt requested. Notices shall be effective upon receipt if delivered personally, one business day after sent if delivered by courier service (three Business Days if the addressee is outside the United States) and three Business Days after sent if delivered by registered or certified mail (five Business Days if the addressee is outside the United States). All notices must be in English.

1.1.5.1 Notices to OHCA

Sheila Killingsworth  
Contract Officer  
Oklahoma Health Care Authority  
4345 North Lincoln Boulevard  
Oklahoma City, Oklahoma 73105

1.1.5.2 Notices to the Contractor

Name  
Address

**1.1.6 Notification of Material Changes**

The Contractor shall promptly notify OHCA of all changes materially affecting the delivery of care or the administration of its program. Material changes include, but are not limited to, any change in overall business operations, such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent of Dental Health Plan Enrollees or Participating Providers. The Contractor shall also notify OHCA within three Business Days of any change to it Contract Officer and shall provide an updated List of Authorized Signatories reflecting the same.

**1.1.7 Contract Term**

In accordance with Article X of the Oklahoma State Constitution, the initial Contract shall begin upon Contract award and terminate on June 30, 2021. There shall be options to renew for five additional one-year periods. The option to renew shall be contingent upon the needs of OHCA and funding availability, as more fully discussed below, and is at the sole discretion of OHCA.

The engagement under this Contract and any purchase order issued under this Contract are contingent upon sufficient appropriations being made by the federal government, the Oklahoma state legislature or

other appropriate government entity. Notwithstanding any language to the contrary in this Contract or in any purchase order or other document, OHCA may terminate its obligation under this Contract if sufficient appropriations are not made by the legislature or other appropriate governing entity to pay amounts due for multiple year agreements. OHCA's decision whether sufficient appropriations are available shall be accepted by the Contractor and shall be final and binding.

OHCA may choose to exercise an extension for up to 180 days beyond the final renewal option period at the Contract pricing rate; the extension shall be executed by mutual agreement. If this option is exercised, OHCA shall notify the other party in writing prior to the Contract end date.

OHCA may choose to exercise subsequent extensions, up to 180 days each, by mutual agreement and at the Contract pricing rate, to facilitate the finalization of related terms and conditions of a new contract or as needed for transition to a new Contractor. Payment terms for any renewal period shall be administered in accordance with Section 1.2: "Payments to Contractor" of this Model Contract.

The Contractor shall have certain obligations that will survive Contract expiration. These obligations are described in the relevant sections of the Contract, including but not limited to Section 1.23: "Termination" of this Model Contract.

The initial Rating Period shall be nine months (October 1, 2020 through June 30, 2021). Each subsequent Rating Period shall be 12 months (July 1-June 30).

#### **1.1.8 Consideration of New Contracts during Contract Period**

OHCA, at its discretion, reserves the right to enter into new Contracts with outside organizations during this Contract term. For the purposes of this Section, Contract Term is in accordance with the requirements outlined in Section 1.1.7: "Contract Term" of this Model Contract. Changes to the composition of Contractors shall be effective at the start of a Contract year, unless otherwise necessary to ensure a continued choice of Contractors.

#### **1.1.9 Amendments or Modifications**

This Contract contains all of the agreements of the parties and no oral representations from either party that contradict the terms of this Contract are binding. Any modifications to this Contract must be in writing and signed by both parties.

Legislative, regulatory and programmatic changes may require changes in the terms and conditions of this Model Contract. Modifications of terms and conditions of this Contract shall be authorized in such cases upon approval by OHCA and the Contractor. At all times, all parties shall adhere to the overall intent of the Contract.

#### **1.1.10 Assignment**

The Contractor shall not assign or transfer any rights or obligations under this Contract without prior written consent of OHCA. Such consent, if granted, shall not relieve the Contractor of its responsibilities under the Contract. For purposes of this section, any change in ownership of the Contractor shall constitute an assignment of the Contract.

#### **1.1.11 Waivers**

No covenant, condition, duty, obligation or undertaking in or made a part of this Contract shall be waived except by the written agreement of the parties and approval of the CMS. Forbearance or indulgence in any form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation or undertaking to be kept, performed or discharged by the party to which the same may apply. Notwithstanding any such forbearance or indulgence, the other party shall have the right to invoke any remedy available under law or equity until complete performance or satisfaction of all such covenants, duties, obligations and undertakings is achieved.

Waiver of any breach of any term or condition in the Contract shall not be deemed a waiver of any prior or subsequent breach. No term or condition of the Contract shall be held to be waived, modified or deleted except by an instrument, in writing, signed in advance by the parties hereto.

#### **1.1.12 Policy Determinations**

In the event that the Contractor may, from time to time, request OHCA to make policy determinations or to issue operating guidelines required for proper performance of the Contract, OHCA shall do so in a timely manner, and the Contractor shall be entitled to rely upon and act in accordance with such policy determinations and operating guidelines and shall incur no liability in doing so unless the Contractor acts negligently, maliciously, fraudulently or in bad faith.

Such determinations shall only be made by the OHCA's contracts designee.

#### **1.1.13 Disputes**

A Contract dispute shall mean a circumstance whereby the Contractor and OHCA are unable to arrive at a mutual interpretation of the requirements, limitations or compensation for performance of the Contract.

Prior to the institution of arbitration or litigation concerning any dispute arising under the Contract, the CEO or such CEO's designee (CEO designee) is authorized to settle, compromise, pay or otherwise adjust the dispute by or against or in controversy with, the Contractor. This authority to settle or resolve disputes, as well as the process for such settlement or resolution, is subject to any limitations or conditions imposed by federal and State law. Such disputes or controversy may include a claim or controversy based on the Contract, mistake, misinterpretation or other cause for Contract modification or rescission, but excludes any claim or controversy involving penalties or forfeitures prescribed by statute or regulation where an official, other than the CEO or CEO designee, are specifically authorized to settle or determine such controversy.

The CEO designee shall be authorized to settle Contract disputes between the Contractor and OHCA, upon submission of a request in writing from either party. Such a request shall provide:

- A description of the problem, including all appropriate citations and references from the Contract;
- A clear statement by the party requesting the decision or interpretation of the Contract; and
- A proposed course of action to resolve the dispute.

The CEO designee shall determine whether the interpretation provided is appropriate, whether the proposed solution is feasible and/or whether another solution is feasible or negotiable. If a dispute or controversy cannot be resolved by mutual agreement, the CEO designee shall promptly issue a decision

in writing after receipt of a request for dispute resolution. A copy of the decision shall be mailed or otherwise furnished to the Contractor.

If the CEO designee does not issue a written decision within 45 days after written request for a final decision, or within such longer period as might be established in writing by the parties to the Contract, then the Contractor may proceed as if an adverse decision had been received.

#### **1.1.14 Inspection and Audit Rights**

As used in this clause, “records” includes books, documents, accounting procedures and practices, statistical, fiscal and other data regardless of type and regardless of whether such items are in written form, in the form of computer data, or in any other form. In accordance with 42 C.F.R. § 438.3(h), the Contractor shall allow any pertinent State or federal Agency, including, but not limited to, OHCA, the State Auditor and Inspector (SA&I), Office of State Finance—Central Purchasing Division (CPD), Oklahoma Attorney General’s Medicaid Fraud Control Unit (MFCU), CMS, the Office of the Inspector General (OIG), the Comptroller General, and their designees or Subcontractors to:

- Inspect and audit any records or documents of the Contractor or Subcontractors at any time; and
- Inspect the Contractors and Subcontractors premises, physical facilities, and equipment where Medicaid-related activities are conducted at any time.

This right to inspect and audit Contractor’s records extends beyond the term of Agreement pursuant to federal regulation.

In accordance with Section 1903(m)(2)(A)(iv) of the Act and 42 C.F.R. 438.230(c)(3)(ii), the Secretary, DHHS and the State, or any person or organization designated by either, shall also have the right to audit and inspect any books or records of the Contractor or its Subcontractors, Subsidiaries or Affiliates pertaining to:

- The ability of the Contractor to bear the risk of financial losses; and
- Services performed or payable amounts under the Contract.

In accordance with 42 C.F.R. § 438.3(u), the Contractor and its Subcontractors shall retain, as applicable:

- Dental Health Plan Enrollee Grievance and Appeal records, in accordance with 42 C.F.R. § 438.416;
- Base data, in accordance with 42 C.F.R. § 438.5(c);
- MLR reports, in accordance with 42 C.F.R. § 438.8(k); and
- Data, information, and documentation, specified in 42 C.F.R. §§ 438.604, 438.606, and 438.610.

This list is neither exclusive nor exhaustive and Contractor, Subsidiaries, Affiliates and Employees shall retain records in compliance with both the provisions and spirit of 42 C.F.R. § 438. The Contractor and its Subcontractors, Affiliates and Employee are required to retain records relative to the Contract for the duration of the Contract and for a period of ten years following completion and/or termination of the Contract. If an audit, litigation or other action involving such records is started before the end of the ten-year period, the records are required to be maintained for two years from the date that all issues arising out of the action are resolved, or until the end of the ten-year retention period, whichever is later. The State, CMS, the OIG, the Comptroller General and their designees shall maintain the right to audit records or documents of the Contractor and its Subcontractors for the duration of this record retention requirement. The Contractor shall not destroy or dispose of records that are under audit, review or

investigation when the ten-year limit is met. The Contractor shall maintain such records until informed in writing by the auditing reviewing, or investigating agency that the audit, review or investigation is complete.

Pursuant to 74 O.S. § 85.41, OHCA, the SA&I, the State Purchasing Director and OMES shall have the right to examine the Contractor's books, records, documents, accounting procedures, practices or any other items relevant to this Model Contract.

The Contractor acknowledges that OHCA has advised the Contractor that it is a "governmental body" subject to the Oklahoma Open Records Act, which provides generally that all records relating to a public body's business are open to public inspection and copying unless exempted under such act, and the Oklahoma Open Meetings Act, which provides generally for open meetings for public bodies, and record retention requirements applicable to agencies of the State of Oklahoma (collectively with the Open Records Act, the "Public Records Laws"), and that the Contractor is familiar with the legal requirements imposed upon OHCA by the Public Records Laws. Accordingly, OHCA is not required to maintain the confidentiality of non-public information that is furnished by the Contractor to OHCA to the extent that OHCA believes, after due inquiry, that it is required to disclose such information pursuant to the Public Records Laws. The Contractor acknowledges and agrees that OHCA in its sole discretion shall determine whether OHCA is legally required to disclose non-public information pursuant to the Public Records Laws.

OHCA shall allow for the inspection of public records in accordance with the provisions of the Oklahoma Open Records Act, 51 O.S. §§ 24A.1--29.

#### **1.1.15 Confidentiality; HIPAA and Business Associate Requirements**

##### 1.1.15.1 Definitions

The following terms in this section shall have the same meaning as those terms in the HIPAA Rules: Breach, Business Associate, Covered Entity, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information (PHI), Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information and Use.

Discovery or Discovered shall generally mean the first day a Security Incident or Breach is known to Contractor or, by exercising reasonable diligence, would have been known to Contractor. Contractor shall be deemed to have knowledge of a Security Incident or Breach if known, or if, by exercising reasonable diligence, the Security Incident or Breach would have been known, to any person other than the person committing the Breach, who is an employee or Agent of Contractor (determined in accordance with the federal common law of agency).

HIPAA Rules shall mean Health Insurance Portability and Accountability Act of 1996, the Privacy, Security, Breach, Notification and Enforcement Rules at 45 C.F.R. Parts 160 and 164 and related regulations, including the Administrative Simplification rules at 42 U.S.C. § 1320d *et seq.*, and the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH") and its associated rules, including but not limited to those at 45 C.F.R. Parts 160 and 164.

##### 1.1.15.2 Permitted Uses and Disclosures by Contractor

Except as otherwise provided in this Contract, Contractor may use or disclose PHI on behalf of, or to provide services to, OHCA solely to provide the services specified in this Contract (including any additional services necessary to carry out the specific services in this Contract) and only if such use or disclosure of

PHI would not violate the HIPAA Rules if performed by OHCA. Any use or disclosure of PHI shall be consistent with OHCA's minimum necessary standards and the regulations and guidance issued by the Secretary regarding minimum necessary standards for Contractor to perform its obligations under this Model Contract. Subject to the foregoing, Contractor may:

- Use the PHI for the purpose of determining and reporting potential improper billing and fraud in the Oklahoma Medicaid Program and, if directed to do so in writing by OHCA, disclose the PHI as needed to cooperate in Oklahoma Medicaid Fraud investigations conducted by authorized state or federal entities.
- Use PHI to de-identify the information in accordance with 45 C.F.R. § 164.514(a)-(c), with OHCA's prior written consent.
- Disclose PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(1). OHCA shall be furnished with a copy of all correspondence sent by Contractor to a federal or state authority.
- If directed to do so in writing by OHCA, create a limited data set as defined at 45 C.F.R. § 164.514(e)(2), for use in public health, research, or health care operations. Any such limited data sets shall omit all of the identifying information listed in 45 C.F.R. § 164.514(e)(2). Contractor will enter into a valid HIPAA-compliant Data Use Agreement, as described in 45 C.F.R. § 164.514(e)(4), with the limited data set recipient. Contractor will report any material breach or violation of the data use agreement to OHCA immediately after it becomes aware of any such material breach or violation.
- If authorized to do so in writing by OHCA, use or disclose PHI for public health activities in accordance with 45 C.F.R. § 164.512(b)(1)(i)-(iv) and State public health reporting requirements established by the Oklahoma State Department of Health.
- Use or disclose PHI within limitation(s) of the OHCA's notice of privacy practices, in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect the Contractor's use or disclosure of PHI.

Contractor may not use or disclose PHI in a manner that would violate the HIPAA Rules (including but not limited to Subpart E of 45 C.F.R. Part 164) if done by OHCA, except that Contractor may, if necessary:

- Use PHI for the proper management and administration of Contractor or to carry out the legal responsibilities of Contractor.
- Disclose PHI for the proper management and administration of the Contractor or to carry out the legal responsibilities of Contractor if the disclosure is required by law; or if the Contractor obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person and the person notifies Contractor of any instances of which it is aware in which the confidentiality of the information has been breached.
- Provide data aggregation services relating to the health care operations of OHCA.

#### 1.1.15.3 Obligations of the Contractor

Contractor is OHCA's Business Associate and agrees to comply with the HIPAA Rules and all other terms as required in this Model Contract.

Contractor agrees not to use or further disclose PHI (including but not limited to electronic PHI) in whole or in part, other than as permitted by this Contract or as Required by Law.

Contractor agrees not to use or disclose information in a manner that would violate the provisions of 42 C.F.R. Part 2 (regarding substance abuse information), 43A O.S. § 1-109 (regarding mental health records), or any other applicable privacy law.

Contractor acknowledges that SoonerSelect Dental Health Plan Enrollee information is confidential and not to be released pursuant to 42 USC § 1396a(a)(7), 42 C.F.R. §§ 431.300 - 431.307, 42 C.F.R. 438.224 and 63 O.S. § 5018. The Contractor agrees not to release the information governed by these laws and regulations to any other person or entity without the approval of OHCA, or as required by law or court order.

Contractor agrees that SoonerSelect Dental Health Plan Enrollee and Provider information cannot be re-marketed, summarized, distributed, or sold to any other organization without the express written approval of OHCA.

Contractor will not use or further disclose PHI other than as permitted or required by this Contract or as Required by Law, including but not limited to HIPAA.

Contractor will implement, maintain, and document appropriate technical, physical, and administrative safeguards and comply with 45 C.F.R. Part 164 with respect to electronic PHI to prevent use or disclosure of PHI other than as provided for by this Model Contract, and will protect the confidentiality, integrity, and availability of PHI that it creates, receives, maintains, or transmits for or on behalf of OHCA in accordance with the HIPAA Rules, including but not limited to training all employees, agents, and Subcontractors in HIPAA to protect OHCA's PHI and prevent, detect, contain, and correct security violations in accordance with the HIPAA Rules. The Contractor agrees to report potential known violations of 21 O.S. § 1953 to the OHCA Privacy Officer within one hour of discovery of an unauthorized act. In general, this criminal statute makes it a crime to willfully and without authorization gain access to, alter, modify, disrupt or threaten a computer system.

The Contractor shall report to OHCA any Use or Disclosure of PHI not provided for by this Contract of which it becomes aware, including breaches of Unsecured PHI, as provided herein and in accordance with the HIPAA Rules, including but not limited to 45 C.F.R. § 164.410. Where this Contract requires a shorter notification period than the HIPAA Rules, the Contract provisions control. Contractor shall notify the OHCA Privacy Officer of such breach in writing within one hour from Discovery. Contractor shall be diligent in monitoring systems and taking appropriate measures to become aware of Security Incidents.

The Contractor shall report to OHCA any Security Incident of which it becomes aware within one hour of Discovery of the incident. For purposes of this Model Contract, 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. Examples of Security Incidents include, but are not limited to, unauthorized use of a system for processing, accessing, or storing ePHI; changes to system hardware, firmware, or software without Contractor's consent; or suspicious patterns of DDoS attacks, pings, port scans, and similar exploratory contacts or access attempts. Security Incidents will be reported to the OHCA Privacy Officer and the OHCA Compliance Risk Management Analyst via telephone and email within one hour from Discovery. Notwithstanding anything herein, Contractor may report innocuous

Security Incidents consisting of unsuccessful attempts that, in Contractor's reasonable determination, do not present a legitimate risk of unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations (such as random pings, DDoS attempts, port scans, similar exploratory contacts, and unsuccessful log-on attempts) in the form of a brief general summary statement provided via email not more than every 60 days upon OHCA's request.

Contractor will cooperate, if requested, with OHCA's breach analysis and response procedures, including risk assessment. Contractor shall cooperate with OHCA in the determination as to whether a Breach of Unsecured PHI has occurred and whether notice to Individuals and/or other entities is required. Contractor will investigate the potential Breach and report its findings to OHCA, and will continuously provide OHCA with additional information related to a suspected or actual Breach as it becomes available.

In the event that OHCA informs Contractor that (i) OHCA has determined that the affected Individuals must be notified because a Breach of unsecured PHI has occurred and (ii) Contractor is in the best position to notify the affected Individuals of such Breach, Contractor shall, within ten days from receipt of such notice, provide a draft letter for OHCA to approve for use in notifying the Individuals, and upon OHCA's approval, Contractor shall give the required notice (1) within the time frame defined by 45 C.F.R. § 164.404(b); (2) in a form and containing such information reasonably requested by OHCA; (3) containing the content specified in 45 C.F.R. § 164.404(c), and (4) using the method(s) prescribed by 45 C.F.R. § 164.404(d). In addition, in the event that OHCA indicates to Contractor that OHCA will make the required notification, Contractor shall promptly take all other actions reasonably requested by Covered Entity related to the obligation to provide a notification of a Breach of unsecured PHI under 45 C.F.R. § 164.400 *et seq.*

In addition, the Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to the Contractor of a use or disclosure of PHI by the Contractor in violation of the requirements of this Model Contract. If OHCA requests, Contractor shall promptly submit a proposed remediation plan to address the Breach and prevent further Breaches for OHCA's approval. Once approved by OHCA, Contractor will remediate the Breach in accordance with the approved plan.

In accordance with 45 C.F.R. §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, the Contractor will ensure that any Subcontractors, vendors, and agents to whom it provides PHI or that create, receive, maintain, transmit, or access PHI on behalf of the Contractor agree to the same restrictions, conditions and requirements that apply to the Contractor with respect to such information. The Contractor must obtain satisfactory written assurance of this obligation, in the form of a HIPAA-compliant business associate agreement, from the Subcontractor, vendor, or agent. Contractor will provide a copy to OHCA upon request.

Contractor will make available, in a timely manner, PHI maintained by Contractor in a Designated Record Set to OHCA, or if directed by OHCA, to an Individual as necessary to satisfy OHCA's obligations under 45 C.F.R. § 164.524, including, if requested, a copy in electronic format.

Contractor will, in a timely manner, make any amendment(s) to PHI in a designated record set as directed or agreed to by OHCA pursuant to 45 C.F.R. § 164.526 at the request of OHCA or an Individual, and take other measures as necessary to satisfy OHCA's obligations under 45 C.F.R. § 164.526, including the obligation to make PHI available in a timely manner for amendment.



The Contractor shall maintain and make available the information necessary to provide an accounting of disclosures to OHCA as necessary to satisfy OHCA's obligations under 45 C.F.R. § 164.528. Contractor will provide all such information requested by OHCA within 15 days from OHCA's request. If directed by OHCA, Contractor agrees to provide all such information to an Individual, as necessary to satisfy OHCA's obligations under 45 C.F.R. § 164.528. Contractor shall meet documentation and retention requirements as necessary to satisfy OHCA's obligations under 45 C.F.R. § 164.528.

To the extent the Contractor is to carry out one or more of OHCA's obligations under Subpart E of 45 C.F.R. Part 164, the Contractor shall comply with the requirements of Subpart E that apply to OHCA in the performance of such obligations.

The Contractor shall make its internal policies, procedures, practices, books and records related to the use and disclosure of PHI received from, or created or received by Contractor on behalf of OHCA available to the Secretary for purposes of determining compliance with HIPAA Rules.

Contractor will indemnify and hold OHCA harmless from all liability, costs, expenses, claims, or other damages that OHCA or any of its directors, officers, agents, or employees may sustain as a result of Contractor's breach or Contractor's Subcontractor's, Affiliate's, Agent's, employee's or independent contractor's breach, of its obligations under this section.

Contractor will respond to OHCA's request for confirmation and certification of Contractor's ongoing compliance with the HIPAA Rules, including but not limited to conducting regular security audits and assessments as necessary to evaluate its security and privacy practices.

Contractor will timely provide OHCA with all information, documentation, or other artifacts, access, and resources needed for OHCA to conduct or comply with required audits, inspections, assessments, or evaluations.

Contractor will not receive remuneration from a third party in exchange for disclosing PHI received from or on behalf of OHCA.

Except as otherwise provided for in this Model Contract, any disclosure of OHCA data shall be approved in advance and in writing by OHCA and then only to persons expressly authorized to review such information under applicable federal or State laws. If Contractor, employees, or Subcontractors disclose(s) or attempt(s) to disclose OHCA data, an injunction may be sought to prevent that disclosure as well as any other remedies of law that may be available. Contractor shall provide written notice to OHCA of any use or disclosure of OHCA data not provided for by this Contract of which Contractor becomes aware within five Calendar Days of its discovery.

Notwithstanding anything to the contrary herein, Contractor shall promptly provide written notice to OHCA upon receipt of a subpoena or other legal process that seeks disclosure of OHCA data, so that OHCA may have the opportunity to seek a protective order, on its own behalf, with respect to such data. Contractor will, to the extent allowed by law, fully cooperate with any attempt by OHCA to seek such a protective order, including but not limited to withholding from production any data before OHCA has had a reasonable opportunity to seek such an order or to seek review of the denial of such an order or the issuance of an order that OHCA deems insufficiently protective.

#### 1.1.15.4 Obligations of Contractor upon Termination

Upon termination of this Contract for any reason, the Contractor, with respect to PHI received from OHCA, or created, maintained or received by the Contractor on behalf of OHCA, shall:

- Retain only that PHI which is necessary for the Contractor to continue its proper management and administration or to carry out its legal responsibilities;
- Return to OHCA or, if agreed to by OHCA, and if feasible, destroy the remaining PHI that the Contractor still maintains in any form. If return or destruction is not feasible, Contractor will limit further uses and disclosures to those purposes that make the return or destruction infeasible;
- Extend the protections of this Contract and continue to use appropriate safeguards to protect PHI it maintains in any form and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this section, for as long as the Contractor retains the PHI; and
- Return to OHCA or, if agreed to by OHCA, destroy the PHI retained by the Contractor when it is no longer needed by the Contractor for its proper management and administration or to carry out its legal responsibilities.

The Contractor will transmit the PHI to another Business Associate or designee of OHCA at termination and the Contractor is obligated to obtain or ensure the destruction of PHI created, received or maintained by Subcontractors. Contractor shall send OHCA written certification on oath of such destruction within 20 days from the date of destruction.

The obligations of the Contractor under Section 1.1.15: “Confidentiality; HIPAA and Business Associate Requirements” of this Model Contract shall survive the termination of the underlying Contract.

#### 1.1.15.5 Obligations of OHCA

OHCA shall notify the Contractor of any limitation(s) in OHCA’s notice of privacy practices, in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect the Contractor’s use or disclosure of PHI.

OHCA shall notify the Contractor of any changes in, or revocation of, permission by an individual to use or disclose PHI, to the extent such changes may affect the Contractor’s use or disclosure of PHI.

OHCA shall notify the Contractor of any restriction to the use or disclosure of PHI that OHCA has agreed to or is required to abide by in accordance with 45 C.F.R. § 164.522, or as mandated pursuant to Section 13405(c) of the HITECH Act, to the extent that such restriction may affect the Contractor’s use or disclosure of PHI.

Except to the extent allowed by 45 C.F.R. § 164.502(b), OHCA agrees to make reasonable efforts to disclose to the Contractor only the minimum amount of PHI necessary to accomplish the services covered under this Model Contract.

#### 1.1.15.6 Miscellaneous

Any reference to the HIPAA Rules within this Contract section refers to the HIPAA Rules in current effect. Any ambiguity in this section shall be interpreted to permit compliance with the HIPAA rules.

#### **1.1.16 Conflict of Interest**

The Contractor certifies and agrees that it presently has no interest and shall not acquire any interest, either direct or indirect, which would conflict in any manner or degree with the performance of the Contract.

If Contractor acquires such a conflict it shall notify OHCA in writing within five Business Days.

#### **1.1.17 Hold Harmless**

The Contractor shall indemnify, defend, protect and hold harmless OHCA and the state and any of its officers, Agents and employees from:

- Any claims for damages or losses arising from any breach of this Contract by the Contractor, its officers, Agents, employees, Subcontractors, or Providers and any of their respective Affiliates;
- Any claims for damages or losses arising from services rendered by any Subcontractor, person or firm performing or supplying services, materials or supplies in connection with the performance of the Contract;
- Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including but not limited to, disregard of federal or state Medicaid regulations or legal statutes, by the Contractor, its officers, Agents, employees, Subcontractors, or Providers and any of their respective Affiliates, in performance of the Contract;
- Any claims for damages or losses resulting to any person or firm injured or damaged by the Contractor, its officers, Agents, employees, Subcontractors or Providers and any of their respective Affiliates by the publication, translation, reproduction, delivery, performance, use or disposition of any data processed under the Contract in a manner not authorized by the Contract or by federal or state regulations or statutes;
- Any damages or losses arising from any failure of the Contractor, its officers, employees, Agents, or Subcontractors or Providers and any of their respective Affiliates to comply with any federal or State laws, regulations, rules, policies or guidance, including but not limited to labor laws and minimum wage laws; and
- Any claims for damages, losses or costs associated with legal expenses, including but not limited to those incurred by or on behalf of OHCA in connection with the defense of claims for such injuries, losses, claims or damages specified above.

Before delivering services under the Contract, the Contractor shall provide adequate demonstration to OHCA that insurance protections necessary to address each of these risk areas are in place. Minimum requirements for coverage are defined in Section 1.1.18: "Insurance" of this Model Contract.

#### **1.1.18 Insurance**

The Contractor shall procure, at its own expense, the following insurance coverage with the applicable liability limits set forth below:

- Automobile insurance;
- Comprehensive liability insurance;
- Errors and omissions insurance;
- Commercial general liability insurance;
- Medical malpractice insurance;
- Professional liability insurance;

- Directors and officers liability insurance;
- Security and privacy liability insurance;
- Property damage insurance; and
- Worker's compensation and employer's liability insurance.

Before commencement of any work in connection with the Contract, the Contractor shall provide proof of such insurance showing annual coverage, and providing proof of coverage annually on the anniversary date thereafter. The Contractor's obligation to maintain insurance coverage under the Contract is a continuing obligation until the Contractor has no further obligation under the Contract. In addition, the Contractor shall promptly notify OHCA of any modification, restriction, or limitation on coverage.

The required insurance policies shall be provided by carriers authorized to do business within Oklahoma and rated as "A+" or higher by the A.M. Best Rating Service. The required insurance policies shall contain the following endorsement:

"The State of Oklahoma and the Oklahoma Health Care Authority are hereby added as additional insureds. Coverage afforded under this Certificate shall be primary and any insurance carried by the state or any of its agencies, boards, departments or commissions shall be in excess of that provided by the insured Contractor. No policy shall expire, be cancelled or materially changed without 30 days' written notice to the State. This Certificate is not valid unless countersigned by an authorized representative of the insurance company."

The Contractor's Certificates of Insurance shall be incorporated as an attachment to the Contract. Each certificate will state the policy number, the insured and the insurance period. Each insurance policy shall contain a clause that requires OHCA to be notified in writing at least 30 days prior to cancellation and shall name the State of Oklahoma and OHCA as additional named insureds. Such Certificates of Insurance must be submitted to OHCA within 30 days of notification of Contract award and prior to commencement of services under this Model Contract. Upon request by OHCA or the State, the Contractor shall promptly provide proof to the state of any renewals, additions, or changes to such insurance coverage.

The Contractor shall require that each of its Subcontractors, independent contractors, or Affiliates of those entities or individuals, maintain insurance coverage as specified in this section or, in the alternative, the Contractor may provide coverage for each Subcontractor's, independent contractor's, agent's, or employees and Affiliates thereof, liability and employees. The provisions of this clause shall not be deemed to limit the liability or responsibility of the Contractor or any of its Subcontractors.

The insurance requirements herein are minimum requirements for this Contract and in no way limit the indemnity covenants contained in this Model Contract. The State in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that arise out of the performance of the work under this Contract by the Contractor, its agents, representatives, employees or Subcontractors, and the Contractor is free to purchase additional insurance.

OHCA reserves the right to review or make modifications to the insurance limits, required coverages, or endorsements throughout the term of this Model Contract, as deemed necessary by OHCA in its sole discretion. Such action will not require a formal Contract amendment. The Contractor shall be in compliance with all applicable insurance laws of the State and federal government throughout the duration of the Contract.

1.1.18.1 Professional Liability Insurance

The Contractor shall obtain and maintain, for the duration of the Contract, professional liability insurance in the amount of at least \$1,000,000 for each occurrence.

No later than June 1 of each Contract year, the Contractor shall advise OHCA if any of its Subcontractors are covered by the Oklahoma Governmental Tort Claims Act and thus, in the Contractor's opinion, do not require professional liability insurance. Such proposed coverage of the Subcontractors by the Oklahoma Governmental Tort Claims Act as a substitute for professional liability insurance is subject to OHCA's approval.

Failure to advise OHCA that it is the Contractor's intention for Subcontractors, independent contractors, agents, or employees or affiliates thereof, to utilize such insurance coverage in lieu of professional liability insurance will result in the Contractor being obligated to substitute professional liability insurance for said Subcontractors during the Contract term.

1.1.18.2 Minimum Liability and Property Damage Insurance

The Contractor shall obtain, pay for and keep in force:

- Commercial general liability insurance covering the risks of personal injury, bodily injury (including death) and property damage, including coverage for contractual liability, with a limit of liability of not less than \$5,000,000 per occurrence;
- Automobile liability insurance with limits of liability of not less than \$5,000,000 combined single limit each accident;
- Insurance against liability for property damages, as well as first party fire insurance, including contents coverage for all records maintained pursuant to the Contract, in the amount of \$500,000 for each occurrence; and

1.1.18.3 Director's and Officer's Liability Insurance

The Contractor shall obtain, pay for and keep in force directors and officers liability insurance which shall include employment practices liability as well as consultant's computer errors and omissions coverage, with limits not less than \$5,000,000 per occurrence.

1.1.18.4 Security and Privacy Liability Insurance

The Contractor shall obtain, pay for and keep in force security and privacy liability insurance, including coverage for failure to protect confidential information and failure of the security of the Contractor's computer systems that results in unauthorized access to OHCA data with limits \$10,000,000 per occurrence.

1.1.18.5 Errors and Omissions Insurance

The Contractor shall obtain, pay for and keep in force for the duration of the Contract errors and omissions insurance in the amount of \$10,000,000.

1.1.18.6 Workers' Compensation and Employer's Liability Insurance

The Contractor shall obtain, pay for and keep in force for the duration of the Contract worker's compensation and employer's liability insurance in accordance with and to the extent required by applicable law.

#### 1.1.18.7 Reinsurance

The Contractor shall have the option of purchasing reinsurance from a commercial reinsurer. The Contractor may elect to self-insure based upon the Contractor's ability to survive a series of adverse financial events. ~~The Contractor shall provide to OHCA the risk analysis, assumptions, cost estimates and rationale supporting its proposed reinsurance arrangements. OHCA reserves the right to require the Contractor to modify its coverage arrangements and level of coverage, including reinsurance attachment point and coinsurance percentage, if the Contractor's proposed coverage is deemed insufficient, or its cost excessive.~~

#### Ownership of Data and Reports

Data, information and reports collected or prepared by the Contractor in the course of performing its duties and obligations under the Contract shall be deemed to be owned by the State of Oklahoma. This provision is made in consideration of the Contractor's use of public funds in collecting or preparing such data, information and reports.

#### **1.1.19 Intellectual Property Infringement, Hold Harmless and Specific Performance**

Contractor represents that it owns and/or has secured all intellectual property rights and all other rights, approvals, and releases necessary to provide the services pursuant to this Model Contract. The Contractor represents that, to the best of its knowledge, none of the software or any other products, information, or materials to be used, developed or provided pursuant to the Contract violates or infringes upon any patent, copyright, trademark, trade secret, or any other right of a third party.

If any claim or suit is brought against OHCA for the alleged infringement of such patents, copyrights, trademarks, trade secrets, or any other proprietary property arising from the Contractor's products, materials or services provided by Contractor under this Model Contract, or from OHCA's use thereof, then the Contractor shall, at its expense, hold harmless and defend, at its own expense, all suits, claims or proceedings against OHCA. The Contractor shall satisfy any final award for such infringement (including attorney's fees), whether it is resolved by settlement or judgment involving such a claim or suit.

If use of the products or services in question is held to infringe and the use thereof enjoined, or if in light of the circumstances OHCA determines that it is advisable to do so, Contractor shall, at its own expense, either (i) procure the right for OHCA to continue to use such products or services, (ii) replace the same with products or services which do not give rise to allegations of infringement, or (iii) modify such products or services to remove the basis for allegations of infringement without interruption of services under this Model Contract. Because a breach of these provisions may give rise to damages suffered by OHCA which may be difficult or impossible to ascertain, OHCA may at its option obtain specific enforcement of Contractor's obligations hereunder.

#### **1.1.20 Publicity**

Any publicity given to the program or services provided therein, including but not limited to notices, information pamphlets, press releases, research, reports, signs and similar public notices prepared by or for the Contractor or its Subcontractors, shall identify the State of Oklahoma as the sponsor and shall not be released without prior written approval from OHCA. In circumstances where time is of the essence, OHCA will make a good faith effort to review and respond within one Business Day.

#### **1.1.21 Employment Relationship**

This Contract does not create an employment relationship with Contractors, its Agents, Subcontractors, independent contractors, or affiliates thereof. Individuals performing services required by this Contract are not employees of the State of Oklahoma or OHCA. The Contractor's employees shall not be considered employees of the State of Oklahoma, nor of OHCA for any purpose, and accordingly shall not be eligible for rights or benefits accruing to State employees.

#### **1.1.22 Force Majeure**

Neither the Contractor nor OHCA shall be liable for any damages or excess costs for failure to perform their Contract responsibilities if such failure arises from causes beyond the reasonable control and without fault or negligence by the Contractor (including its Subcontractors) or OHCA. Such causes may include, but are not limited to, catastrophic events, pandemics or acts of God. In all cases, the failure to perform must be beyond the reasonable control of, and without fault or negligence of, either party or its Subcontractors.

The Contractor shall have in place a disaster recovery plan that has been reviewed and approved by OHCA and that meets the specifications of Section 1.18.7: "Disaster Preparation and Data Recovery" of this Model Contract.

#### **1.1.23 Compliance with Law**

The parties hereto acknowledge that this bid process and Medicaid managed care are highly regulated by federal statutes and regulations. The parties further acknowledge that any and all references to Code of Federal Regulation (C.F.R.) citations in this Model Contract, and other statutes and regulations applicable to Medicaid managed care, are to those in effect on October 15, 2020. The parties to this Contract acknowledge and expect that changes may occur over the term of this Contract regarding federal or State Medicaid statutes and regulation and State statutes and rules governing health insurers and the practice of health care professions. In the event any indicated C.F.R. citation, federal or State Medicaid statute or regulation or State statute or rule governing health insurers and the practice of health care professions or related requirements are amended during the term of this Model Contract, all parties to this Model Contract shall be mutually bound by the amended requirements in effect at any given time following Contract execution.

In accordance with 42 C.F.R. § 438.3(f)(1), the Contractor shall comply, and shall ensure that its officers, employees, Providers, Subcontractors and their respective Affiliates comply, with all applicable federal and State laws, regulations, rules, policies, and guidance including but not limited to:

- Federal requirements within 42 C.F.R. § 438.1 et seq., as applicable to PAHPs;
- Title VI of the Civil Rights Act of 1964;
- The Age Discrimination Act of 1975;
- The Rehabilitation Act of 1973;
- Title IX of the Education Amendments of 1972 (regarding education programs and activities);
- The Americans with Disabilities Act of 1990 as amended;
- Section 1557 of the Patient Protection and Affordable Care Act (ACA);
- Healthcare Insurance Portability and Accountability Act, 42 U.S.C. 290dd-2;
- Mental Health Parity and Addiction Equity Act, 42 C.F.R. Part 2;

- Oklahoma Electronic Information Technology Accessibility (EITA) Act (Oklahoma 2004 HB 2197) regarding information technology accessibility standards for persons with disabilities;
- Oklahoma Medicaid False Claims Act, 63 O.S. §§ 5053 – 5054;
- Oklahoma Worker’s Compensation Act, 85A O.S. §1 et seq.;
- 74 O.S. § 85.44(B) and (C) and 45 C.F.R. § 75.320 with regard to equipment (as defined by 2 C.F.R. Parts 220, 225 or 230 as applicable to the Contractor’s entity) purchased with monies received from OHCA pursuant to this Contract;
- Title 317 of the Oklahoma Administrative Code ("OAC");
- Oklahoma Taxpayer and Citizen Protection Act of 2007, 25 O.S. § 1313 and participates in the Status Verification System. The Status Verification System is defined at 25 O.S. § 1312; and
- Deceptive Trade Practices; Unfair Business Practices
  - Contractor represents and warrants that neither Contractor nor any of its Subcontractors:
  - Have been found liable in any administrative hearing, litigation or other proceeding of Deceptive Trade Practices violations as defined under the Oklahoma Consumer Protection Act, 15 O.S. §751 *et seq.*;
  - Have outstanding allegations of any Deceptive Trade Practice pending in any administrative hearing, litigation or other proceeding;
  - Have officers who have served as officers of other entities who have been found liable in any administrative hearing, litigation or other proceeding of Deceptive Trade Practices violation; and,
  - Have officers who have outstanding allegations of any Deceptive Trade Practice pending in any administrative hearing, litigation or other proceeding.

In accordance with 42 C.F.R. § 438.100(a)(2), the Contractor shall also comply with any applicable federal and State laws that pertain to Dental Health Plan Enrollee rights and ensure that its employees and Participating Providers observe and protect those rights.

The explicit inclusion of some statutory and regulatory duties in this Contract shall not exclude other statutory or regulatory duties.

All questions pertaining to the validity, interpretation and administration of this Contract shall be determined in accordance with the laws of the State of Oklahoma, regardless of where any service is performed.

The venue for civil actions arising from this Contract shall be Oklahoma County, Oklahoma. For the purpose of federal jurisdiction, in any action in which the State of Oklahoma is a party, venue shall be United States District Court for the Western District of Oklahoma.

If any portion of this Contract is found to be in violation of State or federal statutes, that portion shall be stricken from this Contract and the remainder of the Contract shall remain in full force and effect.

Should any part of the scope of work under this Contract relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority. The State must adjust Capitation Rates to remove



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

**1.1.24 Titles Not Controlling**

Titles of paragraphs used herein are for the purpose of facilitating ease of reference only and shall not be construed to infer a contractual construction of language.

**1.1.25 Counterparts**

The Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

**1.1.26 Administrative Procedures Not Covered**

Administrative procedures not covered in the Contract will be set forth where necessary in separate memoranda from time to time.

**1.1.27 Days Terminology**

Unless otherwise specified, “days” as used in this Contract shall mean Calendar Days.

**1.1.28 Performance Bond or Substitutes**

The Contractor shall furnish a performance bond, cash deposit, US Treasury Bill or an irrevocable letter of credit. The performance bond shall be in a form acceptable to OHCA. For Contractors who are self-insured, the value of the performance bond or substitute shall not be less than \$25,000,000.00.

If a cash deposit is used, it must be placed in different financial institutions to a maximum of \$250,000 per deposit. If a letter of credit is used, it must be issued by a bank or savings and loan institution doing business in the State of Oklahoma and insured by the Federal Deposit Insurance Corporation or a credit union doing business in the State of Oklahoma and insured by the National Credit Union Administration.

The amount of the performance bond, cash deposit or letter of credit shall be one dollar for each capitation dollar expected to be paid to Contractor in month one of the Rating Period.

This requirement must be satisfied within ten Business Days following notification by OHCA of the required amount. Thereafter, OHCA shall evaluate enrollment and Capitation Payment data on a monthly basis. If there is an increase in Contractor’s monthly Capitation Payment that equals or exceeds ten percent above the payment amount used to calculate the performance bond, cash deposit, US Treasury bill or letter of credit requirement, OHCA shall require a commensurate increase in the amount of the performance bond, cash deposit, US Treasury bill or letter of credit. The Contractor shall have ten Business Days to comply with any such increase.

OHCA may, at its discretion, permit the Contractor to offer substitute security in lieu of a performance bond, cash deposit, US Treasury bill or letter of credit. In that event, the Contractor shall be solely responsible for establishing the credit worthiness of all forms of substitute security. The Contractor also

shall agree that OHCA may, after supplying written notice, withdraw its permission for substitute security, in which case the Contractor shall provide OHCA with a form of security as described above.

In the event of termination for default, as described in Section 1.23: "Termination" of this Model Contract, the performance bond, cash deposit, US Treasury bill, letter of credit or substitute security shall become payable to OHCA for any outstanding damage assessments against the Contractor. Up to the full amount also may be applied to the Contractor's liability for any administrative costs and/or excess medical or other costs incurred by OHCA in obtaining similar services to replace those terminated as a result of the default. OHCA may seek other remedies under law or equity in addition to this stated liability.

## **1.2 Payments to Contractor**

OHCA shall pay the Contractor a monthly Capitation Payment for each Dental Health Plan Enrollee through the MMIS, in accordance with the rate schedule provided in the bidder's library. The Contractor and OHCA agree that Capitation Payments must be in accordance with 42 C.F.R. § 438.3(c) and approved as actuarially sound by the CMS in accordance with 42 C.F.R. § 438.4. Capitation rates shall be certified by an actuary meeting the qualification standards of the American Academy of Actuaries following generally accepted actuarial principles.

The Contractor agrees the Capitation Payment shall represent the OHCA's payment in full (subject to any risk mitigation provisions) for all services furnished under this Model Contract. In accordance with 42 C.F.R. § 438.3(c)(2), Capitation Payments may only be made by OHCA and retained by the Contractor for Medicaid-eligible Dental Health Plan Enrollees.

The Contractor shall accept payment from OHCA by direct deposit to Contractor's financial institution. OHCA shall make payment in accordance with information supplied by Contractor via an electronic funds transfer (EFT) form to be provided by OHCA. The Contractor shall update direct deposit information as needed by sending a signed EFT form to OHCA.

### **1.2.1 Payment Schedule**

The Contractor shall be notified of Enrollment and Disenrollment updates through receipt of outbound ANSI ASC X 12 834 electronic transactions. The Contractor shall receive notification of Capitation Payment through receipt of an ASC X12N 820 electronic transaction. Capitation Payment will be made through electronic funds transfer in accordance with a schedule to be published by OHCA.

### **1.2.2 Capitation Reconciliation**

The Contractor shall be responsible for performing a monthly reconciliation of enrollment roster data against Capitation Payments and notifying OHCA of discrepancies in a manner and on a schedule to be defined by OHCA.

### **1.2.3 Report of Capitation Overpayment**

In accordance with 42 C.F.R. § 438.608(c)(3), the Contractor shall report to OHCA within 60 days when it has identified Capitation Payments or other payments in excess of amounts specified in the Contract.

### **1.2.4 Capitation Payment Recoupment**

OHCA shall be the sole determiner of a Dental Health Plan Enrollee's Enrollment and Disenrollment effective dates, as described in Section 1.5: "Enrollment and Disenrollment" of this Model Contract. For Dental Health Plan Enrollees whose enrollment lapses for any portion of a month in which a Capitation

Payment was made, as described in Section 1.5.7.4: “Disenrollment Effective Date” of this Model Contract, OHCA shall adjust the Capitation Payment through a reconciliation process to be defined by OHCA.

### **1.2.5 Capitation Rate Changes**

Material programmatic changes made during the Rating Period that affect Capitation Payment rates shall result in an adjustment to the rates, to be calculated by OHCA’s consulting actuary. The rate change(s) shall be included in the Contract amendment issued to the Contractor in accordance with the provisions outlined in Section 1.1.9: “Amendments or Modifications” of this Model Contract.

### **1.2.6 Capitation Withhold**

OHCA shall withhold one percent of the Contractor’s Capitation Payments beginning January 1, 2022. The Contractor shall be eligible to receive some or all of the withheld funds based on the Contractor’s performance in the areas outlined in Appendix 1D “Pay for Outcomes.” OHCA reserves the right to adjust the percent of Capitation Payments withheld in future Contract Rating Periods. Such adjustments shall be made through a formal Contract amendment.

## **1.3 Administrative Requirements**

### **1.3.1 Licensure**

The Contractor shall be licensed and authorized to transact dental business in the state of Oklahoma. A Certificate of Authority for accident and health insurance or pre-paid dental issued by the Oklahoma Insurance Department shall be submitted as an attachment with Contractor’s response to demonstrate compliance with this requirement.

### **1.3.2 Accreditation**

The Contractor shall be accredited by an Accrediting Entity within 18 months of ~~Contract award~~ **initial enrollment implementation**. If the Contractor is undergoing accreditation, the Contractor shall submit reports documenting the status of the accreditation process as required by OHCA. In accordance with 42 C.F.R. § 438.332(a), the Contractor shall inform OHCA when it has been accredited.

In accordance with 42 C.F.R. § 438.332(b), the Contractor shall authorize the Accrediting Entity to provide OHCA a copy of the Contractor’s most recent accreditation review, including:

- Accreditation status, survey type, and level (as applicable);
- Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and
- Expiration date of the accreditation.

OHCA and the Contractor shall post information about the Contractor’s accreditation status on OHCA and the Contractor’s website. The posted accreditation information shall include the name of the Accrediting Entity, accreditation program, and accreditation level. The website information shall be updated at least annually.

The Contractor shall undergo reaccreditation in accordance with the timeframes required by the Accrediting Entity and federal regulations. Failure to achieve or maintain accreditation in accordance with the provisions of this Model Contract shall be considered a breach of this Model Contract and may result in penalties or termination.

### 1.3.3 Subcontracting

The Contractor may enter into written subcontract(s) for performance of certain responsibilities listed in the Contract. All subcontracts must be in writing and fulfill the requirements of 42 C.F.R. §§ 438.230 and 438.3(k) that are appropriate to the service or activity being delegated. The Contractor shall make available all subcontracts in electronic format for inspection by OHCA and all Subcontractors, including Major Subcontractors, will be approved in advance by OHCA.

If the Contractor uses a Major Subcontractor, as defined below, the Contractor shall obtain OHCA's consent prior to the effective date of any subcontract. A Major Subcontractor is defined as:

- Administrative – Entity anticipated being paid \$2,000,000 or more **annually** for Dental Health Plan Enrollee- or Provider-facing administrative activities, including but not limited to operation of call centers, claims processing and Dental Health Plan Enrollee/Provider education;
- Health Service – Entity, not including Participating Providers, that has an executed agreement to deliver or arrange for the delivery of any benefit covered under the Contract in accordance with Section 1.6: “Covered Benefits” of this Model Contract.

If the Contractor proposed a Major Subcontractor in its response to the RFP, and this was accepted by OHCA, no separate OHCA consent is required. Subcontractors include Subsidiaries and Affiliates of the Contractor.

The Contractor shall be responsible for the performance of all Subcontractors and shall be wholly responsible for meeting all the terms of the Contract. The Contractor shall actively monitor Subcontractors to ensure their compliance with the Contract and verify the quality of their services.

No subcontract or delegation shall relieve or discharge the Contractor from any obligation or liability under the Contract. Any Major Subcontractor shall be subject to the same conditions as the Contractor, including Contract modifications subsequent to award, confidentiality, audit, certifications, and other relevant Contract terms.

In accordance with 42 C.F.R. § 438.230(c), if any of the Contractor's activities or obligations under the Contract with OHCA are delegated to a Subcontractor, the activities and obligations, and related reporting responsibilities, must be specified in the Contract or written agreement between the Contractor and the Subcontractor. The Contract or written agreement must also:

- Provide for revocation of the delegation of activities or obligations, or must specify other remedies in instances where OHCA or the Contractor determines that the Subcontractor has not performed satisfactorily;
- Require Subcontractor compliance with all applicable Medicaid laws, regulations, and applicable subregulatory guidance and Contract provisions;
- Specify that the Subcontractor agrees that the State, CMS, the DHHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contract for ten years from the later of final date of the Contract period or from the date of completion of any audit; and specify that the Subcontractor will make available its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid enrollees; and

- Specify that if the State, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of Fraud or similar risk, the State, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

The Contractor shall provide OHCA written notice at least 30 days in advance of any contractual changes in subcontracted services. Notice of these changes shall include a written transition plan describing how the Contractor will notify Dental Health Plan Enrollees of the change and how the Contractor will maintain continuity of care for those affected Dental Health Plan Enrollees. At its discretion, OHCA may elect to conduct a Readiness Review of the Contractor and/or Subcontractor(s) pursuant to a change in subcontracted services, to ensure continued compliance with Contract terms.

The Contractor shall provide immediate notice to OHCA of any action or suit filed, including a bankruptcy filing, and of any claim made against the Contractor or its Subcontractor(s) that, in the opinion of the Contractor, may result in litigation related in any way to the Contract with OHCA.

OHCA shall consider the Contractor to be the sole point of contact with regard to contractual matters, including all charges and payments resulting from the Contract.

#### **1.3.4 Business Relationship Disclosure**

The Contractor shall provide to OHCA information on its business relationships. This includes any applicable parent organizations, joint ventures, affiliates, subsidiaries and other related parties of the Contractor. The Contractor and its Subcontractors shall agree to disclose business transaction information upon request of OHCA and as otherwise specified in federal and state regulations.

#### **1.3.5 Oklahoma Presence**

The Contractor shall have an office no more than 25 miles from OHCA office, from which, at a minimum, Key Staff members in accordance with Section 1.3.6.2: “Key Staff” of this Model Contract physically perform the majority of their daily duties and responsibilities, and a major portion of the Contractor’s operations take place. The Contractor shall maintain the following roles and positions at the Oklahoma Office:

- Dental Health Plan Enrollee services staff;
- Dental Health Plan Enrollee care support staff;
- Provider services staff;
- Tribal Government liaison staff;
- Program Integrity staff;
- Grievances and Appeals staff; and
- Quality management staff.

The Contractor may maintain certain Key Staff such as Dental Health Plan Enrollee Services staff throughout Oklahoma in order to best serve the needs of the Dental Health Plan Enrollees. Any staff working outside of the 25 mile radius of OHCA office must be approved by OHCA.

Additionally, the following staff must be located and operate within 25 miles of the OHCA office:

- Dental Health Plan Enrollee services call center as required under Section 1.10.7: “Dental Health Plan Enrollee Services Call Center” of this Model Contract and

- Provider services call center as required under Section 1.12.2 “Provider Services Call Center” of this Model Contract.

The Contractor shall ensure the location of any staff or operational functions outside of Oklahoma does not compromise the delivery of integrated services to Dental Health Plan Enrollees and Providers. The Contractor shall be responsible for ensuring all staff functions conducted outside of Oklahoma are readily reportable to OHCA to ensure such location does not hinder OHCA’s ability to monitor the Contractor’s performance and compliance with Contract requirements.

The Contractor shall enforce Tobacco-Free policies covering 100% of the Contractor’s offices statewide. This is an evidence-based intervention for smoking cessation as tobacco free policies create environments that make it much easier to quit and stay quit.

#### 1.3.5.1 Prohibition on Off-Shoring

In accordance with 42 C.F.R. § 438.602(i), the Contractor shall not enter into any subcontract which uses any public funds within its control to purchase services which will be provided outside the United States. This reflects prohibition on the purchase of offshore services. As requested by OHCA, the Contractor shall:

- Disclose the location(s) where all services will be performed by the Contractor and Subcontractor(s);
- Disclose the location(s) where any State data associated with any of the services are provided, or seek to be provided, will be accessed, tested, maintained, backed-up or stored;
- Disclose any shift in the location of services being provided by the Contractor or Subcontractor(s); and
- Disclose the principal location of business for the Contractor and all Subcontractor(s) who are supplying services to the State of Oklahoma under the proposed Contract(s).

If contracted or subcontracted services shall be performed at multiple locations, the known or anticipated value of the services performed shall be identified and reported to OHCA. This information and economic impact on Oklahoma and its residents may be considered in the evaluation.

The Contractor may perform some development functions outside of Oklahoma but within the continental United States. Oklahoma health data must never leave the continental United States. If any Contractor’s or Subcontractor(s) work identified for performance in the United States is moved to another country, outside the continental United States, such action may be deemed a breach of the Contract.

#### **1.3.6 Staffing**

The Contractor shall have sufficient staff to meet all Contract standards. Pursuant to the Oklahoma Privatization Act, 74 OS § 588 *et seq*, the Contractor shall be required to offer available employee positions pursuant to the Model Contract to qualified regular employees of the agency whose state employment is terminated because of the privatization contract and who satisfy the hiring criteria of the Contractor. This includes, at a minimum, the following:

- Key Staff in accordance with Section 1.3.6.2: “Key Staff” of this Model Contract;
- Utilization and dental management staff dedicated to performing utilization management and review activities in accordance with Section 1.7: “Dental Services Utilization Management” of this Model Contract;

- Dental Health Plan Enrollee care support staff as described under Section 1.3.6.3: “Dental Health Plan Enrollee Care Support Staff” of this Model Contract;
- Quality management staff dedicated to quality management and improvement activities in accordance with Section 1.9: “Quality” of this Model Contract;
- Grievances and Appeals staff to ensure the timely and accurate processing of all Grievances and Appeals in accordance with Section 1.15: “Dental Health Plan Enrollee Grievances and Appeals” of this Model Contract;
- Provider reconsiderations and appeals staff to ensure timely and accurate processing of all reconsiderations and appeals in accordance with Section 1.12.6: “Provider Complaint System” of this Model Contract;
- Technical support staff to ensure the timely and efficient maintenance of all health information management system functionality, including Encounter Data reporting, required under Section 1.18: “Information Technology” of this Model Contract;
- Dental Health Plan Enrollee services, Marketing and outreach staff to conduct all Member activities required under Section 1.10: “Dental Health Plan Enrollee Services” of this Model Contract;
- Compliance and reporting staff to complete all reporting required under Section 1.20: “Reporting” of this Model Contract;
- Program integrity staff to comply with the requirements of Section 1.17: “Program Integrity” of this Model Contract;
- Provider services staff to develop the Contractor’s network and coordinate communications with Participating and Non-Participating Providers as required under Section 1.12: “Provider Services” of this Model Contract;
- Claims processing staff sufficient to meet the timely claims processing standards in Section 1.13.4.2: “Timely Claims Filing and Processing” of this Model Contract;
- Accounting and finance staff; and
- Website staff to maintain and update the Contractor’s Dental Health Plan Enrollee and Provider websites.

The Contractor may combine functions as long as it is able to demonstrate that all tasks are being performed. The Contractor may also use administrative service organizations to perform some or all of the above functions, subject to the conditions specified in Section 1.3.3: “Subcontracting” of this Model Contract.

In addition to meeting the requirements delineated elsewhere in the Contract, the Contractor’s staffing shall comply with the requirements listed below.

#### 1.3.6.1 Board of Directors

The Contractor shall have a Board of Directors specifically constituted for purposes of this Model Contract, and any subsequent contracts, with OHCA.

#### 1.3.6.2 Key Staff

The Key Staff positions required under the Contract include:

- *Chief Executive Officer (CEO)* who shall have ultimate responsibility for the administration and implementation of all Contract provisions.

- *Chief Financial Officer (CFO)* who shall oversee the budget and accounting systems under the Contract and ensure compliance with Contract requirements for financial performance and reporting.
- *Compliance Officer* who shall, in accordance with 42 C.F.R. § 438.608, be responsible for developing and implementing policies, procedures and practices designed to ensure Contract compliance and shall report directly to the CEO and Board of Directors. The Compliance Officer shall be responsible for oversight and evaluation of any Contractor corrective actions required to correct non-compliance in accordance with the requirements of Section 1.22: “Non-Compliance Remedies” of this Model Contract. The Compliance Officer shall be responsible for development and oversight of Regulatory Compliance Committee.
- *Information Systems Manager* who shall oversee, manage and maintain the Contractor’s management information systems in accordance with the requirements of Section 1.18: “Information Technology” of this Model Contract. The Information Systems Manager will serve as a liaison between the Contractor and the state regarding encounter claims submissions, capitation payment, member eligibility, enrollment and other data transmission interface and management issues. The IS Manager, in close coordination with other key staff, is responsible for ensuring all program data transactions are in compliance with the terms of the Contract. The IS Manager is responsible for attending all technical meetings called by the state. If the IS Manager is unable to attend a technical meeting, the IS Manager shall designate a representative to take his or her place.
- *Dental Director* who shall be qualified, full-time, licensed dentist in the state of Oklahoma designated by the DBM to exercise general supervision over the provision of core dental benefits and services by the DBM and is responsible for ensuring the proper provision of covered services to participants, and representation at all dental Administrative Hearings.
- *Dental Health Plan Enrollee Services Director* who shall oversee all Dental Health Plan Enrollee services functionality in accordance with Section 1.10: “Dental Health Plan Enrollee Services” of this Model Contract.
- *Provider Services Director* who shall oversee all Provider services and network development functionality in accordance with Section 1.12: “Provider Services ” of this Model Contract. The Provider Services Director is responsible for managing a staff of provider representatives who assist SoonerCare Select Dental providers. The Provider Services Manager is also responsible for the growth and retention of SoonerCare Select Dental providers, creating a qualified and comprehensive provider network.
- *Business Process Manager* who shall be responsible for:
  - The operation of the Contractor’s utilization management functionality in accordance with the requirements of Section 1.7: “Dental Services Utilization Management” of this Model Contract.
  - Ensuring prompt and accurate claims processing in accordance with the requirements of Section 1.13.4: “Claims Processing” of this Model Contract.
- *Quality Management Director* who shall be responsible for operation of the Contractor’s QAPI program in accordance with the requirements of Section 1.9: “Quality” of this Model Contract.
- *Data Compliance Manager* who shall provide oversight to ensure all Contract data conforms to OHCA data standards and policies. The Data Compliance Manager shall have extensive experience in managing data quality and exchange processes, including data integration and verification.



- *Dental Health Plan Enrollee Advocate* who shall be responsible for representation of Member’s interest, including input in policy development, planning and decision-making. The Dental Health Plan Enrollee Advocate should have lived experience as a SoonerCare Dental Health Plan Enrollee. The Dental Health Plan Enrollee Advocate shall be responsible for development and oversight of the Dental Health Plan Enrollee Advisory Board.
- *Grievances & Appeal Manager* who shall manage the Contractor’s Grievance and Appeal System in accordance with the requirements of Section 1.15: “Dental Health Plan Enrollee Grievances and Appeals” of this Model Contract.
- *Tribal Government Liaison* who shall be responsible for outreach to Dental Health Plan Enrollees, Indian Health Care Providers (IHCPs), I/T/Us and Indian Tribe representatives. The Tribal Government Liaison shall serve as a resource to and advocate for AI/AN Dental Health Plan Enrollees and IHCPs in their interactions with the Contractor.
- *Program Integrity Lead Investigator* who shall be responsible for oversight of all Provider or Dental Health Plan Enrollee investigations related to possible Fraud, Waste, or Abuse and coordinating all referrals, investigations, and audits with OHCA in accordance with the requirements of Section 1.17: “Program Integrity” of this Model Contract.
- *Internal Audit Director* who shall serve as an independent party, responsible for oversight of the Contractor’s risk management process. The Internal Audit Director shall analyze operations and critically assess compliance with all requirements as outlined in this Model Contract.
- *Community Dental Health Coordinator* who shall be responsible for ensuring appropriate, coordinated care and communication occurs between the medical and dental providers when the Dental Health Plan Enrollee has complex medical/dental needs. He/she is also responsible for helping the Dental Health Plan Enrollee understand his/her responsibilities in achieving optimal care.

All Key Staff shall be dedicated full-time to the SoonerSelect Dental Contract and based in Oklahoma as required under Section 1.3.5: “Oklahoma Presence” of this Model Contract. OHCA reserves the right to interview any Key Staff, approve or deny the individuals filling Key Staff positions, and request reassignment of Key Staff.

#### 1.3.6.3 Dental Health Plan Enrollee Care Support Staff

The Contractor shall include Dental Health Plan Enrollee services staff, with responsibility for assisting Dental Health Plan Enrollees by:

- Advocating on behalf of a Dental Health Plan Enrollee and his or her preferences with respect to receiving Dental Health Plan Enrollee- and family-centered care;
- Assisting the Dental Health Plan Enrollee to access community-based resources to address non-medical needs and to support the Dental Health Plan Enrollee’s care plan objectives and independence;
- Obtaining information about available SoonerCare services;
- Helping Dental Health Plan Enrollees with the filing of Grievances and Appeals; and
- Outreach and engagement including, but not limited to re-enrollment and Dental Home assignment.

#### 1.3.6.4 Staffing Plan and Implementation Plan

The Contractor shall provide the following for OHCA review and approval no later than 30 days after Contract execution:

- Identification of the Contractor's implementation team;
- Names of the Board of Directors and their current resumes;
- Implementation plan; and
- Hiring and staffing plan which includes a description of the Contractor's diversity and inclusion plans.

The Contractor shall provide regular status updates to OHCA on implementation plan and hiring and staffing plan activities during the Readiness Review, in the timeframe and manner required by OHCA.

#### 1.3.6.5 Changes in Board of Directors and Key Staff

The Contractor shall notify OHCA of all changes in composition of the Board of Directors and Key Staff. The Contractor shall notify OHCA at least five days in advance of the change, whenever practical. The Contractor shall submit a current resume and job description for the new Board of Directors or Key Staff position for OHCA's review.

#### 1.3.6.6 Staff Training

The Contractor shall ensure all staff and Subcontractor staff receive adequate training on the requirements, policies and procedures of the SoonerSelect Dental program. All Contractor staff shall receive initial and ongoing training and education necessary to fulfill their job responsibilities under this Model Contract.

The Contractor shall ensure distinct staff training for the following positions:

- Dental Health Plan Enrollee Services Call Center that meets the minimum requirements of Section 1.10.7.3: "Call Center Training" of this Model Contract;
- Provider Services Call Center that meets the minimum requirements of Section 1.12.2: "Provider Services Call Center" of this Model Contract;
- Language and cultural competency training as described in Section 1.10.2: "Cultural Competency" of this Model Contract to Subcontractors and all Dental Health Plan Enrollee facing staff; and
- Marketing staff in accordance with Section 1.10.14.2: "Training Curriculum" of this Model Contract.

All Contractor staff and Subcontractors shall receive training on security and compliance in accordance with Section 1.17.2.2: "Compliance Education and Training" of this Model Contract. The Contractor shall track and document completion of all staff training and provide evidence of training completion to OHCA upon request.

#### **1.3.7 Coordination with OHCA**

OHCA shall conduct meetings and collaborative workgroups for the SoonerSelect Dental program. The Contractor must comply with all meeting requirements established by OHCA, and is expected to cooperate with OHCA and its designees in preparing for and participating in these meetings. This includes presenting best practices for topics identified by OHCA as requested. The Contractor shall send qualified representatives to attend those meetings, as instructed by OHCA. OHCA may also require the participation of Subcontractors, as determined necessary.

OHCA reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format, or add meetings to the schedule as it deems necessary. At OHCA's discretion, the Contractor may be permitted to have representatives attend remotely, rather than in person.

The Contractor shall also participate in meetings and proceedings with external entities as directed by OHCA, including but not limited to, the DUR Board, Medicaid Advisory Committee, and legislative hearings.

### **1.3.8 Coordination with Other State Agencies**

The Contractor shall coordinate with other State agencies, in the manner to be determined by OHCA, to ensure that coordinated care is provided to Dental Health Plan Enrollees. This includes, but is not limited to coordination with:

- The Oklahoma Office of Juvenile Affairs (OJA);
- The Oklahoma Department of Corrections (ODOC);
- The Oklahoma State Department of Education (OSDE);
- The Oklahoma Department of Human Services (DHS); and
- Tobacco Settlement Endowment Trust (TSET).

### **1.3.9 Policies and Procedures**

The Contractor and any Subcontractor(s) shall develop and maintain written policies and procedures for administration of the Contract. The policies and procedures shall describe in detail how the Contractor and any Subcontractor(s) will fulfill the responsibilities outlined in the Contract.

The Contractor and any Subcontractor(s) must submit policies and procedures for OHCA's review and approval prior to their adoption and implementation. The Contractor and any Subcontractor(s) shall furnish policies and procedures to OHCA upon request. OHCA will examine policies and procedures as part of Readiness Review activities described in Section 1.3.10: "Readiness Review" of this Model Contract and may require modifications or additions as part of Readiness Review findings.

OHCA reserves the right to review and approve the Contractor and any Subcontractor(s) policies and procedures and related matters associated with meeting the requirements of this Model Contract. Such review and approval may occur as part of the Contractor's Readiness Review but may also occur as part of ongoing oversight activities. This provision applies to all sections of the Contract regardless of whether a section contains separate language concerning review of policies and policies pertaining to that section.

If OHCA identifies necessary revisions to the Contractor's and any Subcontractor(s) policies and procedures to conform to Contract standards, OHCA shall notify the Contractor of the required changes and the date by which proposed revised policies and procedures must be furnished. The Contractor and any Subcontractor(s) shall not be required to adopt the revised policies and procedures until after OHCA has given approval to the revisions.

OHCA shall require an annual certification from the Contractor attesting to updated policies and procedures and the operational execution of such.

### **1.3.10 Readiness Review**

The Contractor shall be required to participate in a Readiness Review process prior to the start of Eligible enrollment. The Contractor must complete all Readiness Review activities to the satisfaction of OHCA and CMS before being eligible to receive enrollment of Eligibles.

In accordance with 42 C.F.R. § 438.66, the Readiness Review shall include a desk review of Contractor documentation and an on-site review at the Contractor's offices. The Contractor's ability and capacity to perform satisfactorily on the following minimum components shall be assessed during the Readiness Review:

- Administrative staffing and resources;
- Subcontracted functionality;
- Dental Health Plan Enrollee and Provider communications;
- Grievances and Appeals;
- Dental Health Plan Enrollee services and outreach;
- Participating Provider management;
- Program integrity and compliance;
- Quality improvement;
- Utilization management;
- Financial reporting and monitoring;
- Financial solvency; and
- Information technology including claims management, Encounter Data and enrollment information management.

Failure of the Contractor to meet Readiness Review requirements shall subject the Contractor to the remedies in Section 1.22: "Non-Compliance Remedies" of this Model Contract.

#### **1.4 Mandatory, Voluntary and Excluded Populations**

##### **1.4.1 Eligibility Determinations**

OHCA has sole authority for determining eligibility for SoonerCare and for determining whether an Eligible is able to be enrolled in the SoonerSelect Dental Program. The eligibility and enrollment process is described in Section 1.5: "Enrollment and Disenrollment" of this Model Contract.

##### **1.4.2 Mandatory Enrollment Populations**

The following Eligibles will be mandatorily enrolled with a Dental Benefit Manager under the SoonerSelect Dental program:

- Expansion Adults;
- Parents and Caretaker Relatives;
- Pregnant Women;
- Deemed Newborns;
- Former Foster Children;
- Juvenile Justice Involved;
- Foster Care;
- Children Receiving Adoption Assistance; and
- Children.

##### **1.4.3 Voluntary Enrollment Populations**

Notwithstanding the requirements outlined in Section 1.4.2: "Mandatory Enrollment Populations" of this Model Contract, AI/AN Eligibles who are determined eligible for a SoonerCare population will have the option to voluntarily enroll in the SoonerSelect Dental program through an opt-in process.

#### **1.4.4 Excluded Populations**

The following Eligibles will be excluded from enrollment in SoonerSelect Dental:

- Dual Eligible Individuals;
- Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Workers (QDW) and Qualified Individuals (QI);
- Persons with a nursing facility or ICF-IID level of care, with the exception of Dental Health Plan Enrollees with a pending level of care determination.
- Individuals during a period of Presumptive Eligibility;
- Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;
- Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;
- Individuals enrolled in a §1915(c) Waiver;
- Undocumented persons eligible for Emergency Services only in accordance with 42 C.F.R. § 435.139;
- Insure Oklahoma Employee Sponsored Insurance (ESI) dependent children in accordance with the Oklahoma Title XXI State Plan;
- Coverage of Pregnancy-Related Services under Title XXI for the benefit of unborn children ('Soon-to-be-Sooners'), as allowed by 42 C.F.R. § 457.10; and
- Individuals determined eligible for Medicaid on the basis of age, blindness or disability.

#### **1.4.5 Enrollment Phase-In**

OHCA does not anticipate phasing in enrollment of the populations in Section 1.4.2: "Mandatory Enrollment Populations" of this Model Contract. However, OHCA reserves the right to phase-in enrollment by eligibility category, geographic area or other means if deemed necessary for the successful implementation of the SoonerSelect Dental program. The Contractor shall cooperate in the implementation of a phase-in schedule, if one is implemented.

#### **1.4.6 Changes in Covered Populations**

OHCA reserves the right, and intends, to enroll Eligibles in a SoonerCare eligibility group outlined in Section 1.4.4: "Excluded Populations" of this Model Contract into the SoonerSelect Dental program in future years. Expansion of enrolled populations would be implemented through the procurement or Contract amendment process and the Contractor would be required to go through the Readiness Review process.

### **1.5 Enrollment and Disenrollment**

#### **1.5.1 Non-Discrimination**

Consistent with 42 C.F.R. § 438.3(d), the Contractor may not refuse an assignment or seek to disenroll a Dental Health Plan Enrollee or otherwise discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. The Contractor also may not discriminate against a Dental Health Plan Enrollee on the basis of expectations that the Dental Health Plan Enrollee will require frequent

or high cost care, or on the basis of health status or need for health care services or due to an adverse change in the Dental Health Plan Enrollee's health in Enrollment, Disenrollment, or re-enrollment.

The Contractor shall accept individuals eligible for enrollment in the order in which they are enrolled (unless otherwise authorized by CMS) up to the limits set under the Contract.

The Contractor shall not request Disenrollment because of a change in the Dental Health Plan Enrollee's health status, or because of the Dental Health Plan Enrollee's utilization of dental services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs, except when his or her continued enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular Dental Health Plan Enrollee or other Dental Health Plan Enrollees. The Contractor may only request Disenrollment of the Dental Health Plan Enrollee in accordance with the provisions outlined in Section 1.5.7.1: "Contractor Request" of this Model Contract.

## **1.5.2 Enrollment Process**

### **1.5.2.1 Enrollment Choice Counseling**

OHCA, or its designee, will be responsible for educating Eligibles about the SoonerSelect Dental program and providing unbiased Choice Counseling concerning enrollment options. Choice Counseling will be available at the time of initial enrollment, during the annual Open Enrollment Period described in Section 1.5.5: "Annual and Special Enrollment Periods" of this Model Contract and under the provisions described in Section 1.5.7: "Disenrollment Request Process" of this Model Contract.

OHCA will provide notice to prospective Eligibles regarding the Dental Benefit Manager selection process and the importance of making a selection in accordance with informational and timing requirements as specified in 42 C.F.R. § 438.54.

### **1.5.2.2 Materials for Enrollment Choice Counseling**

The Contractor shall furnish materials regarding its dental plan and up-to-date Participating Provider rosters in a manner and on a schedule to be defined by OHCA. Materials must comply with OHCA review and approval process described in Section 1.10.14.4: "OHCA Review and Approval Process" of this Model Contract, including adherence to allowable and prohibited Marketing and Material requirements. The rosters shall include up-to-date information on whether each Participating Provider has an open or closed panel with respect to accepting new patients. Inaccurate Participating Provider information shall be grounds for Non-compliance Remedies, as described in Section 1.22: "Non-Compliance Remedies" of this Model Contract.

The Contractor shall also supply Participating Provider rosters to the State of Oklahoma HIE vendor in a manner and on a schedule to be defined by OHCA.

The Contractor shall also conduct Marketing and outreach efforts to raise awareness of the SoonerSelect Dental program and their product, subject to the requirements of Section 1.10.14: "Marketing and Outreach" of this Model Contract.

### **1.5.2.3 Initial Health Plan Selection Process**

OHCA, at its discretion, may allow up to 60 days for Eligibles to select a Dental Benefits Manager prior to the start of the SoonerSelect Dental program. Subsequent to program start, SoonerCare applicants eligible

for the SoonerSelect Dental program will have an opportunity to select a Dental Benefits Manager on their application. Eligibles who do not make an election within the allowed timeframe will be assigned to a Dental Benefits Manager in accordance with the rules outlined in Section 1.5.2.4: “Auto Assignment” of this Model Contract.

#### 1.5.2.4 Auto Assignment

Applicants who are eligible to choose a Dental Benefit Manager and fail to make an election on the SoonerCare application, will be assigned to the Dental Benefits Manager that is due next to receive an auto assignment taking into account quality weighted assignment factors. Once assigned to an initial DBM, the Dental Health Plan Enrollee shall have 90 Calendar Days to request a transfer to another DBM.

OHCA reserves the right to modify the auto-assignment algorithm at any time.

Notwithstanding the above language, OHCA will not make auto-assignments to the Contractor if any of the following conditions exist:

- The Contractor’s maximum enrollment has been capped under the terms outlined in Section 1.5.6: “Enrollment Caps” of this Model Contract and actual enrollment has reached 95% of the cap;
- The Contractor has been excluded from receiving new enrollment due to the imposition of Non-Compliance Remedies, as outlined in Section 1.22: “Non-Compliance Remedies” of this Model Contract; or
- The Contractor has failed to meet Readiness Review requirements.

It is OHCA’s intent to modify the assignment algorithm in year two of the SoonerSelect Dental program to take into consideration the Contractor’s performance on improving oral health outcomes. The revised algorithm will be included as part of a Contract amendment to be issued in accordance with Section 1.1.9: “Amendments or Modifications” of this Model Contract.

#### **1.5.3 Enrollment Effective Date**

It is OHCA’s intent that Eligibles, with the exception of Deemed Newborns, who select or are assigned to a Dental Benefits Manager before the fifteenth day of the month shall be enrolled effective on the first day of the following month. Eligibles who select or are assigned to a Dental Benefit Manager on the fifteenth day of the month or later will be enrolled effective on the first day of the second following month. Prior to these enrollment dates, most Eligibles will be covered by a fee-for-service payment structure administered by OHCA. Deemed Newborns eligible for the SoonerSelect Dental program shall be enrolled effective as of the date of birth, if the newborn’s mother also is enrolled in the SoonerSelect Dental program.

Notwithstanding the foregoing, the effective date of enrollment with the Contractor shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by OHCA.

#### **1.5.4 Enrollment Lock-In Period**

Dental Health Plan Enrollees will be permitted to change Dental Benefit Managers, without showing cause, during their first 90 days of enrollment with the Contractor, or during the 90 days following the date OHCA sends the Dental Health Plan Enrollee notice of that enrollment, whichever is later. After the

Dental Health Plan Enrollee's period for Disenrollment from the Contractor has lapsed, Dental Health Plan Enrollees will remain enrolled with the Contractor until the next annual Open Enrollment Period, unless:

- The Dental Health Plan Enrollee is disenrolled due to loss of SoonerCare eligibility;
- The Dental Health Plan Enrollee becomes a foster child under custody of the State;
- The Dental Health Plan Enrollee becomes juvenile justice involved under the custody of the state;
- The Dental Health Plan Enrollee demonstrates cause in accordance with Section 1.5.7.2: "Dental Health Plan Enrollee Request" of this Model Contract;
- A temporary loss of eligibility or enrollment has caused the Dental Health Plan Enrollee to miss the annual Disenrollment period, then the Dental Health Plan Enrollee may disenroll without cause upon reenrollment; or
- OHCA imposes Intermediate Sanctions on the Contractor and allows Dental Health Plan Enrollees to disenroll without cause.

#### **1.5.5 Annual and Special Enrollment Periods**

OHCA will conduct an annual Open Enrollment Period. Written notice of the Open Enrollment Period and Dental Health Plan Enrollee Disenrollment rights will be provided to Dental Health Plan Enrollees at least 60 days prior to the start of the Open Enrollment Period, in accordance with 42 C.F.R. § 438.56. OHCA, or its designee, will provide Dental Health Plan Enrollees information on their Dental Benefit Manager options for the coming year. The Contractor shall cooperate with OHCA in furnishing requested materials to current and prospective Dental Health Plan Enrollees.

Dental Health Plan Enrollees will be informed that if they do not request a new Dental Benefit Manager, they will remain in their current Dental Benefit Manager. All Dental Health Plan Enrollees, including those who do not make a change, will be permitted to change Dental Benefit Managers during the first 90 days of the new enrollment period in accordance with the process outlined in Section 1.5.4: "Enrollment Lock-In Period" of this Model Contract.

OHCA, at its sole discretion, may schedule a special Open Enrollment Period, under the following circumstances:

- In the event of the early termination of a Dental Benefit Manager under the process described in Section 1.23.1: "Early Termination" of this Model Contract; or
- The loss of a major Participating Provider places the Contractor at risk of failing to meet service accessibility standards and the Contractor does not have an acceptable plan for mitigating the loss or finding of non-compliance.

The Contractor shall cooperate as directed by OHCA in facilitating the special Open Enrollment Period.

#### **1.5.6 Enrollment Caps**

OHCA, at its sole discretion, may impose a cap on the Contractor's enrollment, in response to a request by the Contractor or as part of a corrective action occurring under Section 1.22: "Non-Compliance Remedies" of this Model Contract.



### **1.5.7 Disenrollment Request Process**

#### **1.5.7.1 Contractor Request**

The Contractor must comply with Section 1.5.1: “Non-Discrimination” of this Model Contract, and seek to disenroll a Dental Health Plan Enrollee only for good cause. The following actions, if found by OHCA, comprise good cause:

- Dental Health Plan Enrollee has been enrolled in error, as determined by OHCA;
- Dental Health Plan Enrollee has exhibited disruptive behaviors to the extent that the Contractor cannot effectively manage their care, and the Contractor has made all reasonable efforts to accommodate the Dental Health Plan Enrollee; or
- Dental Health Plan Enrollee has committed Fraud, including but not limited to, loaning an ID card for use by another person.

The Contractor must make a written request to OHCA for Dental Health Plan Enrollee Disenrollment, in a format to be specified by OHCA. The Contractor’s request for disenrollment must document that reasonable steps were taken to educate the Dental Health Plan Enrollee regarding proper behavior and that the Dental Health Plan Enrollee refused to comply, if applicable. The Contractor also must communicate its request to the Dental Health Plan Enrollee in writing, in a format to be specified by OHCA.

OHCA shall have sole authority to grant or deny the Disenrollment request.

#### **1.5.7.2 Dental Health Plan Enrollee Request**

Dental Health Plan Enrollees shall be permitted to disenroll from the Contractor without cause, in accordance with the provisions of Section 1.5.4: “Enrollment Lock-In Period” of this Model Contract.

During the lock-in period, Dental Health Plan Enrollees may be disenrolled for cause, at any time, in accordance with 42 C.F.R. § 438.56(d) and under the following conditions:

- The Dental Health Plan Enrollee moves out of the Contractor’s service area;
- Dental Health Plan Enrollee seeks covered benefits that the Contractor does not cover for moral or religious reasons;
- Dental Health Plan Enrollee needs related services to be performed at the same time; not all related services are available within the Contractor’s network; and the Dental Health Plan Enrollee’s PCD Provider or another Provider determines that receiving the services separately would subject the Dental Health Plan Enrollee to unnecessary risk;
- Dental Health Plan Enrollee has filed and prevailed in a Grievance regarding poor quality of care, lack of access to services covered under the Contract or lack of access to Providers experienced in dealing with the Dental Health Plan Enrollee’s oral health care needs or other matters deemed sufficient to warrant Disenrollment; or
- Dental Health Plan Enrollee has been enrolled in error, as determined by OHCA.

Dental Health Plan Enrollees shall seek redress through the Contractor’s Grievance process before OHCA will make a determination on a Dental Health Plan Enrollee’s request for Disenrollment. The Contractor shall accept Dental Health Plan Enrollee requests for Disenrollment orally or in writing. The Contractor shall complete a review of the request within ten days of the Dental Health Plan Enrollee filing the Grievance. If the Dental Health Plan Enrollee remains dissatisfied with the result of the Grievance process,

the Contractor shall refer the Disenrollment request to OHCA. The Contractor shall send records gathered during the Grievance process to OHCA to facilitate OHCA's decision-making process. Disenrollment requests will be adjudicated by OHCA and, if approved, will become effective on a date established by OHCA consistent with Section 1.5.7.4: "Disenrollment Effective Date" of this Model Contract.

1.5.7.3 At OHCA's Initiation

OHCA will initiate Disenrollment of Dental Health Plan Enrollees under the following circumstances:

- Loss of eligibility for Medicaid;
- Transition to a SoonerCare eligibility group excluded from the SoonerSelect Dental program;
- Dental Health Plan Enrollee becomes enrolled in Medicare;
- Death;
- Dental Health Plan Enrollee becomes an inmate of a public institution;
- Dental Health Plan Enrollee commits Fraud or provides fraudulent information; or
- Disenrollment is ordered by a hearing officer or court of law.

1.5.7.4 Disenrollment Effective Date

Consistent with 42 C.F.R. § 438.56(e), except as provided for below, and unless OHCA determines that a delay would have an adverse effect on a Dental Health Plan Enrollee's health, it is OHCA's intent that a Disenrollment shall be effective on the first day of the second following month. Grievance resolution for poor quality of care, lack of access to services covered under the Contract or lack of access to Providers experienced in dealing with the Dental Health Plan Enrollee's oral health care needs or other matters deemed sufficient to warrant Disenrollment under Section 1.5.7.2: "Dental Health Plan Enrollee Request" of this Model Contract must be completed within this timeframe. If the Contractor fails to complete the Grievance process in time to permit Disenrollment by OHCA, the Disenrollment shall be considered approved for the effective date that would have been established had the Contractor complied with this timeframe.

Disenrollments for any of the following reasons shall be effective as of the date that the Dental Health Plan Enrollee's SoonerSelect Dental Program eligibility status changes:

- Loss of eligibility for Medicaid;
- Transition to a SoonerCare eligibility group excluded from the SoonerSelect Dental Program;
- Dental Health Plan Enrollee becomes eligible for Medicare;
- Death;
- Dental Health Plan Enrollee becomes an inmate of a public institution;
- Dental Health Plan Enrollee commits Fraud or provides fraudulent information; or
- Disenrollment is ordered by a hearing officer or court of law.

Dental Health Plan Enrollees requiring long-term care in a nursing facility or ICF-IID shall be disenrolled from the Contractor when the level of care determination being done by the medical MCO is complete.

Notwithstanding the foregoing, the effective date of Disenrollment from the Contractor shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by OHCA.

### **1.5.8 Dental Health Plan Enrollee Status Changes**

The Contractor shall notify OHCA, in the manner required by OHCA, within five Business Days of learning of any change in a Dental Health Plan Enrollee's status or circumstances that could affect the Dental Health Plan Enrollee's eligibility for the SoonerSelect Dental program.

### **1.5.9 Retroactive Dual Eligibility**

Dual Eligible Individuals are excluded from SoonerSelect Dental program enrollment. Dental Health Plan Enrollees who become a Dual Eligible Individual will be disenrolled as of their Medicare eligibility effective date. In the event a Dental Health Plan Enrollee becomes retroactively Medicare eligible, the Contractor shall recover claims payments made to Providers during the months of retroactive Medicare eligibility. The Contractor shall also notify the Provider of the requirement to submit the claim to Medicare for reimbursement. OHCA will recoup the Capitation Payments paid for months of retroactive Medicare eligibility.

### **1.5.10 Reenrollment Following Loss of Eligibility**

Dental Health Plan Enrollees who lose and regain eligibility for SoonerSelect Dental program for a period of two months or less will be re-enrolled automatically with the Contractor. Re-enrolled Dental Health Plan Enrollees will have the right to change Dental Benefit Managers in accordance with Section 1.5.4: "Enrollment Lock-In Period" of this Model Contract.

## **1.6 Covered Benefits**

The Contractor shall be responsible for furnishing the dental benefits described in this section. The Contractor shall also coordinate with Providers of benefits outside of the SoonerSelect Dental capitation to promote service integration and the delivery of holistic, person- and family-centered care. This includes:

- SoonerCare-covered non-capitated benefits, as outlined in Section 1.6.2: "Benefits" of this Model Contract; and
- Other benefits a Dental Health Plan Enrollee receives, regardless of payer, including volunteered services.

In accordance with 42 C.F.R. § 438.210(a), in furnishing covered benefits, the Contractor shall ensure:

- Each service is provided to Dental Health Plan Enrollees in an amount, duration and scope that is no less than the amount, duration and scope for the same services provided under the SoonerCare fee-for-service program;
- Services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished; and
- It does not arbitrarily deny or reduce the amount, duration, or scope of a required service on the basis of the diagnosis, type of illness, or condition of the Dental Health Plan Enrollee. Notwithstanding the foregoing, in accordance with Section 1.7: "Dental Services Utilization Management" of this Model Contract, the Contractor may place appropriate limits on a service on the basis of criteria applied under the Medicaid State Plan, such as medical necessity, or for utilization control, provided the services furnished can reasonably achieve their purpose and services supporting Dental Health Plan Enrollees with ongoing or Chronic Conditions are authorized in a manner that reflects the Dental Health Plan Enrollee's ongoing need for such services and supports.

The Contractor shall furnish all Medically Necessary capitated benefits in accordance with applicable OHCA policies and rules in effect at the time of Contract execution, or as updated in accordance with the amendment process outlined in Section 1.1.9: "Amendments or Modifications" of this Model Contract.

The Contractor may require Prior Authorization of benefits to the extent these are required under OHCA's policies and rules. The Contractor may propose to impose additional Prior Authorization requirements, subject to OHCA's review and approval, except for those benefits identified as exempt from Prior Authorization, as delineated in this section.

**1.6.1 Dental Benefits**

The Contractor shall ensure that all Medically Necessary Covered Services are available to Dental Health Plan Enrollees on a timely basis and that services are consistent with appropriate dental guidelines, generally accepted practice parameters and Contract requirements.

The Contractor shall furnish the dental benefits outlined in the table below, and as described in 317:30-5-695 through 317:30-5-700, which may be modified as OHCA deems necessary. Annual benefit limits are tracked on a Contract year basis.

Service	Children (under 21)	Adults
Oral Examinations	Limited, Comprehensive and Periodic Evaluations Covered	Limited Evaluation Covered*
Images	Covered as needed for diagnostic purposes	Covered as Medically Necessary*
Preventive Services	Dental Prophylaxis, Fluoride Varnish, and Dental Sealants Covered	Not Covered*
Periodontal Services Including but not Limited to Scaling and Root Planing and Scaling in the Presence of Gingivitis	Covered Prior Authorization Required	Not Covered*
Stainless Steel Crowns	Covered for Primary and Permanent Teeth	Not Covered
Space Maintenance Including band and loop type space	Covered	Not Covered

Service	Children (under 21)	Adults
maintenance and lingual arch bars		
Endodontic Services	Pulpotomy, Pulpectomy, Pulp Caps, Apexification, and Root Canals Covered	Not Covered
Anesthesia	Covered	Covered as Needed for Medically Necessary Procedures
Restorative	Amalgam and Resin-Based Restorations, Including Protective Restorations Covered	Not Covered*
Fixed Prosthetics	Covered Prior Authorization Required	Not Covered
Removable Prosthetics	Covered Prior Authorization Required	Not Covered*
Oral and Maxillofacial Surgery	Covered Some services may require Prior Authorization	Medically Necessary Extractions Oral Pathology as Medically Necessary for Malignant Lesions
Tobacco Cessation	Covered [See Attachment 1 Tobacco Cessation Services]	Covered [See Attachment 1 Tobacco Cessation Services]
Orthodontic Services	Covered Meeting OHCA Qualifications as stated in Policy Prior Authorization	Not Covered

\*As discussed in Section 1.5: “Future Reform,” contingent upon the receipt of required federal and State authorities as well as availability of funding, the Contractor shall insure that the following benefits are covered for Dental Health Plan Enrollees ages 21 and older: exams, x-rays, extractions, fluoride, prophylactic cleaning, non-prosthetic restorations, periodontal scaling, and dentures.

**1.6.2 Benefits Not Covered Under This RFP**

Medical, behavioral health, pharmacy, and non-emergency transportation services will be reimbursed by OHCA outside of the Contractor’s capitation and delivered through a Managed Care Organization.

Additionally, in accordance with Section 1.14.4.3: “Payments to IHCPs” of this Model Contract, the Contractor shall not be financially responsible for services rendered by IHCPs that are eligible for 100% federal funding.

### **1.6.3 Referrals**

The Contractor shall develop referral policies and procedures to ensure that Dental Health Plan Enrollees have access to participating specialty Providers for Medically Necessary dental care for their covered conditions. All Dental Health Plan Enrollees and Providers shall be educated on the referral policy and procedures, including which services require referrals.

Dental Health Plan Enrollees shall be educated on the possible consequences of self-referrals, including, but not limited to, experiencing a delay in accessing service. If the Dental Health Plan Enrollee attempts to receive a non-covered service, the Dental Health Plan Enrollee shall be made aware at the point of service that he or she may be billed for the service and how much he or she will be billed.

If the Contractor has exhausted all in state options, and demonstrated that a Medically Necessary service is unavailable within the State, the Contractor shall provide for these services through out-of-state Providers in accordance with OAC 317:30-3-89 – OAC 317:30-3-92. The Contractor shall facilitate such referrals as appropriate.

The Contractor shall make good faith efforts to ensure that PCD Providers track and follow up on Dental Health Plan Enrollee referrals. The Contractor shall ensure that the PCD Providers maintain dental records documenting referrals. The Contractor shall maintain referral records which may be audited by OHCA as part of routine oversight activities.

The Contractor must have a process, such as Standing Referrals or approved number of visits, to allow Dental Health Plan Enrollees to directly access a specialist as appropriate for a Dental Health Plan Enrollee’s condition and identified needs, when Dental Health Plan Enrollees are determined through an assessment by an appropriate health care professional to need a course of treatment or regular care monitoring.

Dental Health Plan Enrollees shall be permitted to self-refer to:

- Emergency services and
- Services provided by Indian Health Care Providers to AI/AN Dental Health Plan Enrollees.

### **1.6.4 Value-Added Benefits**

The Contractor may offer Value-Added Benefits and Services in addition to the capitated benefit package to support the health, wellness and independence of Dental Health Plan Enrollees and to advance the State’s objectives for the SoonerSelect Dental program. This may include, but is not limited to dental services in excess of fee-for-service program limits.

Value-Added Benefits and Services, if offered, shall not be included in determining the Contractor’s Capitation Rates.

If the Contractor has proposed any Value-Added Benefits or services in its response to the Solicitation, and OHCA has approved the proposed benefits and services, the Contractor must furnish these benefits for the duration of the Contract. However, the Contractor may submit a request for revision of the benefits

and services for OHCA's review and approval prior to the start of a Contract year, to take effect in the upcoming Contract year.

#### **1.6.5 Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT)**

The Contractor shall provide EPSDT benefits to all Dental Health Plan Enrollees under age 21, including necessary health care, diagnostic services, treatment and other measures described in Section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered during screening, whether or not such services are covered under the State Plan.

#### **1.6.6 School-Based Services**

The Contractor shall reimburse OHCA-enrolled qualified schools as providers of health-related services for all SoonerCare covered benefits for which the Contractor is responsible. Contractor must also contract with Independent School Districts to reimburse qualified schools for all SoonerCare covered benefits for which the contractor is responsible.

#### **1.6.7 Prohibited Payments**

The Contractor shall not pay for an item or service for which payment is prohibited by Section 1903(i) of the Act, including but not limited to, services:

- Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Act.
- Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) or the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).
- Furnished by an individual or entity to whom the State has failed to suspend payments 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 such payments.
- With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.
- With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.

#### **1.6.8 Emergency and Post-Stabilization Services**

In accordance with Section 1852(d)(2) of the Act and 42 C.F.R. §§ 438.114(b), 422.113(c), 438.114(d), and 438.114(e), the Contractor must cover and pay for Emergency and Post-Stabilization Care Services. This includes ensuring the determination of the attending emergency physician, or the Provider actually treating the Dental Health Plan Enrollee, of when the Dental Health Plan Enrollee is sufficiently stabilized for transfer or discharge is binding on the Contractor and State for coverage and payment of Emergency and Post-Stabilization Care Services.

##### **1.6.8.1 Emergency Services**

In accordance with Section 1932(b)(2) of the Act and 42 C.F.R. § 438.114(c)(1)-(2) the Contractor shall:

- Pay Non-Participating Providers for dental Emergency Services no more than the amount that would have been paid if the service had been provided under the State's fee-for-service Medicaid program.
- Cover and pay for dental Emergency Services regardless of whether the Provider that furnishes the services has a contract with the Contractor.
- Not deny payment for treatment obtained when a Dental Health Plan Enrollee had a dental Emergency Medical Condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- Not deny payment for treatment obtained when a representative of the Contractor instructs the Dental Health Plan Enrollee to seek dental Emergency Services.
- Provide coverage and payment for services until the attending emergency physician, or the Provider actually treating the Dental Health Plan Enrollee, determines that the Dental Health Plan Enrollee is sufficiently stabilized for transfer or discharge.

In accordance with 42 C.F.R. §§ 438.114(d)(1)-(2), the Contractor shall not:

- Limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.
- Refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Dental Health Plan Enrollee's PCD or the Contractor, or applicable State entity of the Dental Health Plan Enrollee's screening and treatment within ten Calendar Days of presentation for Emergency Services.
- Hold a Dental Health Plan Enrollee who has had an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the condition.

#### 1.6.8.2 Post-stabilization Services

In accordance with 42 C.F.R. §§ 438.114(e), 422.113(c)(2)(i) - (ii), and 422.113(c)(2)(iii)(A) - (C), the Contractor shall cover Post-Stabilization Care Services that are:

- Obtained within or outside the Contractor network that are:
  - Pre-approved by a Contractor Provider or representative.
  - Not pre-approved by a Contractor Provider or representative, but administered to maintain the Dental Health Plan Enrollee's stabilized condition within one hour of a request to the Contractor for pre-approval of further Post-Stabilization Care Services.
- Administered to maintain, improve, or resolve the Dental Health Plan Enrollee's stabilized condition without preauthorization, and regardless of whether the Dental Health Plan Enrollee obtains the services within the Contractor network when the Contractor:
  - Did not respond to a request for pre-approval within one hour.
  - Could not be contacted.
  - Representative and the treating physician could not reach agreement concerning the Dental Health Plan Enrollee's care and a Contractor physician was not available for consultation.

In accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c)(2)(iv), the Contractor shall limit charges to Dental Health Plan Enrollees for Post-Stabilization Care Services to an amount no greater than what the



Contractor would charge the Dental Health Plan Enrollee if he or she obtained the services through the Contractor.

In accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c)(3)(i) - (iv), the Contractor's financial responsibility for Post-Stabilization Care Services if not pre-approved ends when:

- A Contractor physician with privileges at the treating hospital assumes responsibility for the Dental Health Plan Enrollee's care.
- A Contractor physician assumes responsibility for the Dental Health Plan Enrollee's care through transfer.
- A Contractor representative and the treating physician reach an agreement concerning the Dental Health Plan Enrollee's care.
- The Dental Health Plan Enrollee is discharged.

#### **1.6.9 Delivery Network**

In addition to the benefits described in the sections above, the Contractor shall also cover services in the following situations:

- The Contractor shall provide for a second opinion from a Participating Provider, or arrange for the Dental Health Plan Enrollee to obtain a second opinion outside the network, at no cost to the Dental Health Plan Enrollee, in accordance with 42 C.F.R. § 438.206(b)(3).
- If the Contractor's provider network is unable to provide necessary medical services covered under the Contract to a particular Dental Health Plan Enrollee, the Contractor must adequately and timely cover the services out of network, for as long as the Contractor's provider network is unable to provide them, in accordance with 42 C.F.R. § 438.206(b)(4).

The Contractor shall coordinate payment with Non-Participating Providers and ensure the cost to the Dental Health Plan Enrollee is no greater than it would be if the services were furnished within the network.

#### **1.6.10 Moral Objections**

The Contractor shall provide, reimburse for, or provide coverage of all counseling and referral services covered under the Contract unless the Contractor objects to the service on moral or religious grounds. The Contractor shall furnish information about the services it does not cover because of an objection on moral or religious grounds to the State in its response to the Solicitation and whenever the Contractor adopts such a policy during the term of the Contract. Pursuant to 42 C.F.R. § 438.10(e)(2)(v)(C), the State will provide information about counseling or referral services the Contractor will not cover on the basis of moral or religious objections at least 30 days before the effective date of the policy for any particular service.

#### **1.7 Dental Services Utilization Management**

The Contractor and OHCA acknowledge that the purpose of dental services utilization management is to ensure Dental Health Plan Enrollees have appropriate access to Medically Necessary covered dental services. For the purpose of this Model Contract, Medically Necessary covered dental services must be furnished in a manner that:

- Is no more restrictive than that used in the Oklahoma Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan and other State policies and procedures;
- Addresses the prevention, diagnosis and treatment of a Dental Health Plan Enrollee's disease, condition and/or disorder that results in health impairments and/or disability;
- Allows Dental Health Plan Enrollees to achieve age-appropriate growth and development; and
- Allows Dental Health Plan Enrollees the ability to attain, maintain or regain functional capacity.

#### **1.7.1 Dental Utilization Management Program Components**

The Contractor shall develop a dental management structure for the SoonerSelect Dental that is integrated with and complementary to the Contractor's QAPI program. This program should have a Dental Utilization Management Program description, work plan, an implementation mechanism, policies and procedures and program evaluation with evaluative criteria, all of which shall be reviewed and updated annually.

The Dental Utilization Management Program must include:

- Prior authorization;
- Profiling of primary care dentists and analysis of utilization data to detect underutilization and overutilization of services;
- Investigation and intervention, as appropriate, when utilization and/or quality of care issues are identified; and
- Direction and analysis of periodic reviews of members' service utilization patterns.

OHCA reserves the right to review and approve the Contractor's Dental Utilization Management Program description, work plan, policies and procedures and program evaluation with evaluative criteria during Readiness Review, annually and at times specified by OHCA.

#### **1.7.2 Qualified Staff**

The dental management function shall be overseen by a full-time Business Process Manager, or equivalent, and a Dental Management (Utilization Management) Committee, which shall be comprised of appropriately credentialed dental Providers. This committee shall report to the Contractor's Quality Improvement Committee.

The Dental Management Program shall be staffed by an appropriate number of credentialed dental professionals. The Contractor shall submit a staffing plan for the Dental Management Program for review by OHCA during Readiness Review. This staffing plan should cover the training that staff receive specific to the area of dental management.

The Contractor shall have sufficient staff with clinical expertise and training to interpret and apply the utilization management criteria and practice guidelines to Providers' requests for oral health care or Service Authorizations for the Contractor's Dental Health Plan Enrollees. Utilization management staff shall receive ongoing training regarding interpretation and application of the utilization management guidelines. The Contractor shall be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon OHCA request.

In accordance with 42 C.F.R. § 438.210(e), the Contractor shall ensure compensation to staff and Subcontractors conducting utilization management activities is not structured to provide incentives for denying, limiting, or discontinuing Medically Necessary services to any Dental Health Plan Enrollee.

### **1.7.3 Clinical Practice Guidelines**

Pursuant to 42 C.F.R. § 438.236, the Contractor shall adopt oral health Clinical Practice Guidelines that meet the following requirements:

- Are based on valid and reliable clinical evidence or a consensus of dental professionals;
- Consider the needs of Dental Health Plan Enrollees in each of the eligibility groups enrolled with the Contractor;
- Are adopted in consultation with Participating Providers; and
- Are reviewed and updated as needed, or at least every two years.

The Contractor shall ensure decisions regarding utilization management, Dental Health Plan Enrollee education, coverage of services, and other areas to which practice guidelines apply are consistent with the practice guidelines. The Contractor may coordinate the development of Clinical Practice Guidelines with other Dental Benefit Managers to avoid the possibility that Providers would receive conflicting Clinical Practice Guidelines from different Dental Benefit Managers. The Contractor shall disseminate Clinical Practice Guidelines to all affected Participating Providers and, upon request, to Dental Health Plan Enrollees or Eligibles. The Contractor shall take steps to encourage adoption of the Clinical Practice Guidelines by Providers and to measure compliance with the Clinical Practice Guidelines.

### **1.7.4 Authorization Process**

The Contractor shall develop a Prior Authorization (PA) process as part of the Dental Management Program that comports with all State and federal requirements. In accordance with 42 C.F.R. § 438.210(b), the Contractor and any applicable Subcontractors shall have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services. The Contractor's Prior Authorization process shall also put in place mechanisms to ensure consistent application of review criteria for authorization decisions, and consult with the Provider that requested the services when appropriate.

The Contractor shall provide information sufficient for OHCA to comply with its statutory responsibilities under 63 O.S. § 2560 – 2565, as requested.

OHCA reserves the right to standardize certain parts of the PA reporting process across Dental Benefit Managers, such as requiring Contractors to adopt and apply the same definitions regarding approved, pending, denied, suspended requests, and other policies and processes, as determined by OHCA.

The Contractor shall develop plans and processes to monitor Prior Authorization requests and denials. The Contractor shall use this information to identify strategies to address over- and under-utilization of services, sharing monitoring and strategies with OHCA upon request.

#### **1.7.4.1 Services Requiring PA**

The Contractor may require PA to the extent required under OHCA's policies and rules and may propose additional PA requirements, subject to OHCA review and approval.

The Contractor shall not be permitted to impose Prior Authorization on emergency dental care or urgent dental care.

#### 1.7.4.2 Preauthorization of Orthodontic Services

The DBM shall make a determination of medical necessity on a case-by-case basis for services requiring preauthorization. Prior Authorize for the provision of orthodontics to individuals under the age of 21 when the orthodontic treatment plan meets all of the criteria set by OHCA.

The DBM shall:

- Cover orthodontic services for members under the age of 21 demonstrating medical necessity through dysfunction and a score of at least 30 on the Handicapping Labio-Lingual Deviations Index (HLD) [See Solicitation 8070001235 Attachment 2 Index of Malocclusion].
- Follow OHCA's criteria and preauthorization process for orthodontic procedures;
- Follow OHCA's established rate of reimbursement for the approved orthodontic services and remit the total reimbursement for comprehensive orthodontia, after the corrective appliances are installed in the recipient's mouth; and
- Ensure that treatment is completed, despite the loss of eligibility, provided the recipient was eligible on the date the banding occurred.

#### 1.7.4.3 Methods of PA Submission

To ease Provider administrative burden, the Contractor shall utilize the standardized OHCA-developed PA Request Form. Providers shall be able to request PAs online. The Contractor shall implement strategies to streamline and simplify online submission processes as that is the primary mode of PA submission currently utilized by SoonerCare Providers. Online requests shall be submitted through the secure Provider portal on the Contractor's website. The Contractor may also allow Providers to submit PA requests by fax or toll-free phone call at their discretion.

If phone requests are allowed, those requests shall be handled by the Contractor's toll-free provider services call center, as described in Section 1.12.2: "Provider Services Call Center" of this Model Contract or a dedicated toll-free authorization line.

#### 1.7.4.4 Timeliness Standards

The Contractor shall decide standard Prior Authorization requests within 72 hours of receipt of the request or as expeditiously as the Dental Health Plan Enrollee's health requires.

If the Dental Health Plan Enrollee, or Provider on behalf of the Dental Health Plan Enrollee in the case of standard authorizations, requests the extension or if the Contractor can justify to OHCA the need for additional information and show that the extension is in the Dental Health Plan Enrollee's best interest, the Contractor may have an extension of up to 14 days to complete the PA request, in accordance with a process to be defined by OHCA. If an extension is granted that is not requested by the Dental Health Plan Enrollee, the Contractor shall provide the Dental Health Plan Enrollee with a written explanation and information on how an Appeal may be filed in response to the extension.

#### 1.7.4.5 Service Authorization Approval Notices

When the Contractor denies a Service Authorization request or authorizes services in an amount, duration and scope less than requested, the Contractor shall send a notice in accordance with Section 1.15.2:

“Adverse Benefit Determinations” of this Model Contract. The Contractor shall also provide written notification to Dental Health Plan Enrollees and Providers when a service request is authorized.

#### 1.7.4.6 Retrospective Review

The Contractor shall develop retrospective review policies and procedures as part of its Dental Management Program. The retrospective review component of the Dental Management Program shall evaluate the appropriateness of care previously received by a Dental Health Plan Enrollee.

The Contractor shall ensure the retrospective review process evaluates suspended claims within 14 days or sooner, if feasible, and shall deliver the decision on coverage to the Provider no later than the next Business Day after a decision is reached.

#### 1.7.4.7 Authorization Denials and Peer-to-Peer Review

In accordance with 42 C.F.R. § 438.210(b)(3), any decision to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by an individual who has appropriate expertise in addressing the Dental Health Plan Enrollee’s oral health needs.

The Contractor shall permit Providers to request a peer-to-peer review process for all Service Authorization denials or authorizations in an amount, duration, or scope less than requested.

#### 1.7.4.8 Direct Access to Specialists

In accordance with 42 C.F.R. § 438.208(c)(4), for Dental Health Plan Enrollees with Special Health Care Needs determined through the a comprehensive assessment to need a course of treatment or regular care monitoring, the Contractor shall have a mechanism in place to allow Dental Health Plan Enrollees to directly access a specialist as appropriate for the Dental Health Plan Enrollee’s condition and identified needs.

### **1.7.5 Coordination with Other SoonerCare Programs**

In accordance with 42 C.F.R. §§ 438.208(b)(2)(ii) – (iv), the Contractor shall implement procedures to coordinate services delivered under this Contract with the services the Dental Health Plan Enrollee receives from:

- The SoonerSelect MCO;
- The SoonerSelect Specialty Children’s Plan;
- The fee-for-service SoonerCare program; and
- Community and social support providers.

The Contractor’s policies and procedures for coordination under this section shall be subject to OHCA review and approval and will be designed to ensure continuity of care and avoid duplication.

## **1.8 Transition of Care**

### **1.8.1 Transition of Care General Provisions**

The Contractor shall take all necessary steps to ensure continuity of care when Dental Health Plan Enrollees transition to the Contractor from another Dental Benefit Manager or SoonerCare program. The Contractor shall ensure that established Dental Health Plan Enrollee and Provider relationships, current services and existing Prior Authorizations will remain in place during the Continuity of Care Period in accordance with the requirements outlined in this section. Transition to the Contractor shall be as seamless as possible for Dental Health Plan Enrollees and their Providers.

The Contractor shall take special care to provide continuity of care for newly enrolled Dental Health Plan Enrollees who have oral health needs and are under the care of existing treatment Providers and whose health could be placed in jeopardy, or who could be placed at risk of hospitalization, if covered services are disrupted or interrupted.

The Contractor shall make transition of care policies available to Dental Health Plan Enrollees and provide instructions to Dental Health Plan Enrollees on how to access continued services during the Continuity of Care Period. This information shall be available, at minimum, in the Dental Health Plan Enrollee Handbook, new Dental Health Plan Enrollee materials and via Dental Health Plan Enrollee call center representatives. Language used in all forms of communication shall conform with requirements specified in Section 1.10: “Dental Health Plan Enrollee Services” of this Model Contract and 42 C.F.R. § 438.10.

The Contractor shall ensure that all Dental Health Plan Enrollees are held harmless by Providers for payment for any existing covered services, other than required Cost Sharing, during the Continuity of Care period.

### **1.8.2 Transition of Care Policies and Procedures**

The Contractor shall implement a transition of care policy that, at a minimum, is consistent with the requirements in 42 C.F.R. § 438.62(b)(1) and at least meets OHCA’s defined transition of care policy. The Contractor shall have additional transition of care policies and procedures that include at least the following:

- A schedule that ensures that the transition does not create a lapse in service;
- A process for timely information exchange (including transfer of a Dental Health Plan Enrollee record);
- A process for assuring confidentiality;
- A process for allowing Dental Health Plan Enrollees to request and be granted a change of Provider;
- An appropriate schedule for transitioning Dental Health Plan Enrollees from one Provider to another when it is Medically Necessary for ongoing care, including a process for ensuring the Dental Health Plan Enrollee’s new Provider(s) are able to obtain copies of the Dental Health Plan Enrollee’s dental records, as appropriate and consistent with federal and State law;
- A process for transitioning Dental Health Plan Enrollees from one care setting to another; and
- A process for transitioning Dental Health Plan Enrollees from or to another Dental Benefit Manager.

The Contractor’s transition of care policy shall also ensure compliance with 42 C.F.R. §438.62(b)(1)(vi) regarding the process for the electronic exchange of, at a minimum, the data classes and elements included in the content standard adopted at 45 C.F.R. § 170.213.

### **1.8.3 Transition of Prior Authorizations**

The Contractor shall ensure all Prior Authorizations for covered benefits in place on the day prior to the Dental Health Plan Enrollee’s enrollment with the Contractor remain in place for 90 days following a Dental Health Plan Enrollee’s enrollment. This requirement applies during both Initial Program Implementation and Steady State Operations. During the 90-day Continuity of Care period, Prior Authorizations may not be denied on the basis that the authorizing Provider is not a Participating Provider. Payment to Non-Participating Providers shall be made at the current Medicaid fee schedule rate, and in

accordance with OHCA's payment timeliness standards, as outlined in Section 1.13.4.2.1: "Timely Claims Filing Requirements" of this Model Contract, during the Continuity of Care Period.

#### **1.8.4 Continuity of Provider Assignment**

The Contractor shall allow Dental Health Plan Enrollees with an existing relationship with a Participating Provider to retain that Provider during and after transition to the Contractor. The Contractor shall continue to pay a Dental Health Plan Enrollee's existing Providers until such time as the Contractor can reasonably transfer the Dental Health Plan Enrollee to a Participating Provider without impeding service delivery necessary to the Dental Health Plan Enrollee's health or to prevent hospitalization or institutionalization. In the event there is no Participating Provider available who meets the Dental Health Plan Enrollee's needs, the Contractor shall allow the Dental Health Plan Enrollee to retain his/her current Provider until either the current Provider becomes a Participating Provider or a Participating Provider who meets the Dental Health Plan Enrollee's needs becomes available.

Notwithstanding the foregoing, Dental Health Plan Enrollees shall be permitted to receive care from a Non-Participating Provider if OHCA determines that circumstances warrant out of network treatment.

#### **1.8.5 Transitions between Dental Benefit Managers and OHCA**

When a Dental Health Plan Enrollee transitions from another Dental Benefit Manager to the Contractor, the Contractor shall be responsible for making a request to the surrendering Dental Benefit Manager for any data that will facilitate a seamless transition, including but not limited to, utilization data and Provider information. When the Contractor receives requests from a Dental Benefit Manager for transition information on a former Dental Health Plan Enrollee, the Contractor shall transmit the information within five days for data which is available electronically, and within 30 days for data which is not stored electronically. This includes, but is not limited to, processes for contacting the Dental Health Plan Enrollee's PCD Provider to coordinate the pending transition and processes to contact the Dental Health Plan Enrollee to assist in the transition.

#### **1.8.6 Terminated Provider to New Provider**

The Contractor shall actively assist Dental Health Plan Enrollees in transitioning to another Participating Provider when a current Provider has terminated participation with the Contractor.

#### **1.8.7 Age Transitions**

The Contractor shall monitor the age status of Dental Health Plan Enrollees and offer assistance to Dental Health Plan Enrollees approaching age thresholds that will affect SoonerCare coverage or eligibility, as well as Dental Health Plan Enrollee transitions of care including, but not limited to, transition aged youth, transitioning from the child/adolescent healthcare system to the adult system. The Contractor shall educate these Dental Health Plan Enrollees or their parents/guardians concerning the upcoming changes in their coverage and shall update Care Plans in advance of the age threshold being reached, to minimize any disruption in care.

### **1.9 Quality**

The Contractor shall comply with all OHCA requirements regarding quality oversight, monitoring and evaluation. The Contractor shall comply with OHCA's comprehensive quality strategy developed in accordance with 42 C.F.R. § 438.340 and with all State and federal regulations.

The Contractor shall provide quality care that includes, at minimum:

- Adequate capacity and service to ensure Dental Health Plan Enrollee choice and timely access to appropriate services and care;
- Protection of Dental Health Plan Enrollee rights and the provision of services in a manner that is sensitive to the cultural needs of Dental Health Plan Enrollees;
- Encouragement and assistance to Dental Health Plan Enrollees in participating in decisions regarding their care;
- Emphasis on health promotion and prevention, as well as early diagnosis, treatment and health maintenance;
- Appropriate utilization of Medically Necessary services; and
- A continuous quality improvement approach.

### **1.9.1 Quality Rating System**

OHCA shall develop and implement a Medicaid managed care quality rating system, in accordance with 42 C.F.R. § 438.334, to evaluate the annual performance of all Dental Benefit Managers participating in the SoonerSelect Dental program. The Contractor shall comply with all necessary OHCA reporting requirements for the quality rating system adopted by OHCA.

In accordance with 42 C.F.R. § 438.334(d), OHCA shall issue an annual quality rating to the Contractor based on the performance measures collected. OHCA shall prominently display the quality rating given to the Contractor by OHCA on OHCA's website in accordance with 42 C.F.R. § 438.334(e) and in a manner that complies with the standards at 42 C.F.R. § 438.10(d).

### **1.9.2 External Quality Review**

In accordance with 42 C.F.R. § 438.350, the Contractor shall undergo an annual, external independent review (EQR) of the quality, timeliness, and access to the services covered under this Contract. To conduct this EQR, OHCA will retain the services of a qualified External Quality Review Organization (EQRO) in accordance with the qualifications for competence and independence at 42 C.F.R. § 438.354. The SoonerSelect Dental program EQRO retained by OHCA shall conduct EQR activities including all necessary audits and review of information in accordance with 42 C.F.R. § 438.358(b), as well as any additional optional audits and review of information outlined in 42 C.F.R. § 438.358(c), that further OHCA's management and oversight of the SoonerSelect Dental program. All EQRO-related quality activities performed by the SoonerSelect Dental program EQRO will comply with all State and federal regulations, including 42 C.F.R. § 438.358. The Contractor shall cooperate fully with the EQRO and demonstrate to the SoonerSelect Dental program EQRO the Contractor's compliance with managed care regulations and quality standards as set forth in federal regulation and OHCA's policy.

The EQRO will conduct the following mandatory activities, in accordance with 42 C.F.R. §438.358(b):

- Validation of the Contractor's Performance Improvement Projects required in accordance with 42 C.F.R. § 438.330(b)(1) that were underway during the preceding 12 months;
- Validation of the Contractor's performance measures required in accordance with 42 C.F.R. § 438.330(b)(2) or Contractor performance measures calculated by the state during the preceding 12 months;
- A review, conducted within the previous three-year period, to determine the Contractor's compliance with the standards set forth in 42 C.F.R. subpart D and the quality assessment and performance improvement requirements described at 42 C.F.R. § 438.330; and



- Validation of the Contractor's network adequacy during the preceding 12 months to comply with requirements set forth in 42 C.F.R. §§ 438.68 and 438.14(b)(1).

OHCA may elect to have the SoonerSelect Dental program EQRO perform the following optional review activities in accordance with 42 C.F.R. §438.358(c):

- Validation of the Contractor's Encounter Data;
- Administration or Validation of Dental Health Plan Enrollee or Provider surveys of quality of care;
- Calculation of performance measures in addition to those reported by the Contractor;
- Performance improvement projects in addition to those conducted by the Contractor;
- Studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time; and
- Assisting with the quality rating of the Contractor.

The SoonerSelect Dental program EQRO will produce an annual report on quality outcomes, including timeliness of services and access to services covered by the SoonerSelect Dental program. The report will detail, analyze and aggregate the data from all activities conducted in accordance with 42 C.F.R. § 438.358. The report will include the following for each activity conducted:

- Objectives;
- Technical methods of data collection and analysis; and
- Descriptions of data obtained and conclusions drawn from the data.

The information obtained by the SoonerSelect Dental program EQRO will be obtained consistent with protocols established in 42 C.F.R. § 438.352 and the results made available as specified in 42 C.F.R. § 438.364.

The Contractor shall participate with the SoonerSelect Dental program EQRO in various other tasks and projects identified by OHCA to gauge Contractor performance in a variety of areas, including, but not limited to management and treatment of special populations. The Contractor shall ensure that the SoonerSelect Dental Program EQRO has sufficient information to carry out this review.

As provided in 42 C.F.R. § 438.358(d), OHCA may also request that the SoonerSelect Dental program EQRO provide technical assistance to the Contractor in conducting activities relating to the mandatory and optional activities described in this section.

OHCA reserves the right, pursuant to 42 C.F.R. § 438.362, to exempt the Contractor from the EQR if all conditions of 42 C.F.R. § 438.362(a) and all other relevant State and federal regulations are met and OHCA determines it is the appropriate course of action.

### **1.9.3 Quality Assessment and Performance Improvement (QAPI) Program**

#### **1.9.3.1 QAPI Program**

In accordance with 42 C.F.R. § 438.330(a)(1), the Contractor shall establish and implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes. The Contractor's QAPI program shall comply with all requirements of State and federal law and regulations. The QAPI program shall use standards and guidelines from the Contractor's Accrediting Entity

including standards for quality management, quality improvement, Quality Assessment and Performance Improvement programs.

The QAPI program shall include all of the following, at minimum:

- Performance improvement projects (PIPs) that evaluate clinical and nonclinical areas, in accordance with 42 C.F.R. § 438.330(b)(1) and (d)(1), including all SoonerSelect Dental program population groups, care settings and types of services.
- In accordance with 42 C.F.R. § 438.330(b)(2), collection of and submission of performance measurement data, including the performance measures determined by OHCA as required pursuant to 42 C.F.R. § 438.330(c)(1)(i), or as determined by CMS in the event CMS identifies standard required measures pursuant to 42 C.F.R. § 438(a)(2).
- Mechanisms to detect both underutilization and overutilization of services, in accordance with 42 C.F.R. § 438.330(b)(3).
- Mechanisms to assess the quality and appropriateness of care furnished to Dental Health Plan Enrollees with Special Health Care Needs, in accordance with 42 C.F.R. § 438.330(b)(4). Dental Health Plan Enrollees with Special Health Care Needs will be defined by OHCA in the quality strategy developed pursuant to 42 C.F.R. § 438.340.

OHCA or its designee shall perform oversight and monitoring functions, evaluate the impact and effectiveness of the Contractor's QAPI program, and perform all reporting and SoonerSelect Dental program contractual obligations. The Contractor shall be responsible for the day-to-day performance and operational requirements. The Contractor shall report to OHCA Quality Assurance Advisory Group. Any changes to the QAPI program structure shall require prior written approval from OHCA, 90 days prior to implementation.

The Contractor shall review outcome data at least quarterly for performance improvement, recommendations and interventions. The Contractor shall include QAPI activities to improve health care disparities identified through data collection.

The Contractor shall use the results of QAPI activities to improve the quality of Dental Health Plan Enrollee oral health, with appropriate input from Participating Providers and Dental Health Plan Enrollees. The Contractor shall take appropriate action to address service delivery, Provider and other QAPI issues as they are identified. The Contractor shall make all information about its QAPI program available to Providers and Dental Health Plan Enrollees. The Contractor shall provide technical assistance, corrective action plans and follow-up activities as necessary to Participating Providers to assist them in improving their performance.

The Contractor may be required to conduct special focus studies as determined by OHCA and shall participate in workgroups and agree to establish and implement policies and procedures that are agreed to and described by OHCA in order to address specific quality concerns.

OHCA reserves the right to require the Contractor to develop a process for its own evaluation of the impact and effectiveness of its QAPI program.

#### 1.9.3.2 Oversight of QAPI Program

The Contractor shall have a Quality Department within its organizational structure that is separate and distinct from all other units or departments. The Quality Department shall be accountable to the Contractor's Board of Directors and executive management team, who set strategic direction for the QAPI program and ensure that the QAPI plan is incorporated into the Contractor's operations.

The Contractor shall have a Quality Improvement Committee (QIC), chaired by the Contractor's Dental Director that oversees all QAPI functions. Other QIC representatives shall be selected to meet the needs of the Contractor but must include representation from the following functional areas:

- Quality Improvement;
- Grievances and Appeals;
- Dental Management;
- Credentialing;
- Compliance;
- Dental Health Plan Enrollee Care Support Staff (at least one staff member); and
- Providers.

Individual staff members may serve in multiple roles on the QIC if they also serve in multiple positions within the Contractor's organization. The QIC shall meet no less than quarterly. Its responsibilities shall include the development and implementation of a written QAPI plan, which incorporates the strategic direction provided by the Board of Directors and executive management team.

The QIC shall:

- Direct and review QAPI activities;
- Analyze and evaluate the results of QAPI activities and suggest new or improved activities;
- Ensure that Participating Providers and other stakeholders are involved in the QAPI program;
- Direct task forces or committees in specific improvement areas;
- Publicize findings to appropriate staff and departments within the Contractor's organization;
- Report findings and recommendations to the Contractor's executive management team;
- Direct and analyze periodic reviews of Dental Health Plan Enrollees' service utilization patterns, institute needed action and ensure that appropriate follow-up occurs; and
- Review and approve the QAPI work plan and annual evaluation.

The QIC shall keep written minutes of all committee and sub-committee meetings. A copy of the signed and dated written minutes for each meeting shall be available on file after the completion of the following QIC meeting in which the minutes are approved. Minutes shall be available for review upon request by OHCA and during the annual on-site EQRO review or accreditation review.

#### 1.9.3.3 QAPI Documentation

The Contractor shall submit an annual QAPI program description and associated work plan to OHCA that addresses its strategies for performance improvement and for conducting the quality management activities described in this Section. In addition, the Contractor shall submit an annual evaluation of the previous year's QAPI program to OHCA. The Contractor's QAPI program description, work plan and program evaluation shall be submitted exclusive to Oklahoma Medicaid and shall not contain

documentation from any other State Medicaid program(s). The annual QAPI program description, associated work plan and program evaluation shall be submitted in a format specified by OHCA.

The QAPI program description shall include goals, objectives, structure and policies and procedures. At a minimum, the QAPI program description shall include the following:

- Guiding philosophy and strategic direction for the QAPI program;
- Communication mechanism between the Contractor's executive management team and the QIC;
- QAPI program committee structure, including specific committees, committee representatives and why the representatives were chosen;
- Roles of Dental Health Plan Enrollee and Provider representatives on the QIC;
- Process for selecting and directing task forces or subcommittees;
- Types of training, including any quality protocols developed by the CMS, provided to quality staff and QIC members;
- Specific components of the QAPI plan;
- Process the QAPI program will use to review and suggest new or improved quality activities;
- Process to report findings to appropriate executive leadership, staff and departments within the Contractor's organization, as well as relevant stakeholders, such as Participating Providers;
- Methodology for which and how many Participating Providers to profile and how measures for profiling will be selected;
- Process for selecting evaluation and study design procedures;
- How data will be collected and used;
- How the Contractor will ensure that QAPI program activities take place throughout the Contractor's organization and the procedures to document results;
- The health management information systems that will support the QAPI program;
- Process for reporting findings to OHCA, Participating Providers and Dental Health Plan Enrollees; and
- Process for annual program evaluation.

The annual QAPI work plan shall contain the scope, objectives, planned activities, timeframes and data indicators for tracking performance and other relevant QAPI information.

The annual QAPI program evaluation to OHCA shall include, the following, at minimum:

- A description of ongoing and completed QAPI activities;
- Measures that are trended to assess performance;
- Year-over-year findings that contain an analysis of demonstrable improvements in the quality of clinical care and service;
- Development of future QAPI work plans based on previous year findings;
- Results of QAPI projects and reviews;
- HEDIS, CAHPS and other performance measure results;
- Monitoring and evaluation of non-clinical aspects of service with timely resolution of problems and improvement in processes; and
- Monitoring and evaluation of network quality, including, at minimum:
  - Credentialing and recredentialing processes,
  - Performance improvement projects,

- Performance measurement,
- Problem resolution and improvement approach and strategy,
- Annual program evaluation,
- Metrics for monitoring the quality and performance of Participating Providers related to their continued participation in the Contractor's network.

In accordance with 42 C.F.R. 438.330(e)(1), OHCA or its designees shall annually review the impact and effectiveness of the Contractor's QAPI program. This review shall utilize a variety of methods, including at minimum:

- Reviewing, evaluating and reporting all QAPI Program documents, the Contractor's performance measures and Contractor reports regularly required by OHCA or its designees;
- Reviewing outcomes and trended results of the Contractor's Performance Improvement Projects;
- Reviewing, evaluating, or validating implementation of specific policies and procedures or special reports relating to areas such as Dental Health Plan Enrollee choice, rights and protections, services provided to Dental Health Plan Enrollees with Special Health Care Needs, utilization management, network access standards, measurement and improvement standards, Clinical Practice Guidelines and continuity and coordination of care;
- Performing medical records reviews; and
- Conducting on-site reviews to interview the Contractor's staff for clarification, to review records, or to validate implementation of processes and procedures.

The Contractor shall furnish specific data requested in order for OHCA and its designees to conduct evaluations, including medical records, Participating Provider credentialing records, Provider reimbursement records, utilization reports, the Contractor's personnel records and any other documents and files as required by OHCA and its designees.

#### **1.9.4 Surveys**

##### **1.9.4.1 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys**

The Contractor shall conduct annual CAHPS surveys. Annual CAHPS survey reports will be due to OHCA no later than June 15th of each year. The Contractor shall enter into an agreement with a vendor that is certified by NCQA to perform annual CAHPS surveys. The Contractor's vendor shall perform the CAHPS Health Plan Survey 5.OH CHIP, Child, and Adult surveys.

The Contractor shall submit to OHCA by November 1st of each year a proposal for survey administration and reporting that includes identification of the survey administrator and evidence of NCQA certification as a CAHPS survey vendor, sampling methodology, administration protocol, analysis plan and reporting description.

Survey results shall be reported to OHCA separately for each required CAHPS survey listed above. Survey results shall be submitted to OHCA, NCQA, AHRQ and OHCA's SoonerSelect Dental program EQRO annually as required in Section 1.20: "Reporting" of this Model Contract.

The Contractor shall:

- Use the annual CAHPS results in the Contractor's internal QAPI plan by using areas of decreased satisfaction as areas for targeted improvement;
- Include additional survey questions that are specified by OHCA in addition to the CAHPS;

- Make available results of the surveys to Participating Providers, OHCA, Dental Health Plan Enrollees and families/caregivers;
- Demonstrate consistent and sustainable patterns of acceptable performance and/or improvement from year to year in the overall survey results; and
- Have mechanisms in place to incorporate survey results in the QAPI plan for program improvements and systems improvements.

#### 1.9.4.2 Provider Satisfaction Surveys

The Contractor shall conduct an annual Participating Provider satisfaction survey that is inclusive of all Participating Providers. OHCA will collaborate with the Contractor and other SoonerSelect Dental DBM to define a uniform set of Provider satisfaction measures and a uniform survey instrument. The Contractor shall conduct the survey and compile and analyze its survey results for submission to OHCA annually.

The survey instrument shall include the following domains:

- Provider relations and communication;
- Clinical management processes;
- Authorization processes, including denials and Appeals;
- Timeliness of claims payment and assistance with claims processing; and
- Grievance resolution process.

The survey report results shall include a summary of the survey methods and findings for oral health Providers, with an analysis of opportunities for improvement.

The Contractor shall provide the survey results to OHCA with an action plan to address the results of the survey in accordance with Section 1.20: "Reporting" of this Model Contract.

#### **1.9.5 Quality Performance Measures**

The Contractor shall comply with all of OHCA's requirements to improve performance for OHCA-established quality performance measures. Annually, the Contractor shall submit a Quality Performance Measure Report for all quality performance measures established by OHCA pursuant to 42 C.F.R. § 438.330(c)(1)(i) and listed in this Section. Quality performance measures shall:

- Be modified annually by OHCA or CMS and published in advance;
- Be specific to the SoonerSelect Dental program population; and
- Include target performance rates that will increase annually. Required quality performance measures will include measures for both physical health and behavioral health.

Annually, the Contractor shall complete the specified measures designated by OHCA as relevant to the Dental Health Plan Enrollees being served in the SoonerSelect Dental program. The Contractor shall contract with an NCQA-certified HEDIS auditor to validate the processes of the Contractor in accordance with NCQA requirements. The Contractor shall submit to OHCA a copy of the signed contract with the NCQA-approved vendor to perform the HEDIS audit. Audited HEDIS results shall be submitted to OHCA, NCQA and OHCA's SoonerSelect Dental Program EQRO annually as required in Section 1.20: "Reporting" of this Model Contract.

In addition to OHCA-established quality performance measures, the Contractor shall report EPSDT information utilizing Encounter Data submissions in accordance with specifications for the CMS-416

report. This report includes information on EPSDT participation, percentage of children identified for referral, percentage of children receiving follow-up services in a timely manner and other measures.

The Contractor shall meet the OHCA-specified performance targets for all quality performance measures. The performance targets for each of the required measures shall be determined by OHCA in collaboration with the Contractor and other SoonerSelect Dental DBMs.

Although quality performance targets will be updated annually, OHCA, at its discretion, may change these targets and/or change the timelines associated with meeting the targets. The quality performance targets will be incorporated into the comprehensive Uniform Performance Monitoring Data Set described in Section 1.21.2: “Performance-Based Contracting” of this Model Contract.

OHCA shall post information about quality measures and performance outcomes on OHCA’s website. This information shall be updated at least annually.

If OHCA determines that the Contractor’s performance relative to any of the quality performance targets is not acceptable, OHCA may require the Contractor to submit a corrective action plan in accordance with Section 1.22: “Non-Compliance Remedies” of this Model Contract. OHCA shall specify a time period for Contractor’s submission of a corrective action plan. OHCA also may impose Non-Compliance Remedies for failure to meet quality performance targets or demonstrate improvement in a measure rate in accordance with Section 1.22.6: “Other Non-Compliance Remedies” of this Model Contract. When considering whether to impose penalties, OHCA may consider the Contractor’s cumulative performance on all quality performance measures.

A report, certification or other information required for performance measure reporting is incomplete when it does not contain all data required by OHCA or when it contains inaccurate data. A report that is incomplete or contains inaccurate data shall be considered deficient and each instance shall be subject to Non-Compliance Remedies as described in Section 1.22.6: “Other Non-Compliance Remedies” of this Model Contract.

A report or certification is “false” if completed or made with the knowledge of the preparer or a superior of the preparer that it contains data or information that is not true or not accurate. The Contractor shall submit a detailed explanation for any measure marked as “not reported” (NR). A report that contains an “NR” due to bias for any or all measures by the HEDIS auditor, or is “false,” shall be considered deficient and will be subject to Non-Compliance Remedies as described in Section 1.22.6: “Other Non-Compliance Remedies” of this Model Contract.

1.9.5.1 Oral Health Performance Measures

The Contractor shall be responsible for reporting on the oral health performance measures that are provided in the table below. These measures are subject to change.

Oral Health Quality Performance Measures	Frequency	Definition	Data Source
Preventive dental care visits.	Annual	Percentage of Dental Health Plan Enrollees aged 1-20 receiving a preventive dental care visit.	CMS-416

Dental Sealant Placement on Permanent Molars	Annual	Percentage of Dental Health Plan Enrollees aged 6-14 receiving dental sealants on permanent molars.	MMIS, Encounters, Eligibility, Medical Records, CMS-416
Annual Dental Visit (NCQA)	Annual	Assesses Medicaid Dental Health Plan Enrollees 2 – 20 years of age with dental benefits, who had at least one dental visit during the year.	HEDIS
Dental Home	Annual	Percentage of Dental Health Plan Enrollees 1-20 having a Dental Home.	MMIS and Eligibility

**1.9.6 Performance Improvement Projects (PIPs)**

Contractors are required to conduct at least two PIPs annually. For Rating Period one, the Contractor shall propose, subject to OHCA’s approval, one non-clinical, and one clinical PIP. In subsequent years, PIP topics may be identified by CMS, the Contractor, or OHCA. All PIPs are subject to final approval by OHCA.

Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and Dental Health Plan Enrollee satisfaction, in accordance with 42 C.F.R. § 438.330(d)(2), and must include the following elements set forth at 42 C.F.R. § 438.330(d)(2)(i)-(iv):

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the intervention based on the performance measures collected as part of the PIP; and
- Planning and initiation of activities for increasing or sustaining improvement.

In accordance with 42 § C.F.R. 438.330(d)(3), the Contractor shall report the status and results of each PIP as requested by OHCA, which shall be no less than annually. Improvement must be measured through comparison of a baseline measurement and an initial re-measurement following application of an intervention. Annual changes shall be evaluated for statistical significance using a 95% confidence interval. Status reports on PIPs may be requested more frequently by OHCA.

PIPs are subject to annual independent Validation by the SoonerSelect Dental program EQRO to ensure compliance with CMS protocols and OHCA’s policy, including timeline requirements.

PIPs that have successfully achieved sustained improvement, as approved by OHCA, shall be considered complete and shall not meet the requirement for one of the number of PIPs required by OHCA, although the Contractor may wish to continue to monitor the performance indicator as part of its overall QAPI program. In this event, the Contractor shall select a new PIP and submit it to OHCA for approval.

**1.9.7 Addressing Health Disparities.**

The Contractor shall participate in, and support OHCA’s efforts to reduce health disparities. According to the U.S. Department of Health and Human Services’ Office of Minority Health, and for the purposes of this Model Contract, a health disparity is “a particular type of health difference closely linked with social or



economic disadvantage.” Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation; or geographic location). To further advance OHCA’s efforts to achieve health equity, the Contractor shall collect and meaningfully use Dental Health Plan Enrollee-identified race, ethnicity, language, and Social Determinants of Health data to identify and reduce disparities in health care access, services and outcomes. This includes, where possible, stratifying HEDIS and CAHPS, and Health Risk Assessment results by race, ethnicity, or other relevant demographics, and implementing a strategy to reduce identified disparities. The Contractor shall maintain health equity representatives who are actively involved in improvement initiatives to reduce disparities by: obtaining input from Dental Health Plan Enrollees and from Providers of direct services which are intended to reduce adverse health outcomes among Dental Health Plan Enrollees, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts.

#### **1.9.8 Provider Profiling**

The Contractor shall conduct PCD Provider and other Participating Provider profiling activities at least quarterly. As part of its QAPI Program, the Contractor shall describe the methodology it uses to identify which and how many Participating Providers to profile and to identify measures to use for profiling such Providers.

Provider profiling activities shall include, without limitation:

- Developing PCD Provider and other Provider-specific reports that include a multi-dimensional assessment of a PCD Provider or other Participating Provider’s performance using clinical, administrative and Dental Health Plan Enrollee satisfaction indicators of care that are accurate, measurable and relevant to the enrolled population;
- Establishing PCD Provider, other Participating Provider, group, service area, or regional benchmarks for areas profiled, where applicable; and
- Providing feedback to individual PCD Providers and other Participating Providers regarding the results of their performance and the overall performance of the Contractor’s Participating Provider network.

#### **1.9.9 Dental Records**

##### 1.9.9.1 Dental Record Standards

As part of its QAPI Program, the Contractor shall establish dental records standards, as well as a record review system to assess and ensure conformity with the standards. The standards shall, at a minimum:

- Require that the dental record be maintained by the Provider;
- Ensure that OHCA’s personnel or personnel contracted by OHCA have access to all records, as long as access to the records is needed to perform the duties under this Contract and to administer the Medicaid program;
- Comply with any and all State and federal laws regarding confidentiality;
- Provide OHCA or its designee(s) with prompt access to Dental Health Plan Enrollees’ dental records;

- Provide Dental Health Plan Enrollees with the right to request and receive copies of their dental records and to request they be amended; and
- Allow for paper or electronic record keeping.

The Contractor and its Participating Providers shall retain all medical records for a minimum of ten years from the last date of entry in the records. For minors, the Contractor and Participating Providers shall retain all medical records during the period of minority plus a minimum of ten years after the age of majority.

#### 1.9.9.2 Dental/Case Record Audits

The Contractor shall furnish specific data requested in order for OHCA to conduct the dental/case record audit, including audit of Dental Health Plan Enrollee care plans, Participating Provider credentialing records, service Provider reimbursement records, utilization reports, the Contractor's personnel records and other documents and files as required under this Model Contract.

If the dental/case record audit and/or other document audits indicate that quality of care is not acceptable within the terms of this Model Contract, the Contractor shall correct the problem immediately and may be subject to Non-Compliance Remedies.

### **1.10 Dental Health Plan Enrollee Services**

The Contractor shall develop and operate a Dental Health Plan Enrollee Services department with adequate resources and qualified staff to deliver responsive, person-centered customer care to Dental Health Plan Enrollees, including those with visual, hearing, functional or cognitive impairments.

The Contractor shall ensure that, through its written materials, Dental Health Plan Enrollee Services Call Center and other Dental Health Plan Enrollee Services activities, it provides timely and accurate information to Dental Health Plan Enrollees and pursuant to 42 C.F.R. § 438.10(c)(7) has appropriate mechanisms for helping Dental Health Plan Enrollees and Eligibles to understand the benefits and requirements of the SoonerSelect Dental program and the Contractor's services.

#### **1.10.1 Accessibility of Dental Health Plan Enrollee Information**

Pursuant to 42 C.F.R. § 438.10(c)(1), the Contractor must provide all required information to Dental Health Plan Enrollees and Beneficiaries in a manner and format that may be understood easily and is readily accessible by such Dental Health Plan Enrollees and Eligibles. All accommodations for the Dental Health Plan Enrollee's special needs or reading proficiency must be provided to the Dental Health Plan Enrollee free of cost. The Contractor shall develop and submit to OHCA a plan to assist Dental Health Plan Enrollees with Limited English Proficiency (LEP) and visually impaired Dental Health Plan Enrollees to understand all Dental Health Plan Enrollee materials. The plan shall be reviewed as part of the Readiness Review.

##### 1.10.1.1 Prevalent Non-English Languages

The Contractor shall make all Dental Health Plan Enrollee materials available in English and Spanish and other prevalent non-English languages identified by OHCA. This includes, but is not limited to, the following written materials that are critical to obtaining services:

- The provider directory described in Section 1.10.12: "Provider Directory" of this Model Contract;
- The Dental Health Plan Enrollee Handbook described in Section 1.10.5.2: "Dental Health Plan Enrollee Handbook" of this Model Contract;
- Grievance and Appeals notices; and

- Denial and termination notices.

The Contractor shall also identify additional languages that are prevalent among Dental Health Plan Enrollees. For purposes of this requirement, prevalent language is defined as any language spoken by at least five percent of the general population in the Contractor's service area.

OHCA will provide information about the Dental Health Plan Enrollee's spoken language on the ANSI ASC X 12 834 electronic transactions. The Contractor shall utilize this information to ensure written materials are distributed in the appropriate prevalent non-English language.

When the Contractor learns the Dental Health Plan Enrollee requires a prevalent non-English language, a note shall be made in the Dental Health Plan Enrollee record and all Contractor correspondence thereafter shall be provided in both English and the required non-English language. If a non-English language is preferred, the Contractor must notify OHCA in a manner to be specified by OHCA so it may note the preferred language in their records.

#### 1.10.1.2 Interpretation Services

Pursuant to 42 C.F.R. § 438.10(d)(4), the Contractor shall make interpretation services available to Dental Health Plan Enrollees at no cost. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that that OHCA identifies as prevalent.

Interpreters shall be made available both in-person, including at Provider's offices, and through the telephone. For telephonic assistance, the Dental Health Plan Enrollee may not be made to disconnect and call a different number. The Contractor shall provide information to its Participating Providers regarding how to access interpretation services for Dental Health Plan Enrollees and shall notify Providers they shall not suggest or require that Dental Health Plan Enrollees with limited-English proficiency, or who communicate through sign language, utilize friends or family as interpreters.

#### 1.10.1.3 Auxiliary Aids and Alternative Formats

Pursuant to 42 C.F.R. § 438.10(d)(3), the Contractor shall make written Dental Health Plan Enrollee materials available in alternative formats and via auxiliary aids and services upon request of the Dental Health Plan Enrollee or Eligible at no cost. Alternative formats include, but are not limited to, braille, large font letters, audiotape and verbal explanations of written materials.

#### 1.10.1.4 Dental Health Plan Enrollee Notification of Interpretation Services and Alternative Formats

Pursuant to 42 C.F.R. § 438.10(d)(5)(i) - (iii), the Contractor shall notify Dental Health Plan Enrollees of the following:

- That oral interpretation is available for any language;
- Written translation is available in prevalent languages;
- That auxiliary aids and services are available upon request and at no cost for Dental Health Plan Enrollees with disabilities; and
- How to access those services.

#### 1.10.1.5 Taglines

Pursuant to 42 C.F.R. § 438.10(d)(3), the Contractor shall include in its written materials taglines in each prevalent non-English language in the State, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY number of the Contractor's Dental Health Plan Enrollee services call center. Large print means printed in a font size no smaller than 18 point.

#### **1.10.2 Cultural Competency**

Pursuant to 42 C.F.R. § 438.206(c)(2), the Contractor shall participate in OHCA's efforts to promote the delivery of services in a culturally competent manner to all Dental Health Plan Enrollees, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

The Contractor shall develop a cultural competency and sensitivity plan for review and approval by OHCA at the time of Readiness Review. The plan shall include guidelines for evaluating and monitoring disparities in membership and service quality, especially with regard to minority groups. Elements of this plan shall address how the Contractor will:

- Identify organizations and advocates that could work with LEP communities and individuals in a culturally competent way;
- Incorporate cultural competence into the Contractor's dental programs, including outreach and referral methods;
- Recruit and train culturally diverse staff that will be able to operate fluently with all Dental Health Plan Enrollee communities throughout the State;
- Ensure Dental Health Plan Enrollee assessments inquire about language preference;
- Conduct self-assessments of cultural and linguistic competence before services commence and with annual frequency thereafter;
- Ensure cultural competence outcomes through internal audits and performance improvement targets;
- Provide annual training to care managers, Participating Providers and Dental Health Plan Enrollee facing staff (e.g., Dental Health Plan Enrollee Services) to ensure the delivery of culturally and linguistically appropriate care.

#### **1.10.3 Written Material Guidelines**

##### 1.10.3.1 General Guidelines

In accordance with 42 C.F.R. § 438.10(d)(6), all written materials the Contractor provides to Dental Health Plan Enrollees and Eligibles shall:

- Use easily understood language and format;
- Use a font size no smaller than 12 point;
- Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of Dental Health Plan Enrollees or Eligibles with disabilities or LEP;
- Be written at a reading level no higher than sixth grade using the Flesch-Kincaid readability test; and

- Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats free of cost. Large print means printed in a font size no smaller than 18 point.

#### 1.10.3.2 Prior Approval Process

The Contractor shall submit to OHCA for review and prior written approval templates of all materials that will be distributed to Dental Health Plan Enrollees and all Marketing Materials. The Contractor must develop and include a Contractor-designated inventory control number on all Dental Health Plan Enrollee and Marketing Materials. The purpose of this inventory control number is to facilitate OHCA's review and approval of Dental Health Plan Enrollee and Marketing Materials and document its receipt and approval of original and revised documents. All submitted content must also include a clearly-marked date issued or date revised and a reading level assessment, using the Flesch-Kincaid readability test. All materials translated into a non-English language shall be submitted to OHCA with a certificate of translation that shall include an official statement in which the translator confirms that he or she has accurately translated the document.

Should the Contractor contract with either a Subcontractor or its Participating Providers to create and/or distribute Dental Health Plan Enrollee or Marketing Materials, the materials shall not be distributed to Dental Health Plan Enrollees unless the materials have been submitted to OHCA by the Contractor for review and prior written approval.

OHCA will review the submitted materials and either approve or deny them. In the event OHCA does not approve the materials, OHCA may provide written comments, and the Contractor shall resubmit the Dental Health Plan Enrollee or Marketing Materials for review. OHCA will either approve or deny the resubmission.

#### 1.10.3.3 Modifications to Approved Dental Health Plan Enrollee Materials

The Contractor shall not make substantive changes to materials developed for use by or distribution to Dental Health Plan Enrollees without OHCA's review and prior approval.

Dental Health Plan Enrollee materials developed by a Subcontractor or Participating Provider operating on the Contractor's behalf, shall not be substantively changed without OHCA's review and prior written approval.

OHCA will review the modified Dental Health Plan Enrollee and Marketing Materials and either approve or deny them. In the event OHCA does not approve the materials, OHCA may provide written comments, and the Contractor shall resubmit the Dental Health Plan Enrollee materials for review.

#### 1.10.3.4 Discontinuation of Use/Modifications to Materials after Approval

OHCA reserves the right to notify the Contractor to discontinue or modify Dental Health Plan Enrollee or Marketing Materials after approval.

#### 1.10.3.5 Oklahoma Department of Libraries

The Contractor shall be held responsible for providing OHCA-approved documents to OHCA for submission to the Department of Libraries, in a method, format, and timing decided by OHCA.

#### 1.10.3.6 Distribution Guidelines

The Contractor shall distribute Dental Health Plan Enrollee materials in the preferred mode of the Dental Health Plan Enrollee, either via mail or electronically. Mailed materials shall be sent to the Dental Health

Plan Enrollee's address as provided in the ANSI ASC X 12 834 electronic transactions. The name of the Contractor and its logo shall be prominently featured, once per item, on each piece of Dental Health Plan Enrollee mail. It should solicit updates to any information, including address.

Pursuant to 42 C.F.R. § 438.10(c)(6), the Contractor may distribute Dental Health Plan Enrollee materials in an electronic format instead of a paper copy with a Dental Health Plan Enrollee's express consent. Dental Health Plan Enrollee materials shall not be provided electronically by the Contractor unless all the following are met:

- The format is readily accessible;
- The information is placed in a location on the Contractor's website that is prominent and readily accessible;
- The information is provided in an electronic form which can be electronically retained and printed;
- The information is consistent with the content and language requirements specified in Section 1.10.1: "Accessibility of Dental Health Plan Enrollee Information" of this Model Contract including Section 508 guidance and guidelines that provide greater accessibility to individuals with disabilities; and
- The Contractor informs the Dental Health Plan Enrollee that the information is available in paper form without charge upon request and shall be provided to the Dental Health Plan Enrollee upon request within five days.

#### 1.10.3.7 Guidelines for Email

The Contractor may attempt to contact Dental Health Plan Enrollees through email unless the Dental Health Plan Enrollee does not have access to email or opts out of email. The Contractor shall not attempt to disseminate information about its program through purchased or rented email lists. The Contractor shall not email Dental Health Plan Enrollees through email addresses obtained by referrals and shall provide an opt-out process for Dental Health Plan Enrollees to no longer be contacted via email. If the email address provided for the Dental Health Plan Enrollee is non-existent, invalid or becomes invalid or otherwise undeliverable, the Contractor shall switch back to paper correspondence and notify OHCA the email address is no longer valid in a manner to be specified by OHCA.

#### 1.10.3.8 Guidelines for Text

The Contractor is permitted to utilize text messaging in communicating with its Dental Health Plan Enrollees. If the Contractor elects to correspond with the Dental Health Plan Enrollee by text messaging, it shall ensure compliance with the Telephone Consumer Protection Act, and all HIPAA requirements as outlined in Section 1.1.15: "Confidentiality; HIPAA and Business Associate Requirements" of this Model Contract, and shall provide indemnification in Section 1.1.15.3: "Obligations of the Contractor" of this Model Contract.

#### 1.10.3.9 Updates to Dental Health Plan Enrollee Contact Information

The Contractor shall use and regularly update a record of the modalities used to reach the Dental Health Plan Enrollee, and shall:

- Update the record based on changes in OHCA's registered addresses and record returned mail and re-mail attempts;
- Call any telephone number maintained in OHCA's records or any publicly available phone book or directory; and

- Notify OHCA, through a method to be specified by OHCA, if the Contractor learns of a new address for the Dental Health Plan Enrollee.

#### 1.10.3.10 Monitoring Effectiveness of Contractor Materials

The Contractor shall monitor and evaluate the effectiveness of its Dental Health Plan Enrollee and Eligible materials and distribution as directed by OHCA. The Contractor may be responsible for tracking, at minimum, website hits and returned mail rates.

#### **1.10.4 OHCA Developed Dental Health Plan Enrollee Materials**

Pursuant to 42 C.F.R. § 438.10(c)(4), the Contractor shall utilize OHCA-developed definitions for managed care terminology as described in Section 1.10.4.1: “Defined Terms” of this Model Contract, the model Dental Health Plan Enrollee Handbook as described in Section 1.10.5.2: “Dental Health Plan Enrollee Handbook” of this Model Contract and Dental Health Plan Enrollee notices. The model materials developed by OHCA may include translations of Dental Health Plan Enrollee materials into prevalent non-English languages.

The Contractor shall be responsible for producing and distributing written materials for Dental Health Plan Enrollees, in addition to OHCA-developed model materials.

##### 1.10.4.1 Defined Terms

For consistency in the information provided to Dental Health Plan Enrollees and pursuant to 42 C.F.R. § 438.10(c)(4)(i), OHCA will develop and require the Contractor to use standardized definitions for managed care terminology, including:

- Appeal;
- Copayment;
- Emergency dental care;
- Excluded services;
- Grievance;
- Health insurance;
- Hospital outpatient care;
- Medically necessary;
- Network;
- Non-participating provider;
- Participating provider;
- Dental services;
- Plan;
- Preauthorization;
- Premium;
- Provider;
- Specialist; and
- Urgent dental care.

#### **1.10.5 New Dental Health Plan Enrollee Materials and Outreach**

The Contractor shall provide the following information to new Dental Health Plan Enrollees:

- Dental Health Plan Enrollee Handbook in accordance with the timing and content requirements of Section 1.10.5.2: “Dental Health Plan Enrollee Handbook” of this Model Contract;
- Dental Health Plan Enrollee ID card in accordance with the timing and content requirements of Section 1.10.5.3: “Dental Health Plan Enrollee ID Card” of this Model Contract; and
- Information regarding how to access a Provider Directory as described in Section 1.10.12: “Provider Directory” of this Model Contract.

Additionally, the Contractor shall make all reasonable efforts during Initial Program Implementation to contact Dental Health Plan Enrollees within 90 days of initial Dental Health Plan Enrollee enrollment and within ten days of a Dental Health Plan Enrollee’s enrollment effective date during Steady State Operations. Reasonable effort is defined as at least three attempts to contact the Health Plan Enrollee with at least one of those attempts by telephone. The three attempts by the Contractor shall not be made within the same day. Telephone attempts should be staggered between different times of the day in an effort to increase the likelihood of making contact with the Dental Health Plan Enrollee.

Upon contacting a new Dental Health Plan Enrollee, the Contractor shall:

- Inquire about any urgent health needs or previously scheduled services or advise the Health Plan Enrollee how to contact the Contractor to provide this information;
- Conduct a Health Risk Screening or inform the Dental Health Plan Enrollee that he or she will be contacted at a later time for this purpose;
- Inform the Dental Health Plan Enrollee about his or her right to continue certain existing services, as applicable, in accordance with Section 1.8: “Transition of Care” of this Model Contract;
- Review with the Dental Health Plan Enrollee what to do in an emergency;
- Inform the Dental Health Plan Enrollee about the Contractor’s policies with respect to obtaining covered services;
- Assist the Dental Health Plan Enrollee in selecting a PCD Provider in accordance with Section 1.10.10: “PCD Selection and Assignment” of this Model Contract;
- Provide the Dental Health Plan Enrollee with the Contractor’s telephone numbers and website address;
- Advise the Dental Health Plan Enrollee about opportunities available for learning about Contractor policies and benefits in greater detail; and
- Confirm the Dental Health Plan Enrollee knows how to access the Contractor’s Provider Directory.

#### 1.10.5.1 Failure to Contact

The Contractor shall report to OHCA all Health Plan Enrollees that it has failed to contact during the first 90 days of initial Health Plan Enrollee enrollment and within ten days of a Health Plan Enrollee’s enrollment effective date during Steady State Operations, the days of enrollment and the nature and disposition of its contact attempts. OHCA will specify the reporting format and timelines in the Reporting Manual.

#### 1.10.5.2 Dental Health Plan Enrollee Handbook

##### 1.10.5.2.1 Distribution Timeframe

The Contractor shall provide each Dental Health Plan Enrollee a Dental Health Plan Enrollee Handbook within ten days after receiving notice of a Dental Health Plan Enrollee’s enrollment on the ANSI ASC X 12 834 electronic transaction and within ten days of the Dental Health Plan Enrollee’s request for a new



Dental Health Plan Enrollee Handbook. The Dental Health Plan Enrollee Handbook serves as a summary of benefits and coverage. Pursuant to 42 C.F.R. § 438.10(g)(4), the Contractor shall give each Dental Health Plan Enrollee notice of any change that OHCA defines as significant in the information provided in the Dental Health Plan Enrollee Handbook. The notice shall be provided at least 30 days before the intended effective date of the change.

#### 1.10.5.2.2 Distribution Methods

Pursuant to 42 C.F.R. § 438.10(g)(3)(i)-(iv), the Contractor shall be considered to have provided a Dental Health Plan Enrollee Handbook to the Dental Health Plan Enrollee if one of the following distribution methods is used:

- Mailing a printed copy of the Dental Health Plan Enrollee Handbook to the Dental Health Plan Enrollee's mailing address;
- Providing the information by email after obtaining the Dental Health Plan Enrollee's agreement to receive the Handbook by email;
- Posting the information on the Contractor's website and advising the Dental Health Plan Enrollee in paper or electronic form that the information is available on the Contractor's website. The Contractor shall include the applicable URL address provided that Dental Health Plan Enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or
- Providing the information by any other method that can reasonably be expected to result in the Dental Health Plan Enrollee receiving that information.

The Contractor shall develop strategies and policies to ensure that Dental Health Plan Enrollee Handbooks may be delivered to homeless Dental Health Plan Enrollees and submit these policies to OHCA for review and approval.

#### 1.10.5.2.3 Number of Dental Health Plan Enrollee Handbooks

If the Dental Health Plan Enrollee Handbook is mailed and there are two or more related Dental Health Plan Enrollees registered to the same address, the Contractor is permitted to mail one copy to that address. The Contractor shall provide information to the Dental Health Plan Enrollee about how to request additional copies of the Dental Health Plan Enrollee Handbook.

Every Dental Health Plan Enrollee that opts to receive information via email shall receive an electronic version of the Dental Health Plan Enrollee Handbook.

#### 1.10.5.2.4 Dental Health Plan Enrollee Handbook Content

Pursuant to 42 C.F.R. § 438.10(c)(4)(ii), the Contractor shall use OHCA's model Dental Health Plan Enrollee Handbook content in developing a Contractor-specific Handbook for OHCA's review and approval. The content of the Dental Health Plan Enrollee Handbook shall include information that enables the Dental Health Plan Enrollee to understand the [program name]. This information shall include at a minimum:

- A table of contents;
- Information about how to update any personal information;
- Information about what managed care is, with emphasis placed on Participating versus Non-Participating Providers;

- The amount, duration and scope of benefits provided by the Contractor in sufficient detail to ensure that Dental Health Plan Enrollees understand the benefits to which they are entitled, including information about the EPSDT benefit and how to access component services;
- Procedures for obtaining benefits, including any policies, procedures and requirements for Service Authorizations and/or referrals for specialty care and for other benefits not furnished by the Dental Health Plan Enrollee's PCD Provider;
- Information required AI/AN-specific policies and procedures, including:
  - Opt-in policies, and
  - Rights in accessing care as described in Section 1.14: "American Indian/Alaska Native Population and Indian Health Care Providers" of this Model Contract;
- Limitations or exclusions to benefits;
- Information on how to access all services, including but not limited to EPSDT ;
- Information on how to access services when out-of-state;
- How and where to access any benefits provided by OHCA and the Dental Benefit Manager;
- Cost Sharing on any benefits,
- The toll-free telephone number and hours of operation for the:
  - Dental Health Plan Enrollee Services Call Center,
  - Dental management, and
  - Any other Contractor unit providing services directly to Dental Health Plan Enrollees;
- Any restrictions on the Dental Health Plan Enrollee's freedom of choice among Participating Providers;
- The process for selecting and changing the Dental Health Plan Enrollee's PCD Provider;
- The extent to which, and how, Dental Health Plan Enrollees may obtain benefits from Non-Participating Providers;
- An assurance of non-discrimination of services;
- Dental Health Plan Enrollee rights and responsibilities, including the Dental Health Plan Enrollee's right to:
  - Receive information on Beneficiary and plan information;
  - Be treated with respect and with due consideration for dignity and privacy;
  - Receive information on available treatment options and alternatives, presented in a manner appropriate to the Dental Health Plan Enrollee's condition and ability to understand;
  - Participate in decisions regarding his or her health care, including the right to refuse treatment;
  - Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
  - Request and receive a copy of their dental records and request that they be amended or corrected; and
  - Obtain available and accessible oral health care services covered under the Contract;
- Grievance, Appeal and State Fair Hearing procedures and timeframes, including:
  - The right to file Grievances and Appeal;
  - Requirements and timeframes for filing a Grievance or Appeal;
  - The availability of assistance in the filing process;

- The right to request a State Fair Hearing after the Contractor has made a determination on the Dental Health Plan Enrollee's Appeal which is adverse to the Dental Health Plan Enrollee;
- The fact that, when requested by the Dental Health Plan Enrollee, benefits that the Contractor seeks to reduce or terminate will continue if the Dental Health Plan Enrollee files an Appeal or requests a State Fair Hearing within the timeframes specified for filing. The Dental Health Plan Enrollee may, consistent with State policy, be required to pay the cost of services furnished while the Appeal or State Fair Hearing is pending if the final decision is adverse to the Dental Health Plan Enrollee.
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- Information on how to report suspected Fraud or Abuse;
- The process of selecting and changing the Dental Health Plan Enrollee's PCD Provider;
- Explanation of the role of the PCD Provider;
- An explanation of how Dental Health Plan Enrollee care needs, conditions and geographic location will factor into the assignment of a PCD Provider;
- Transition of care policies for Dental Health Plan Enrollees and Eligibles;
- The role of the Dental Health Plan Enrollee care/services department and how to contact this individual or department;
- Explanation of circumstances in which the Dental Health Plan Enrollee may be billed for services or fees;
- General health and wellness literacy information;
- Explanation about how to disenroll from the Contractor's plan; and
- Any other content required by OHCA.

The Dental Health Plan Enrollee Handbook shall also explicitly outline the following Dental Health Plan Enrollee responsibilities:

- Checking OHCA/Contractor's information; correcting inaccuracies; and allowing government agencies, employers and Providers to release records to OHCA/Contractor;
- Notifying OHCA/Contractor within ten days if there are changes in income, the number of people living in the home, address or mailbox changes or health insurance changes;
- Transferring, assigning and authorizing to OHCA all claims the Dental Health Plan Enrollee may have against health insurance, liability insurance companies or other third parties. This includes payments for dental services made by OHCA for the Dental Health Plan Enrollee's dependents;
- Working on requests for assistance from the Office of Child Support Services;
- Allowing SoonerCare to collect payments from anyone who is required to pay for medical care;
- Sharing necessary medical information with any insurance company, person or entity who is responsible for paying the bill;
- Inspecting any dental records to see if claims for services can be paid;
- Obtaining permission for Oklahoma DHS or OHCA to make payment or overpayment decisions;
- Storing his or her identification card and knowing his or her Social Security number to receive health care services or prescriptions;
- Confirming that any care received is covered;
- Cost Sharing; and

- Ensuring all information provided to OHCA/Contractor is complete and true upon penalty of fraud or perjury.

#### 1.10.5.3 Dental Health Plan Enrollee ID Card

The Contractor shall distribute Dental Health Plan Enrollee ID cards to each [program name]-enrolled individual in a household within seven days of receiving the ANSI ASC X 12 834 electronic transactions from OHCA.

If the Dental Health Plan Enrollee loses his or her Dental Health Plan Enrollee ID card, or the Dental Health Plan Enrollee's information changes, the Contractor shall update and reissue the Dental Health Plan Enrollee ID card within seven days of receiving notification of the change. The Dental Health Plan Enrollee must also be able to access and print a new card through the Dental Health Plan Enrollee Portal described in Section 1.10.6.3: "Dental Health Plan Enrollee Website Portal" of this Model Contract.

The Dental Health Plan Enrollee ID card must be made out of durable material suitable for everyday use, such as durable plastic or laminated paper.

Each Dental Health Plan Enrollee ID card must include sufficient information to identify the Dental Health Plan Enrollee's identity and Contractor information to facilitate claims filing for all Participating Providers.

The Contractor must submit a sample Dental Health Plan Enrollee ID card as part of the Readiness Review for OHCA review and approval.

### **1.10.6 Dental Health Plan Enrollee Website**

#### 1.10.6.1 General Website Requirements

The Contractor shall develop a Dental Health Plan Enrollee website. In developing the Dental Health Plan Enrollee website, the Contractor shall:

- Maintain a separate and distinct section on its website for [program name] information if the Contractor markets other lines of business;
- Ensure posted information is current and accurate;
- Review and update website content at least monthly;
- Include a date stamp on each webpage with the date the page was last updated;
- Clearly label any links;
- Notify individuals that they will leave the Contractor's SoonerSelect Dental website if there is a link that will take individuals to non-SoonerSelect Dental information or to a different website;
- Comply with HIPAA when providing Dental Health Plan Enrollee eligibility or Dental Health Plan Enrollee identification on the website, including the Dental Health Plan Enrollee and Provider portal(s);
- Ensure website content can be viewed via mobile devices; and
- Minimize download and wait times and avoid tools or techniques that require significant memory or special intervention.

#### 1.10.6.2 Website Content

As part of Readiness Review activities, the Contractor must submit all website pages and content related to the SoonerSelect Dental program to OHCA for review and approval before making the content public. At a minimum, the Contractor shall include the following information on its website:

- Contractor’s contact information, including address, Dental Health Plan Enrollee Services Call Center toll-free number and TTY/TDD number;
- Contractor’s office hours/days, including availability of customer service;
- Provider directory and information on how to find a Participating Provider near the Dental Health Plan Enrollee’s residence;
- Description of any restrictions on the Dental Health Plan Enrollee’s freedom of choice among Participating Providers, as well as the extent to which Dental Health Plan Enrollees may obtain benefits from Non-Participating Providers;
- Link to OHCA website and/or other pages within the website, as specified by OHCA;
- The amount, duration and scope of benefits available by the Contractor in sufficient detail to ensure that Dental Health Plan Enrollees are informed of the services to which they are entitled, including Service Authorization requirements;
- Procedures for obtaining benefits, including authorization requirements;
- Dental Health Plan Enrollee Handbook;
- Accreditation information in accordance with Section 1.3.2: “Accreditation” of this Model Contract; and
- Grievance, Appeals and State Fair Hearing processes.

The Contractor may include the following information on its website:

- Marketing Materials specific to OHCA-approved Value-Added Benefits and/or quality rating reports; and
- Materials intended to be read by Dental Health Plan Enrollees or Eligibles, such as newspaper articles and news releases, with prior approval from OHCA.

Following SoonerSelect Dental program implementation, the Contractor shall request updates to website content in accordance with Section 1.10.3.2: “Prior Approval Process” of this Model Contract.

#### 1.10.6.3 Dental Health Plan Enrollee Website Portal

The Contractor must provide a Dental Health Plan Enrollee portal on its website with a single sign-on process that can be accessed on a variety of electronic devices, including a computer or mobile device. The Dental Health Plan Enrollee portal must at least:

- Allow Dental Health Plan Enrollees to access and print Dental Health Plan Enrollee ID cards; and
- Provide Explanation of Benefits (EOB) information.

#### 1.10.6.4 508 Compliance

The Contractor shall ensure that all electronic information and services will be compliant with all language, formatting and accessibility standards such as Section 508 guidelines or guidelines that provide greater accessibility to individuals with disabilities. The Contractor shall notify Dental Health Plan Enrollees that materials are available in paper form and through auxiliary aids and services upon request and at no cost.

#### 1.10.6.5 Website Translation

The Contractor shall ensure that website content will also be available in the prevalent non-English languages, in accordance with the requirements of Section 1.10.1.1: “Prevalent Non-English Languages” of this Model Contract. The Contractor shall receive approval of the translation from OHCA before

publishing it online in accordance with the requirements of Section 1.10.3.2: “Prior Approval Process” of this Model Contract.

**1.10.6.6 Machine Readable Data**

The Contractor shall post its provider directories and formularies on its website in a machine-readable file and format specified by the DHHS Secretary.

**1.10.6.7 Social Media and Mobile Applications**

The Contractor shall utilize social media platforms and mobile applications to provide Dental Health Plan Enrollees with health topic information and SoonerSelect Dental information. OHCA will work with Contractors on any proposed initiatives. Social media shall be used to maximize Contractor’s communication with Dental Health Plan Enrollees.

The Contractor shall receive approval from OHCA before utilizing a new social media platform. OHCA reserves the right to require changes to any content deemed to be inaccurate or otherwise in conflict with Contract standards.

**1.10.7 Dental Health Plan Enrollee Services Call Center**

**1.10.7.1 Dental Health Plan Enrollee Services Call Center Availability**

The Contractor shall operate a toll-free Dental Health Plan Enrollee Services Call Center in accordance with the location requirements outlined in Section 1.3.5: “Oklahoma Presence” of this Model Contract and aimed at addressing questions from Dental Health Plan Enrollees and their representatives. The Contractor may operate an overflow call center within the United States for the purposes of meeting the Dental Health Plan Enrollee Services Call Center performance requirements described in Section 1.10.7.2: “Dental Health Plan Enrollee Services Call Center Performance Standards” of this Model Contract.

The Contractor shall ensure the Dental Health Plan Enrollee Services Call Center is staffed and operational, at minimum, from 8:00 am to 5:00 pm Central Time on Monday through Friday, except for State Holidays.

The Contractor shall operate an after-hours system for fielding calls outside of Call Center operating hours. This system shall record any message the Dental Health Plan Enrollee leaves, his or her name and telephone number. The Contractor shall ensure that all calls are returned during the next Business Day.

The Contractor shall record all calls and emails received and store them in a searchable database. The Contractor shall have the ability to retrieve these calls and emails within one Business Day.

The Contractor shall also maintain a remote monitoring system that OHCA may be able to use to survey the Contractor and Dental Health Plan Enrollee interaction.

**1.10.7.2 Dental Health Plan Enrollee Services Call Center Performance Standards**

The Contractor shall have a quality control plan to monitor Dental Health Plan Enrollee Services Call Center activities and performance. The Contractor shall ensure the Call Center meets the following minimum performance requirements:

- Call abandonment rate shall be less than five percent;
- 85% of calls shall be answered by a live voice within 30 seconds of the first ring;
- Average wait time shall not exceed 30 seconds;
- Blocked call rate shall not exceed one percent; and

- The overflow call center must not receive more than five percent of all incoming calls to the Call Center.

The Contractor shall have the capability to track these Call Center metrics and issue reporting to OHCA in the timeframe and format specified in the Reporting Manual. Dental Health Plan Enrollee Services Call Center reporting shall break down performance by:

- The Contractor's main Dental Health Plan Enrollee Services Call Center;
- Overflow call center, if applicable; and
- Applicable Subcontractors.

The Contractor shall also have the capability to track Grievances received in the Dental Health Plan Enrollee Services Call Center by volume and type. The Contractor shall have the capability to compare and report its Oklahoma Call Center's performance to the performance of its affiliate health plans in other states, if it has affiliate health plans, and if similar performance standards are tracked.

At the end of each Contract year, the Contractor shall issue to OHCA an annual report detailing performance of the Call Center and mapping out improvement strategies for the following year.

#### 1.10.7.3 Call Center Training

The Contractor shall develop a program to train newly hired Dental Health Plan Enrollee Services Call Center staff and to conduct ongoing training for all Call Center staff. This training program shall address topics that include, at least:

- The populations covered under the SoonerSelect Dental program;
- Covered and non-covered services;
- Enrollment and Disenrollment;
- Fielding eligibility questions;
- Accessing services in- and out-of-network;
- Services for AI/AN Dental Health Plan Enrollees;
- Cultural and linguistic competency;
- Out-of-state services; and
- Filing a Grievance or Appeal.

The training program shall teach Call Center staff to interact with Dental Health Plan Enrollees efficiently, patiently and respectfully. The staff shall be trained so that they are equipped to recognize situations where a Dental Health Plan Enrollee has LEP or is hearing impaired and to direct them to the appropriate resources.

Call Center staff shall receive training quarterly, or more frequently, through instructor-led training or staff meetings. The staff shall also be retrained immediately upon a major change in service delivery or covered services.

The Contractor shall submit its Call Center training program to OHCA during Readiness Review and annually for review and approval.

#### 1.10.7.4 Multilingual Representatives

The Contractor shall have multilingual Dental Health Plan Enrollee Services Call Center representatives able to field calls for every prevalent non-English language. The Contractor shall also submit a plan for identifying Dental Health Plan Enrollees with LEP and providing these Dental Health Plan Enrollees with the translation or interpretation services necessary to have their question or issue resolved in a timely manner. The Contractor's plan must comply with the minimum requirements of Section 1.10.1.2: "Interpretation Services" of this Model Contract.

#### **1.10.8 Dental Health Plan Enrollee Rights**

Pursuant to 42 C.F.R. § 438.100, the Contractor shall have written policies guaranteeing each Dental Health Plan Enrollee's right to:

- Receive information on the SoonerSelect Dental program and the Contractor.
- Be treated with respect and with due consideration for his or her dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the Dental Health Plan Enrollee's condition and ability to understand.
- Participate in decisions regarding his or her health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Request and receive a copy of his or her dental records, and to request that they be amended or corrected.

Pursuant to 42 C.F.R. §§ 438.100(a)(1) and 438.100(c), each Dental Health Plan Enrollee is free to exercise his or her rights without the Contractor or its Participating Providers treating the Dental Health Plan Enrollee adversely.

Dental Health Plan Enrollee rights will at least appear in the Dental Health Plan Enrollee Handbook, described in Section 1.10.5.2: "Dental Health Plan Enrollee Handbook" of this Model Contract.

#### **1.10.9 Advisory Board**

The Contractor shall establish a standing Advisory Board that includes Dental Health Plan Enrollees, Dental Health Plan Enrollee representatives (e.g., family member and caregivers), advocates and Participating Providers. Dental Health Plan Enrollees and Dental Health Plan Enrollee representatives shall constitute a majority of the Board, which shall include at least ten persons in total. The Board, in its composition, shall reflect the Contractor's total membership in terms of geography, aid category, race and ethnicity and shall specifically include Dental Health Plan Enrollees who receive behavioral health services, or other individuals representing the Dental Health Plan Enrollees.

The Contractor shall submit the proposed Advisory Board membership to OHCA for review and approval, prior to convening the first meeting. The Contractor shall keep OHCA advised of changes in membership as they occur.

The Contractor shall convene meetings at least quarterly and shall consult the Advisory Board on matters affecting Dental Health Plan Enrollee and Provider experience, including but not limited to:

- Dental Health Plan Enrollee outreach and educational activities and materials;
- Provider outreach and educational activities and materials;
- Quality improvement plan, including;



- Selection of Performance Improvement Project topics and sharing of results,
- Identification of measures to be evaluated for the purpose of documenting the Contractor's performance in both the short- and long-term; and
- Strategies for addressing operational deficiencies, as identified through Grievance and Appeal trends, Dental Health Plan Enrollee satisfaction data, Dental Health Plan Enrollee appointment wait times, and other quality data.

The Advisory Board shall meet at least quarterly, with the first meeting to be held no later than 90 days after initial Dental Health Plan Enrollee enrollment into the SoonerSelect Dental program. The Contractor shall inform OHCA at least 30 days in advance of each meeting and shall permit OHCA to send representative(s) to observe the meeting, if OHCA so requests.

The Contractor shall make the necessary arrangements, including payment of travel costs for the Dental Health Plan Enrollee and the family Dental Health Plan Enrollee or other person assisting the Dental Health Plan Enrollee to each meeting, to facilitate attendance by board Dental Health Plan Enrollees and their representatives. The Contractor may offer nominal incentives to encourage meeting participation (e.g., refreshments in meetings).

The Contractor shall keep a written record of Advisory Board meetings and Board activities and results. The Contractor shall submit the record in a manner and format specified by OHCA upon OHCA request.

#### **1.10.10 PCD Selection and Assignment**

Pursuant to 42 C.F.R. § 438.208(b)(1), the Contractor shall implement procedures to ensure that each Dental Health Plan Enrollee has an ongoing source of care appropriate to their needs. The Contractor shall formally designate a PCD Provider to all Dental Health Plan Enrollees to be primarily responsible for coordinating services accessed by the Dental Health Plan Enrollee. The Contractor shall allow each Dental Health Plan Enrollee to choose his or her PCD Provider to the extent possible and appropriate and in accordance with Section 1.10.10.2: "Assignment Requirements" of this Model Contract. The Contractor shall have procedures for serving Dental Health Plan Enrollees and reimbursing Provider claims from the first day of Dental Health Plan Enrollee enrollment with the Contractor, whether or not the Dental Health Plan Enrollee has selected or been assigned a PCD Provider.

##### 1.10.10.1 Dental Provider Types

The Contractor shall limit PCD Provider types to those specified in Section 1.11.4.1: "PCD Provider Standards" of this Model Contract. A Dental Health Plan Enrollee whose PCD site is a multi-provider clinic can be assigned either to the clinic or a specific practitioner within the clinic to serve as his or her PCD Provider.

##### 1.10.10.2 Assignment Requirements

In accordance with 42 C.F.R. § 438.3(l), each Dental Health Plan Enrollee shall be allowed to choose his or her PCD Provider to the extent possible and appropriate. The Contractor shall implement procedures to assist Dental Health Plan Enrollees in selecting a PCD Provider upon enrollment with the Contractor. The Contractor shall educate Dental Health Plan Enrollees on factors to consider in making a PCD Provider selection, such as travel distance, special healthcare needs and Providers seen by family member.

If a Dental Health Plan Enrollee does not select a PCD Provider within 90 days of his or her enrollment effective date, the Contractor shall assign one. All Contractor-initiated PCD Provider assignments shall:

- Be within the time and distance standards of the Dental Health Plan Enrollee’s residence as specified in Section 1.11.4: “Time and Distance and Appointment Access Standards” of this Model Contract;
- Be made to an age appropriate Provider;
- Consider the following factors:
  - Previous or current relationship the Dental Health Plan Enrollee has with a Provider;
  - Previous or current relationship the Dental Health Plan Enrollee’s family members have with a Provider;
  - Any special dental needs of the Dental Health Plan Enrollee; and
  - Any Dental Health Plan Enrollee language needs made known to the Contractor.

Pursuant to 42 C.F.R. § 438.208(b)(1), within three days of the Dental Health Plan Enrollee’s selection or Contractor’s assignment to a PCD Provider, the Contractor shall notify the Dental Health Plan Enrollee, in writing, of the name and contact information of the PCD Provider.

OHCA intends to provide the Contractor with Dental Health Plan Enrollees’ historical dental provider claims from the SoonerCare fee-for-service delivery system to facilitate the Contractor’s assignment of Dental Health Plan Enrollees to a PCD Provider during Initial Program Implementation.

#### **1.10.11 PCD Changes**

##### 1.10.11.1 Dental Health Plan Enrollee-initiated PCD Changes

The Contractor must permit Dental Health Plan Enrollees to change PCD Providers, without cause. If the Contractor has made an initial assignment, the Contractor must permit the Dental Health Plan Enrollee to change during the first month, effective the following Business Day. The Contractor may limit the effective date of changes after the first month of enrollment to the beginning of the following month.

The Contractor must ensure that Dental Health Plan Enrollees have at least two age-appropriate PCD Providers within the travel time and distance standards specified in Section 1.11.4: “Time and Distance and Appointment Access Standards” of this Model Contract from which to select.

##### 1.10.11.2 Contractor-initiated PCD Changes

The Contractor may initiate a change in PCD Providers only under the following circumstances:

- Dental Health Plan Enrollee requires specialized care for an oral health condition and the Dental Health Plan Enrollee and the Contractor agree that reassignment to a different Participating Provider is in the Dental Health Plan Enrollee’s interest;
- Dental Health Plan Enrollee’s place of residence has changed such that he or she has moved beyond the PCD Provider travel time and distance standard;
- Dental Health Plan Enrollee’s PCD Provider ceases to participate in the Contractor’s network;
- Dental Health Plan Enrollee has exhibited disruptive behaviors to the extent that the Contractor cannot effectively manage their care, and the PCD Provider has made all reasonable efforts to accommodate the Dental Health Plan Enrollee; or
- Dental Health Plan Enrollee has taken legal action against the Provider.

Whenever initiating a change, the Contractor must offer affected Dental Health Plan Enrollees the opportunity to select a new PCD Provider. The Contractor shall notify the Dental Health Plan Enrollee

within three days of the name and contact information of the new Contactor-assigned or Dental Health Plan Enrollee-selected PCD Provider.

#### 1.10.11.3 Notification of PCD Termination

Pursuant to 42 C.F.R. § 438.10(f)(1), the Contractor shall make a good faith effort to give written notice of termination of a Participating Provider to each Dental Health Plan Enrollee who received his or her primary dental care from, or was seen on a regular basis by, the terminated Provider. The Contractor shall provide notice to a Dental Health Plan Enrollee no more than 15 calendar days after receipt or issuance of the termination notice and earlier if appropriate to ensure quality of care.

"Regular basis," at a minimum, shall be construed to mean any Provider delivering care on a routine basis as defined in the Dental Health Plan Enrollee's care plan, as applicable. When clinically appropriate, the Contractor shall conduct immediate outreach and support for Dental Health Plan Enrollees to select alternative Providers. For Dental Health Plan Enrollees who are receiving treatment for a chronic or ongoing medical condition, the Contractor shall ensure that there is no disruption in services.

### **1.10.12 Provider Directory**

#### 1.10.12.1 Format and Distribution

The Contractor shall have a provider directory available in electronic and paper formats. The directory shall be distributed to Dental Health Plan Enrollees at least annually in paper format or through a reminder notification to Dental Health Plan Enrollees of its availability on the Contractor's website. If the Contractor does not routinely distribute paper copies, the Contractor shall distribute a paper copy if requested by a Dental Health Plan Enrollee.

#### 1.10.12.2 Content

Pursuant to 42 C.F.R. §§ 438.10(h)(1)(i)-(viii) and 438.10(h)(2), the provider directory shall contain the following information about the Contractor's Participating Providers:

- Provider's name as well as any group affiliation, including the following Provider types:
  - Dentists, including specialists,
  - Dental practices, clinics and facilities, and
  - Other Providers required under this Contract;
- Street address(es);
- Telephone number(s);
- Website URL, as appropriate;
- Specialty, if appropriate;
- Gender;
- Whether the Provider will accept new Dental Health Plan Enrollees (necessary only in the online version);
- Mapping capabilities (necessary only in the online version)
- Provider's cultural and linguistic capabilities, including languages (including ASL) offered by the Provider or by skilled medical interpreter at the Provider's office and whether the Provider has completed cultural competence training; and
- Whether the Provider's office/facility has accommodations for persons with disabilities, including offices, exam room(s) and equipment.

#### 1.10.12.3 Submission Process and OHCA Approval

The Contractor shall submit its provider directory to OHCA for review and approval at least 30 days prior to distribution. The open panel status of the Provider shall be updated online as it changes. Review from OHCA is not necessary to change the open panel status.

#### 1.10.12.4 Updates

The Contractor shall update its provider directory at the following timeframes:

- At least monthly for the paper directory; and
- No later than three Business Days after the Contractor receives updated Provider information for the online version of the directory.

#### 1.10.12.5 Website Publication

In accordance with 42 C.F.R. § 438.10(h)(4), the Contractor shall make the provider directory available on its website without a login requirement and in a machine readable file and format as specified by the Secretary.

### **1.10.13 Dentist Incentive Plan Notification**

Pursuant to 42 C.F.R. §§ 438.10(f)(3), if the Contractor uses dentist financial incentive plans, the Contractor must make available, upon request, information about the incentive program. The Contractor shall also provide information about any physician incentive plans to OHCA prior to its initial use and prior to any subsequent revisions.

### **1.10.14 Marketing and Outreach**

Marketing is any communication from the Contractor to an Eligible who is not enrolled with the Contractor that can reasonably be interpreted to try to influence the Eligible to:

- Enroll in the Contractor's Medicaid product; or
- Either not enroll in, or disenroll from, another Dental Benefit Manager.

Marketing does not include:

- Communication to an Eligible from the issuer of a Qualified Health Plan (QHP), as defined in 45 C.F.R. § 155.20, about the QHP; and
- Communication related to educating Dental Health Plan Enrollees about Contractor operations.

Marketing Materials are materials that are produced in any medium, by or on behalf of the Contractor and can reasonably be interpreted by OHCA or its designee as intended to market the Contractor (or its employees, Participating Providers, agents or Subcontractors) to Eligibles. Marketing Materials include verbal presentation and written materials as well as advertising, public service announcements, printed publications, websites, social media, mobile device applications, broadcasts and electronic messages.

#### 1.10.14.1 Policies and Procedures

The Contractor shall develop and maintain written policies and procedures governing the development, implementation and distribution of Marketing activities and materials that, among other things, includes methods for quality control to ensure materials are accurate and do not mislead, confuse or defraud Dental Health Plan Enrollees, OHCA or the State.

#### 1.10.14.2 Training Curriculum

The Contractor shall develop training curriculum and provide training for Marketing representatives, including the Contractor's staff and Subcontractors. The Contractor shall maintain documentation of training efforts and provide such documentation upon request to OHCA.

#### 1.10.14.3 Literacy/Format

The Contractor shall ensure that its Marketing activities and materials are designed to meet the informational needs, relative to Marketing, of the cultural and physical diversity of the SoonerSelect Dental population. All Marketing Materials shall be in compliance with the information requirements in 42 C.F.R. § 438.10 to ensure that, before enrolling, an Eligible receives accurate oral and written information needed to make an informed decision on whether to enroll.

For further instruction on the requirements for written materials, refer to Section 1.10.3: "Written Material Guidelines" of this Model Contract.

#### 1.10.14.4 OHCA Review and Approval Process

In accordance with 42 C.F.R. § 438.104(b), the Contractor shall not distribute Marketing Materials without first obtaining OHCA approval. OHCA shall consult with the Medical Care Advisory Committee established under 42 C.F.R. § 431.12 on the Marketing Material review process.

The Contractor shall submit Marketing Materials to OHCA for review and approval in accordance with the requirements of Section 1.10.3.2: "Prior Approval Process" of this Model Contract at least 60 days prior to expected use and distribution. The Contractor shall not change any approved materials without the consent and approval of OHCA.

#### 1.10.14.5 Use of State Agency Logos

The Contractor shall not refer to or use OHCA or other State agency name or logo in its Marketing Materials without prior written approval. Any approval given for the name or logo is specific to the use requested and shall not be interpreted as blanket approval. The Contractor shall include the State program logo(s) in its Marketing Materials upon the request of OHCA.

#### 1.10.14.6 Service Area Distribution

In accordance with 42 C.F.R. § 438.104(b), the Contractor shall distribute Marketing Materials to its entire service area as indicated in the Contract.

#### 1.10.14.7 Marketing Plan

The Contractor shall develop and implement a plan that details the Marketing activities the Contractor will undertake and Marketing Materials the Contractor will create during the Contract period. The Marketing plan shall comply with the Marketing activity standards listed in 42 C.F.R. § 438.104 and include, at a minimum, the following information:

- Marketing goals and strategies;
- Details of proposed Marketing activities and events, including calendar of planned outreach activities and events for the first Contract year, distribution methods and schedules. This includes any proposed advertising campaigns, website development and launch, social media platform development and launch and printed materials development and distribution;
- Process for removing outdated materials;

- How the Contractor shall meet the informational needs, relative to Marketing, of the cultural and physical diversity of its membership;
- Summary of Value-Added Benefits, if applicable;
- List of all Subcontractors engaged in Marketing activities for the Contractor;
- Copy of training curriculum for Marketing representatives, including employees and Subcontractors;
- Procedures for monitoring and enforcing compliance with Marketing guidelines;
- Methods for tracking Marketing contacts, including (but not limited to) website visits and social media interactions;
- Process for responding to unsolicited direct contact from Dental Health Plan Enrollees or Eligibles; and
- Details regarding the basis the Contractor uses for awarding bonuses or increasing the salary of Marketing representatives or any other employees involved in Marketing activities.

The Contractor shall submit the plan to OHCA for review and approval as part of Readiness Review activities, on a schedule to be defined by OHCA. The Contractor shall submit any changes to OHCA for review and approval a minimum of 30 days before intended implementation of the Marketing activity. The plan also shall be updated quarterly and submitted to OHCA for review.

#### 1.10.14.8 Allowable Marketing Activities

The Contractor and its Subcontractors are allowed to perform the following Marketing activities (either written or verbal):

- Distributing general information through mass media (e.g., newspapers, magazines and other periodicals, radio, television, internet, public transportation advertising and any other media outlets);
- Responding to verbal or written requests for Dental Benefit Manager-specific information made by a Dental Health Plan Enrollee;
- Organizing or attending activities/events that are designed to benefit the entire community, such as health fairs or other health education and promotion activities which have been prior approved by OHCA;
- Attending events at the request of OHCA to disseminate or share information about the Contractor, its services and outcomes; and
- Offering Eligibles and Dental Health Plan Enrollees tokens or gifts of nominal value, as long as the Contractor acts in compliance with all Marketing provisions provided for in 42 C.F.R. § 438.104, which addresses Marketing activities and other State and federal laws, regulations and guidance regarding inducements.

#### 1.10.14.9 Prohibited Marketing Activities

Pursuant to 42 C.F.R. § 438.104, the Contractor and its Subcontractors are prohibited from engaging in the following Marketing activities (either written or verbal):

- Distributing Marketing Materials or attending/organizing Marketing events that have not received prior approval from OHCA;
- Engaging in direct or indirect door-to-door, telephone, email, texting or other Cold-call Marketing techniques or activities;

- Influencing enrollment in conjunction with the sale or offering of any private insurance, except as provided in 42 C.F.R. § 438.104;
- Distributing plans and materials or making any statement that OHCA determines to be inaccurate, false, misleading or intended to defraud Dental Health Plan Enrollees, Eligibles or OHCA. This includes statements that mislead or falsely describe covered services, membership or availability of Participating Providers or Participating Providers' qualifications or skills;
- Asserting that an Eligible must enroll in the Contractor to obtain benefits or to not lose benefits;
- Asserting that the Contractor is endorsed by the CMS, the State or federal government or similar entity, including any other governmental entity;
- Assisting with enrollment or improperly influencing Dental Benefit Manager selection;
- Designing a Marketing plan that discourages or encourages Dental Benefit Manager selection based on health status or risk (however, this provision does not preclude the Contractor from proclaiming expertise or excellence with a specific subpopulation enrolled in the SoonerSelect Dental program); and
- Conducting any other Marketing activity prohibited by OHCA during the term of the Contract.

OHCA reserves the right to prohibit additional Marketing activities at its discretion.

#### 1.10.14.10 Marketing in Provider Offices

The Contractor may distribute brochures and display posters at Provider offices and clinics that inform patients that the Provider/clinic is part of the Contractor's network, provided that all Dental Benefit Managers in which the provider/clinic participates have an equal opportunity to be represented.

The Contractor is prohibited from:

- Requiring Providers to distribute Contractor-prepared Marketing and educational communications to patients;
- Providing incentives or giveaways to Providers to distribute them to Dental Health Plan Enrollees or Eligibles;
- Allowing Providers to solicit Enrollment or Disenrollment with the Contractor or another Dental Benefit Manager; and
- Conducting Marketing activities or distributing Dental Health Plan Enrollee materials in areas where patients primarily receive health care services or are waiting to receive health care services.

The Contractor shall instruct Providers on permissible and prohibited Marketing activities and obtain the written consent of the Provider when conducting any form of Marketing in a Provider's office. The Contractor shall maintain records of the instruction and consent.

#### 1.10.14.11 Media Contacts

The Contractor shall not provide information to the media or participate in media interviews without the prior consent of OHCA. In circumstances where time is of the essence, OHCA will make a good faith effort to review the Contractor's request and respond within one Business Day. The Contractor shall refer to OHCA any contacts by the media or entity/individual not directly related to the program.

## **1.11 Provider Network Development**

### **1.11.1 General Network Development and Contracting Standards**

#### 1.11.1.1 Contractor Approach, Policies and Procedures for Provider Contracting

##### 1.11.1.1.1 Approach

The Contractor shall develop and utilize a standardized approach to contracting with Providers for participation in the Contractor's Participating Provider network. This approach shall incorporate, at a minimum, the following elements as further described in this Section:

- Credentialing and recredentialing process.
- A written Provider Agreement that lists the contractual obligations between the Contractor and the Participating Provider.

##### 1.11.1.1.2 Policies and Procedures

In accordance with 42 C.F.R. §§ 438.12(a)(2) and 42 C.F.R. 438.214(a), the Contractor shall maintain written policies and procedures on:

- Participating Provider selection;
- Retention and termination of a Participating Provider's participation with the Contractor;
- Responding to changes in the Contractor's network of Participating Providers that affect access and ability to deliver services in a timely manner; and
- Access standards.

All policies and procedures required under Section 2.12 of this Contract shall be made available to OHCA upon request and will be reviewed during the Readiness Review.

In accordance with 42 C.F.R. §§ 438.12(a)(2) and 438.214(c), the Contractor's written policies and procedures on Participating Provider selection, retention and termination shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

The Contractor shall develop and follow written policies and procedures for Provider contracting and network development, including at minimum:

- Provider selection, retention and termination;
- Network participation outreach activities;
- Network participation application and processing;
- Network changes impacting access standards and the Contractor's ability to deliver services under this Contract in a timely manner;
- Credentialing and recredentialing processes;
- Nondiscrimination of Providers;
- Excluded Providers;
- Provider Agreements; and
- Provider Payment.

#### 1.11.1.2 Adequate Network

In accordance with 42 C.F.R. § 438.206(b)(1), the Contractor shall maintain and monitor a network of appropriate Participating Providers, supported by a signed Provider Agreement that is sufficient to



provide adequate access and availability to all services covered under this Contract for all Dental Health Plan Enrollees, including those with LEP or physical or mental disabilities. The Contractor shall provide reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for Emergency Medical Conditions and shall make arrangements with, or referrals to, a sufficient number of physicians and other practitioners to ensure that the services under this Contract can be furnished promptly and without compromising the quality of care, in accordance with 42 C.F.R. § 438.3(q)(1) and (q)(3).

In developing an adequate network of Participating Providers, the Contractor shall:

- Meet and require its Participating Providers to meet State standards for timely access to care and services, as specified in this Contract, taking into account the urgency of the need for services, in accordance with 42 C.F.R. § 438.206(c)(1)(i).
- Ensure that its Participating Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to other SoonerCare populations, if the Participating Provider serves only SoonerCare Eligibles, in accordance with 42 C.F.R. § 238.206(c)(1)(ii);
- Make services included in this Contract available 24 hours a day, 7 days a week, when Medically Necessary, in accordance with 42 C.F.R. § 438.206(c)(1)(iii);
- Establish mechanisms to ensure compliance of with timely access requirements by Participating Providers, in accordance with 42 C.F.R. § 438.206(c)(1)(iv);
- Monitor Participating Providers regularly to determine compliance with timely access requirements, in accordance with 42 C.F.R. § 438.206(c)(1)(v); and
- Take corrective action if the Contractor, or its Participating Providers, fail to comply with the timely access requirements, in accordance with 42 C.F.R. § 438.206(c)(1)(vi).

The Contractor shall be able to demonstrate the Contractor's ongoing activities and efforts to comply with these standards. OHCA shall monitor and review the Contractor's compliance with these standards as part of its ongoing oversight activities.

Section 1.11.4: "Time and Distance and Appointment Access Standards" of this Model Contract provides a listing of the minimum required components of network access standards. This is not meant to be an all-inclusive listing of Provider types and components of the Participating Provider network. The Contractor's Participating Provider network for other service Providers must be adequate to ensure that care is available timely and geographically accessible. In addition, the Contractor shall add additional Participating Providers based on the needs of Dental Health Plan Enrollees or due to changes in state or federal requirements.

In accordance with 42 C.F.R. § 438.206(b)(4), if the Contractor is unable to provide necessary dental services covered under this Contract to a particular Dental Health Plan Enrollee, the Contractor shall adequately and timely cover the services provided out-of-network by a Non-Participating Provider, for as long as the Contractor is unable to provide the services within the Contractor's network of Participating Providers. The Contractor shall coordinate payment with Non-Participating Providers and ensure that the cost to the Dental Health Plan Enrollee is no greater than it would be if the services were furnished by a Participating Provider, in accordance with 42 C.F.R. § 438.206(b)(5).

As described in Section 1.6.9: “Delivery Network” of this Model Contract:

- The Contractor shall provide for a second opinion from a Participating Provider, or arrange for the Dental Health Plan Enrollee to obtain a second opinion outside the Contractor’s Participating Provider network, at no cost to the Dental Health Plan Enrollee, in accordance with 42 C.F.R. § 438.206(b)(3).

1.11.1.3 Additional Network Contracting Requirements and Limitations

1.11.1.3.1 Non-Discrimination

In accordance with 42 C.F.R. § 438.12(a)(1), the Contractor may not discriminate in the participation, reimbursement or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

1.11.1.3.2 Written Notice of Decision not to Contract

If the Contractor declines to include individual or groups of Providers in its network of Participating Providers, it must give the affected Providers written notice of the reason for its decision in accordance with 42 C.F.R. § 438.12(a)(1).

1.11.1.3.3 Limits on Network Contracting Requirements in this Model Contract

Notwithstanding other language in this Model Contract, the Contractor:

- In accordance with 42 C.F.R. § 438.12(b)(1), shall not be required to execute a Provider Agreement beyond the number necessary to meet the needs of its Dental Health Plan Enrollees;
- In accordance with 42 C.F.R. § 438.12(b)(2), shall not be precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or
- In accordance with 42 C.F.R. § 438.12(b)(3), shall not be precluded from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Dental Health Plan Enrollees.

1.11.1.3.4 Compliance with OHCA-Determined Provider Selection Requirements

The Contractor shall comply with any and all additional Participating Provider network selection requirements established by OHCA or the State, in accordance with 42 C.F.R. §§ 438.12(a)(2) and 42 C.F.R. 438.214(e). This shall include all requirements included in this Contract and any amendments thereto, along with all other OHCA guidance on Participating Provider selection along with any applicable state law during the term of this Model Contract.

1.11.1.4 Screening, Enrollment and Periodic Revalidation

1.11.1.4.1 SoonerCare Participation

In accordance with the Provider disclosure, screening, and enrollment requirements at 42 C.F.R. §§ 438.608(b), 455.100-106 and 455.400-470, the Contractor shall require Providers seeking to become Participating Providers to be enrolled as a contracted Provider with SoonerCare. OHCA shall screen, enroll and periodically revalidate all Participating Providers as a Provider with SoonerCare, in accordance with 42 C.F.R. 438.602(b)(1).

1.11.1.4.2 Provider Agreement Execution Pending SoonerCare Enrollment

In accordance with 42 C.F.R. § 438.602(b)(2), the Contractor may execute a Provider Agreement pending the outcome of the screening, enrollment and periodic revalidation requirements of 42 C.F.R. § 438.602(b)(1) for up to 60 days, but must terminate a Participating Provider immediately upon notification

from the State that the Participating Provider cannot be enrolled with SoonerCare, or the expiration of one 60 day period without enrollment of the Provider with SoonerCare, and notify affected Dental Health Plan Enrollees.

1.11.1.5 Provider Network Development and Management Plan

In accordance with 42 C.F.R. § 438.207(a), the Contractor shall provide assurances to OHCA and provide a Provider Network Development and Management Plan, in a manner and format to be specified by OHCA, that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with OHCA's standards for access to care and in accordance with 42 C.F.R. §§ 438.68 and 438.206(c)(1).

As part of the Provider Network Development and Management Plan, the Contractor shall demonstrate that:

- It offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of Dental Health Plan Enrollees for the service area, in accordance with 42 C.F.R. § 438.207(b)(1);
- It maintains a network of Participating Providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Dental Health Plan Enrollees in the service area, in accordance with 42 C.F.R. § 438.207(b)(2); and
- It requires its Participating Providers to meet requirements for access to services as set forth at Section 1.11.4: "Time and Distance and Appointment Access Standards" of this Model Contract taking into account the urgency of the need for services, in accordance with 42 C.F.R. § 438.206(c)(1)(i).

The Provider Network Development and Management Plan shall contain, at a minimum, information on the following:

- Summary of Participating Providers, by provider type and geographical location in the State;
- An attestation that the Contractor's network of Participating Providers is sufficient to provide adequate access to all services covered under the Contract for all Dental Health Plan Enrollees, including but not limited to those with LEP or physical or mental disabilities;
- Demonstration of monitoring activities to ensure that OHCA-defined network access standards, including time and distance, are met;
- Summary of capacity of the Contractor's network of Participating Providers and network adequacy issues by type of Provider, service and county and efforts to address those issues; and
- Ongoing activities for Participating Provider development and expansion considerations.

At a minimum, the Plan shall be submitted to OHCA at the following timeframes in accordance with 42 C.F.R. § 438.207(b) - (c):

- At the time the Contractor enters into a Contract with OHCA;
- On an annual basis; and
- At any time there has been a significant change, as defined by OHCA, in the Contractor's operations that would affect adequacy of capacity of services, including changes in the

Contractor’s services, benefits, geographic service area, composition of or payments to its network of Participating Providers or enrollment of a new population in the Contractor’s Dental Benefit Manager.

OHCA shall review and approve the Contractor’s Provider Network Development and Management Plan. Once approved, OHCA shall submit an assurance of compliance to CMS that the Contractor meets OHCA’s requirements for availability of services, as set forth in 42 C.F.R. §§ 438.68 and 438.206. The submission to CMS shall include documentation of an analysis that supports the assurance of the adequacy of the Contractor’s network of Participating Providers. OHCA shall make available to CMS, upon request, all documentation collected by OHCA from the Contractor.

**1.11.1.6 Participating Provider Network Listing**

The Contractor shall supply to OHCA, no later than five Business Days before the end of each month, an up-to-date listing of all Participating Providers. The Contractor’s up-to-date listing must include open capacity for PCD Providers. The listing shall be provided in a format specified by OHCA. OHCA reserves the right to request Participating Provider listing data on a basis more frequently than monthly.

**1.11.1.7 Providers Prohibited from Participating Provider Status**

The Contractor shall conduct background checks and similar activities as required under State and federal law on all Providers before entering into a Provider Agreement with the Provider.

In accordance with 42 C.F.R. § 438.610, the Contractor shall not knowingly have a relationship with and shall have a proactive method to prevent relationship(s) with entities specified in Section 1.23.1.7: “Termination for Debarment” of this Model Contract.

**1.11.1.8 Participating Providers Types**

A list of all Provider types and Provider sub-specialties enrolled by OHCA is included in the table below. The Contractor shall utilize the same respective identifiers, and any updates thereto, for the Contractor’s Participating Providers to ensure appropriate data interfaces with OHCA.

Provider Type	Sub-Specialty
<b>Dentist</b>	Endodontist
	General Dentistry Practitioner
	Oral Surgeon
	Orthodontist
	Pediatric Dentist
	Periodontist
	Oral Pathologist
	Prosthodontist
	General Dentist with Orthodontic Privileges

### 1.11.2 Provider Agreement Requirements

#### 1.11.2.1 General Requirements

In all Provider Agreements, the Contractor shall comply with all requirements specified in 42 C.F.R. §§ 438.12, 438.214 and 489.1 through 489.35. The Contractor shall maintain policies and procedures that reflect these requirements.

All Provider Agreements shall be executed in accordance with all applicable State and federal statutes, regulations, policies, procedures and rules. The Contractor shall identify and incorporate the applicable terms of this Contract and any amendments by or incorporated documents from the State, including the Solicitation for this Model Contract. Under the terms of the Provider Agreement, the Participating Provider shall agree that all applicable terms and conditions set out in this Model Contract, any incorporated documents, the Solicitation for this Contract and all applicable State and federal laws, as amended, govern the duties and responsibilities of the Participating Provider with regard to the provision of services to SoonerSelect Dental Health Plan Enrollees.

If any requirement in the Provider Agreement is determined by OHCA to conflict with this Contract, such requirement shall be null and void and all other provisions of the Provider Agreement shall remain in full force and effect.

#### 1.11.2.2 Minimum Content Requirements

All Provider Agreements shall contain the following provisions, at minimum:

- *Parties to the Provider Agreement.* Identify the parties of the Provider Agreement and each party's legal basis of operation in the State of Oklahoma.
- *Term of Provider Agreement.* Include provisions describing when the Provider Agreement shall become effective and expire.
- *Termination of the Provider Agreement.* Include the procedures and specific criteria for:
  - Reasons for termination;
  - The Contractor's ability to deny, refuse to renew or terminate any Provider Agreement in accordance with the terms of this Contract and any applicable statutes and regulations;
  - Written notice requirements;
  - In the event of termination of the Provider Agreement, the Provider shall immediately make available to OHCA or its designated representative in a usable form any or all records whether medically or financially related to the terminated Participating Provider's activities undertaken pursuant to the Provider Agreement and that the provision of such records shall be at no expense to OHCA;
  - OHCA reserves the right to direct the Contractor to terminate any Participating Provider if OHCA determines that termination is in the best interest of the State.
- *Independent Contractor.* Specify that the Participating Provider is not a third party beneficiary to the Contract between the Contractor and the State and that the Participating Provider is an independent contractor performing services as outlined in this Contract between the Contractor and the State.
- *Scope of Work.* Identify the services, activities and reporting responsibilities to be performed by the Participating Provider.

- *NPI.* Require that any Provider, including Providers ordering or referring a covered service, have an NPI, to the extent such provider is not an atypical provider as defined by the CMS.
- *Credentialing and Recredentialing.* The Contractor shall maintain all Provider Agreements in accordance with 42 C.F.R. § 438.214.
- *Dental Health Plan Enrollee Rights and Responsibilities.* Require all Participating Providers to abide by Dental Health Plan Enrollee rights and responsibilities denoted in this Model Contract.
- *Display Notices of Dental Health Plan Enrollee Rights to Grievances, Appeals and State Fair Hearings.* Require that the Participating Provider display notices in public areas of the Participating Provider's facility/facilities in accordance with all State requirements and any subsequent amendments.
- *Physical Accessibility.* Require Participating Providers to provide physical access, reasonable accommodations, and accessible equipment for Dental Health Plan Enrollees with physical or mental disabilities, in accordance with 42 C.F.R. § 438.206(c)(3).
- *Interpreter Presence.* Require Participating Providers to accommodate the presence of interpreters.
- *Emergency and Urgent Care Services.* Provide that Emergency Services be rendered without the requirement of Prior Authorization.
- *Confidentiality.* Require that Dental Health Plan Enrollee information be kept confidential, as defined by State and federal laws, regulations and policy.
- *Record Keeping.* Require Participating Providers to maintain an adequate record system for recording services and all other commonly accepted information elements, including but not limited to: charges, dates and records necessary for evaluation of the quality, appropriateness and timeliness of services performed. Dental Health Plan Enrollees and their representatives shall be given access to and can request copies of the Dental Health Plan Enrollees' medical records to the extent and in the manner provided under State or federal law.
- *Record Availability.* Require Participating Providers to maintain all records related to services provided to Dental Health Plan Enrollees for a ten- year period. In addition, require Providers to make all Dental Health Plan Enrollee medical records or other service records available for any quality reviews that may be conducted by the Contractor, OHCA or its designated agent(s) during and after the term of the Provider Agreement.
- *Professional Standards for Health Records.* In accordance with 42 C.F.R. § 438.208(b)(5), require Participating Providers furnishing services to Dental Health Plan Enrollees to maintain and share Dental Health Plan Enrollee health records in accordance with professional standards.
- *Facility and Record Access for Evaluation, Inspection or Auditing Purposes.* Include a provision that authorized representatives of OHCA and other State or federal agencies shall have reasonable access to facilities and records for audit purposes during and after the term of the Provider Agreement.
- *Release of Information for Monitoring Purposes.* Include a provision that the Participating Provider shall release to the Contractor any information necessary to monitor Participating Provider performance on an ongoing and periodic basis.

- *Dental Health Plan Enrollee Cost Sharing.* Specify the Participating Provider’s responsibilities and prohibited activities regarding SoonerSelect Dental program Cost Sharing. When the covered service provided requires a Copayment, as allowed by the Contractor, the Participating Provider may charge the Dental Health Plan Enrollee only the amount of the allowed Copayment, which cannot exceed the Copayment amount allowed by OHCA. The Participating Provider shall accept payment made by the Contractor as payment in full for covered services, and the Participating Provider shall not solicit or accept any surety or guarantee of payment from the Dental Health Plan Enrollee, OHCA or the State.
- *Third Party Liability.* Include a provision for Participating Provider responsibility with respect to Third Party Liability, including:
  - The Participating Provider’s obligation to identify Dental Health Plan Enrollee Third Party Liability coverage, including Medicare and long term care insurance as applicable; and
  - Except as otherwise required, the Participating Provider shall seek such Third Party Liability payment before submitting claims to the Contractor.
- *Reimbursement Rates and Risk Assumptions.* Include the reimbursement rates and risk assumptions, if applicable.
- *Claims Submission and Payment.* Provide for prompt submission of claims information needed to make payment within six months of the covered service being provided to a Dental Health Plan Enrollee.
- *Performance-based Provider Payments/Incentive Plans.* Describe, as applicable, any performance-based Provider payment(s)/incentive plan(s) to which the Participating Provider is subject.
- *QM/QI Participation.* The Contractor shall monitor utilization of the quality of services delivered under the Provider Agreement. The Provider Agreement shall require the Participating Provider’s participation and cooperation in any internal and external QM/QI monitoring, utilization review, peer review and/or appeal procedures established by OHCA and/or the Contractor and require the Participating Provider’s participation in any corrective action processes that will be taken where necessary to improve quality of care.
- *Data and Reporting.* Provide for the timely submission of all reports, clinical information and Encounter Data required by the Contractor and OHCA.
- *Indemnify and Hold Harmless.* Specify that at all times during the term of the Provider Agreement, the Participating Provider shall indemnify and hold OHCA harmless from all claims, losses or suits relating to activities undertaken by the Provider pursuant to the Provider Agreement.
- *Non-discrimination.* Require Participating Providers to:
  - Agree that no person, on the grounds of disability, age, race, color, religion, sex, sexual orientation, gender identity, or national origin, shall be excluded from participation in, or be denied benefits of the Contractor’s program or otherwise subjected to discrimination in the performance of the Provider Agreement with the Contractor or in the employment practices of the Participating Provider;
  - Identify Dental Health Plan Enrollees in a manner which will not result in discrimination against the Dental Health Plan Enrollee in order to provide or coordinate the provision of covered services; and

- Not use discriminatory practices with regard to Dental Health Plan Enrollees such as separate waiting rooms, separate appointment days or preference to private pay patients.
- *Access and Cultural Competency.* Require Participating Providers to take adequate steps to promote the delivery of services in a culturally competent manner to Dental Health Plan Enrollees, including those with LEP and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity.
- *Database Screening and Criminal Background Check of Employees.* Require Participating Providers to comply with all State and federal law/requirements for database screening and criminal background checks of new hires and current employees and staff who have direct contact with Dental Health Plan Enrollees and/or access to Dental Health Plan Enrollees' Protected Health Information. Participating Providers are prohibited from employing or contracting with individuals or entities that are excluded or debarred from participation in Medicare, Medicaid or any federal health care program as further detailed at Section 1.17.10: "Prohibited Affiliations and Exclusions" of this Model Contract. The Contractor shall require Participating Providers to conduct initial screenings and criminal background checks and comply with ongoing monitoring requirements of all employees and contractors in accordance with State and federal law. The Participating Provider shall be required to immediately report to the Contractor any exclusion information discovered. OHCA reserves the right to deny enrollment or terminate a Provider Agreement with a Participating Provider as provided under State and/or federal law.

OHCA reserves the right to amend these requirements as it deems necessary.

#### 1.11.2.3 Network Provider Agreement Limitations/Restrictions and Assurances

The Contractor shall not include any of the following limitations or restrictions in any Provider Agreement:

- *Non-Compete Clause.* Prohibit a Participating Provider from entering into a contractual relationship with another PAHP, MCO or IMCE (i.e., no covenant-not-to-compete) or include any compensation terms (i.e., incentive or disincentive) that encourages a Participating Provider not to enter into a contractual relationship with another PAHP, MCO or IMCE.
- *Interference with Provider-Patient Relationship.* In accordance with § 1932(b)(3)(A) of the Act and 42 C.F.R. § 438.102(a)(1)(i)-(iv), the Provider Agreement shall not contain any provisions that prohibit or otherwise restrict Participating Providers acting within the scope of the Participating Provider's license from advising or advocating on behalf of Dental Health Plan Enrollees for the following:
  - Dental Health Plan Enrollee health status, medical care or treatment options, including any alternative treatment that may be self-administered;
  - Any information a Dental Health Plan Enrollee needs to decide among all relevant treatment options;
  - The risks, benefits and consequences of treatment or non-treatment; or
  - The Dental Health Plan Enrollee's right to participate in decisions regarding the Dental Health Plan Enrollee's health care, including the right to refuse treatment and to express preferences about future treatment decisions.



- *The right to request resolution or support to file a Grievance or Appeal on behalf of a Dental Health Plan Enrollee if authorized by the Dental Health Plan Enrollee to do so.* The Contractor must include assurances in any Provider Agreement, including single case agreements in Section 1.11.2.5: “Single Case Agreements” of this Model Contract that it will take no punitive action against a Provider who either requests an expedited resolution or supports a Dental Health Plan Enrollee’s Appeal.

#### 1.11.2.4 Provider Agreement Requirements for Specific Provider Types

The Contractor shall include the following provisions in its Provider Agreements, as applicable to the specific Provider types in this Section.

##### 1.11.2.4.1 PCD Provider Agreements

In addition to the minimum Provider Agreement requirements in Section 1.11.2.2: “Minimum Content Requirements” of this Model Contract and 1.11.2.3: “Network Provider Agreement Limitations/Restrictions and Assurances” of this Model Contract, the Contractor shall include PCD responsibilities in all Agreements with PCD Providers. At a minimum, PCD responsibilities specified in the Provider Agreement shall include:

- Delivering primary dental care services and follow-up care;
- Utilizing and practicing evidence-based dentistry and clinical decision supports;
- Making referrals for specialty care and other covered services and, when applicable, working with the Contractor to allow Dental Health Plan Enrollees to directly access a specialist as appropriate for a Dental Health Plan Enrollee’s condition and identified needs;
- Maintaining a current medical record for the Dental Health Plan Enrollee;
- Using health information technology to support care delivery;
- Ensuring coordination and continuity of care with Providers, including but not limited to specialists;
- Engaging active participation by the Dental Health Plan Enrollee and the Dental Health Plan Enrollee’s family, authorized representative or personal support, when appropriate, in health care decision-making and feedback;
- Providing access to medical care 24-hours per day, seven days a week, either directly or through coverage arrangements made with other Providers, clinics and/or local hospitals;
- Providing enhanced access to care, including extended office hours outside normal business hours and facilitating use of open scheduling and same-day appointments where possible; and
- Participating in continuous quality improvement and voluntary performance measures established by the Contractor and/or OHCA.

##### 1.11.2.5 Single Case Agreements

The Contractor may enter into a single case agreement with any Provider performing covered services who is not willing to become a Participating Provider with the Contractor. The Contractor must ensure that the Provider is an OHCA Provider. In instances where a single case agreement is needed, and the provider is not an OHCA Provider, OHCA must approve the single case agreement prior to contract execution.

### **1.11.3 Credentialing**

The Contractor shall demonstrate that all Participating Providers are credentialed as required under 42 C.F.R. § 438.214. In accordance with 42 C.F.R. §§ 438.12(a)(2) and 438.214(b), the Contractor shall follow OHCA's uniform credentialing and recredentialing policy that addresses comprehensive dental care Providers, and follow a documented process for credentialing and recredentialing of all Participating Providers.

For purposes of this requirement, OHCA has determined, in accordance with OHCA's SoonerCare program credentialing and recredentialing policy, the Contractor shall credential Providers based on requirements of the applicable Accrediting Entity with whom the Provider is accredited. Additionally, the Contractor shall utilize the uniform credentialing application required by OHCA during the credentialing process.

#### 1.11.3.1 Credentialing and Recredentialing Timeframes

The Contractor shall ensure that credentialing of all Providers applying for Participating Provider status shall be completed as follows, or according to any stricter credentialing timeliness requirements as may be required by the applicable Accrediting Entity with whom the Provider is accredited:

- All applications must be credentialed within 45 days of receipt of a completed application.
- **Contractor may request an extension of 15 days from OHCA on a case-by-case basis.**

In the event the Contractor delegates credentialing activities to a delegated credentialing agency, the Contractor shall ensure all credentialed Providers are loaded into the Contractor's Provider files and claims system within 15 calendar days of receipt from the delegated entity.

#### 1.11.3.2 Ongoing Monitoring

The Contractor shall complete ongoing monitoring of Provider sanctions, Grievances and quality issues between recredentialing cycles. The Contractor shall collect and review relevant information and take appropriate and prompt action against Providers when the Contractor identifies occurrences of poor quality.

#### 1.11.3.3 Non-Licensed Providers

When individuals providing services under this Contract are not required to be licensed or certified, the Contractor shall ensure, based on applicable State regulations, rules and/or program standards, that the individuals are appropriately educated, trained, qualified and competent to perform their job responsibilities. In addition, the Contractor shall perform background checks and database screening in accordance with State and federal laws to ensure the Provider has not been excluded or debarred from participation in Medicare, Medicaid or any federal health care program or employed/contracted with an individual/entity that has been excluded or debarred from these health care programs. This provision also applies to agency Providers that employ or hire non-licensed staff.

### **1.11.4 Time and Distance and Appointment Access Standards**

In accordance with 42 C.F.R. § 438.68(a), OHCA has developed and shall enforce the time and distance standards set forth in this Section. In developing the time and distance standards, OHCA considered all applicable requirements of 42 C.F.R. § 438.68(c). The Contractor shall meet the time and distance standards developed by OHCA in accordance with 42 C.F.R. § 438.68(b)(1) set forth in this Section in all geographic areas in which the Contractor operates, with standards varying for Urban and Rural Areas, as required pursuant to 42 C.F.R. § 438.68(b)(3), for the following types of Participating Providers:

- General Dentistry Providers;

- Pediatric Specialty Dental Providers; and
- Specialty Dental Providers;

OHCA has determined that time and distance standards for additional Provider types are necessary to promote the goals of the SoonerSelect Dental program and has set forth minimum access requirements for Providers as outlined in Sections 1.11.4.4.1: “Essential Community Providers” of this Model Contract below. OHCA reserves the right to set time and distance standards for additional Provider types that it determines necessary to improve Dental Health Plan Enrollee access and further the goals of the SoonerSelect Dental program.

1.11.4.1 PCD Provider Standards

The Contractor shall provide and maintain an adequate network of PCD Providers, to ensure that Dental Health Plan Enrollees have access to all comprehensive dental services in SoonerSelect Dental program benefit package. The Contractor shall ensure that each SoonerSelect Dental program Health Plan Enrollee has a PCD Provider.

PCD Providers include the following provider types:

- FQHC and RHC Provider groups, dentists and dental specialists who meet the descriptions above and are authorized within their scope of practice under State law to provide these services; and
- Indian Health Care Providers.

The Contractor may allow SoonerSelect Dental program Health Plan Enrollees to select a specialist or subspecialist as the Dental Health Plan Enrollees’ PCD Provider, where medically appropriate, and provided that the selected specialist Provider is willing to perform all responsibilities of a PCD Provider.

The Contractor shall meet the following access standards for PCD Providers:

Provider Type	Measure	Standard
Distance		
Adult PCD Pediatric PCD	Urban Distance	Within 20 miles of a Dental Health Plan Enrollee’s residence
Adult PCD Pediatric PCD	Rural Distance	Within 60 miles of a Dental Health Plan Enrollee’s residence
Appointment Time		
Adult PCD Pediatric PCD	<ul style="list-style-type: none"> <li>• Not to exceed 30 days from date of the Dental Health Plan Enrollee’s request for routine appointment.</li> <li>• Within 24 hours for Urgent Care.</li> <li>• Each PCD shall allow for at least some same-day appointments to meet acute care needs.</li> </ul>	

1.11.4.2 Specialty Provider Standards

The Contractor’s Participating Provider network shall include a sufficient number and type of adult and pediatric specialty dental Providers to ensure that Dental Health Plan Enrollees have access to all specialty dental care services in the SoonerSelect Dental program benefit package and to meet program access standards for adequate capacity.

The Contractor shall meet the following access standards for Specialty Providers:

Provider Type	Measure	Standard
Distance		
Dental Specialist	Urban Distance	Within 25 miles of a Dental Health Plan Enrollee’s residence
Dental Specialist	Rural Distance	Within 60 miles of a Dental Health Plan Enrollee’s residence
Appointment Time		
Dental Specialist		<ul style="list-style-type: none"> <li>• Not to exceed 60 days from date of the Dental Health Plan Enrollee’s request for routine appointment.</li> <li>• Within 24 hours for Urgent Care.</li> </ul>

1.11.4.3 Indian Health Care Provider Standards

The Contractor shall comply with the network adequacy requirements of Section 1.14.4: “Indian Healthcare Providers (IHCPs)” of this Model Contract.

1.11.4.4 Essential Community Provider Standards

1.11.4.4.1 Essential Community Providers

Essential community providers include the following Provider types:

- FQHCs and RHCs;
- IHCPs;
- State agencies, including but not limited to, OJA, OSDH, and DHS; and
- Other entities certified by the CMS as an essential community provider.

The Contractor shall contract with essential community providers in the Contractor’s service area to the extent possible and practical. If the Contractor is unable to Contract with essential community providers as required below, the Contractor shall demonstrate to OHCA that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected enrollment in the Contractor’s service area without contracting with essential community providers.

1.11.4.5 Department of Health

Upon award of this Contract, the Contractor shall extend an offer to all Oklahoma State Department of Health (OSDH) County Health Departments, including any applicable OSDH mobile clinics, to become a Participating Provider with reimbursement for services at OHCA FFS rates, and any updates thereto, at minimum.

In accordance with Title 63, Section 1-105e, when the OSDH provides a covered service to any Dental Health Plan Enrollee, the OSDH may submit a claim for said service to the Contractor. Upon receipt of the claim, the Contractor shall reimburse the OSDH for the service provided in accordance with OHCA FFS rates and any updates thereto, at minimum. The Contractor shall recognize the public health service delivery model utilized by the OSDH as an appropriate provider of services for reimbursement.

#### **1.11.5 Network Adequacy Exception Process**

OHCA shall allow a Contractor to submit to OHCA a formal written request for a waiver of the distance standards in Section 1.11.4: “Time and Distance and Appointment Access Standards” of this Model Contract where there are no Participating Providers within the required driving distance or the Contractor is unable to enter into a Provider Agreement with a particular Provider type. In accordance with 42 C.F.R. § 438.68(d)(1)(ii), the standard by which the exception will be evaluated and approved by OHCA, at minimum, will be based on the number of Providers in that specialty in which the Contractor is requesting the waiver that are practicing in the Contractor’s service area. In accordance with 42 C.F.R. § 438.68(d)(2), OHCA will monitor Dental Health Plan Enrollee access to the Provider type for which any waiver is granted on an ongoing basis and include the findings to CMS in the managed care program assessment report required under 42 C.F.R. § 438.66.

#### **1.11.6 Provider Agreement Termination**

##### 1.11.6.1 Participating Provider Contract Termination

The Contractor and its Participating Providers shall have the right to terminate the contracts entered into with each other via a Provider Agreement. The Contractor and its Participating Providers may terminate the Provider Agreement for cause with 30 days’ advance written notice to the other party and without cause with 60 days’ advance written notice to the other party.

The Contractor shall terminate its Provider Agreement with the Participating Provider immediately under the following circumstances:

- To protect the health and safety of Dental Health Plan Enrollees;
- Upon credible allegation of Fraud on the part of the Participating Provider;
- When the Participating Provider’s licenses, certifications and/or accreditations are modified, revoked or in any other way making it unlawful for the Provider to provide services under this Contract; or
- Upon request of OHCA.

If OHCA terminates a Provider from SoonerCare participation, OHCA shall notify the Contractor. The Contractor shall be responsible for monitoring all relevant State registries to review any Participating Providers that are terminated by OHCA and subsequently excluded from participation in the Contractor’s Participating Provider network.

The Contractor shall follow a process to be defined by OHCA for notification, facilitation of Dental Health Plan Enrollee records transfer and any other assistance necessary for an orderly transition of health care from a Provider whose Provider Agreement has been terminated.

##### 1.11.6.2 Notification of Participating Provider Network Changes

###### 1.11.6.2.1 Notification to OHCA of Participating Provider Network Changes

The Contractor shall notify OHCA when a Provider Agreement is terminated with:

- A hospital, FQHC, IHCP facility or any practitioner who is actively serving 100 or more of the Contractor's SoonerSelect Dental program Health Plan Enrollees; or
- Any Participating Provider whose termination has the potential to compromise the Contractor's ability to meet one or more network access standards under this Contract.

In such an event, the Contractor shall provide OHCA with a corrective action plan. OHCA reserves the right to allow Dental Health Plan Enrollees affected by the termination of the Provider to disenroll from the Contractor's Dental Benefit Manager in accordance with the provisions of Section 1.22: "Non-Compliance Remedies" of this Model Contract.

The Contractor shall work with the terminated Provider to ensure that any Dental Health Plan Enrollee records and information are provided to the Contractor to facilitate an orderly transition of Dental Health Plan Enrollee care.

#### 1.11.6.2.2 Notification to Authorities of Provider Agreement Termination

If the Contractor terminates a Provider Agreement, the Contractor must report the Provider's termination to the appropriate authorities, including the National Practitioner Data Bank (NPDB), State licensing agencies, and any other entity designated by OHCA.

#### 1.11.6.2.3 Notification to Dental Health Plan Enrollees of Participating Provider Network Changes

The Contractor shall notify Dental Health Plan Enrollees of Provider disenrollment in accordance with Section 1.10.11.3: "Notification of PCD Termination" of this Model Contract.

#### 1.11.6.3 Participating Provider Contract Termination Appeal Rights

The Contractor shall handle Provider Appeals of Provider Agreement terminations using a process substantially the same as the process and requirements set forth in OAC 317:2-1-12. The Contractor shall develop, implement and maintain a system for tracking Appeals related to Provider Agreement contracting issues. Within this process, the Contractor shall respond fully and completely to each Provider's Appeal and establish a tracking mechanism to document the status and final disposition of each. Such documentation shall be made available to OHCA upon request.

OHCA reserves the right to include an independent review process established by OHCA for final determination on these disputes.

#### **1.11.7 Submission of Provider Enrollment and Disenrollment Data to OHCA**

The Contractor shall submit Participating Provider enrollment data to OHCA in an electronic format and timeframe specified by OHCA.

The Contractor shall notify OHCA, in a manner specified by OHCA, of the Contractor's intent to disenroll a Participating Provider at least ten Business Days in advance of sending the notice of disenrollment to the impacted Provider. The Contractor shall also notify OHCA within five days of the Contractor's receipt of notice from a Participating Provider that the Provider intends to disenroll from the Contractor's network.

#### **1.11.8 Direct Access to Specialists**

In accordance with 42 C.F.R. § 438.208(c)(4), the Contractor shall have a mechanism in place to allow Dental Health Plan Enrollees with Special Health Care Needs determined through a comprehensive assessment to need a course of treatment or regular care monitoring to directly access a specialist as appropriate for the Dental Health Plan Enrollee's condition and identified needs.

## **1.12 Provider Services**

The Contractor shall develop and implement a comprehensive Provider services function within the Contractor's organization that shall include responsibility for, at minimum, the Provider communication and training requirements outlined in this Section of the Contract.

### **1.12.1 Policies and Procedures**

The Contractor shall develop and maintain written policies and procedures, which shall be reviewed by OHCA during Readiness Review and made available to OHCA upon request, on the following Provider services topics, at minimum:

- Provider services call center policies and procedures that address, at minimum:
  - Call center staffing;
  - Call center staff training;
  - Call center hours of operation;
  - Call center access and response standards, monitoring of calls and compliance with standards;
- Provider website policies and procedures that address, at minimum:
  - Website content;
  - Frequency of website updates; and
  - Ongoing monitoring of accuracy information provided on the website;
- Provider manual content, review and distribution;
- Provider training and education, including targeted training and education for behavioral health services; and
- Provider Complaint System, including Provider reconsiderations and appeals.

### **1.12.2 Provider Services Call Center**

#### 1.12.2.1 Availability

The Contractor shall maintain a Provider Services Call Center in accordance with the location requirements outlined in Section 1.3.5: "Oklahoma Presence" of this Model Contract. The Provider Services Call Center shall operate a toll-free telephone line to respond to Provider questions, comments, inquiries and requests for Prior Authorizations.

The Contractor may operate an overflow call center within the United States for the purposes of meeting the performance requirements listed in this Contract for the Provider Services Call Center.

The Contractor shall ensure that the Provider services call center is staffed adequately to respond timely to Providers' questions at a minimum from 8:00 am to 5:00 pm Central Time, Monday through Friday, except for State Holidays.

The Contractor shall have an automated system available during business and non-business hours. The automated system shall include, at minimum, a voice mailbox for callers to leave messages. In addition, the Contractor shall return all messages on the next Business Day.

#### 1.12.2.2 Provider Services Call Center Performance Standards

The Contractor shall have a quality control plan to monitor Provider Services Call Center activities and performance. The Contractor shall ensure the Call Center meets the following minimum performance requirements:

- Call abandonment rate shall be less than five percent;
- 85% of all calls shall be answered by a live voice within 30 seconds of the first ring;
- Average wait time shall not exceed 30 seconds;
- Blocked call rate shall not exceed one percent; and
- The overflow call center shall not receive more than five percent of all incoming calls to the Provider Services Call Center.

The Contractor shall have the capability to track these Provider Services Call Center metrics and issue reporting to OHCA in the timeframe and format specified in the Reporting Manual. Provider Services Call Center reporting shall break down performance by:

- The Contractor's main Provider Services Call Center;
- Overflow call center, if applicable; and
- Applicable Subcontractors.

At the end of each Contract year, the Contractor shall issue to OHCA an annual report that details performance of the Provider Services Call Center and maps out improvement strategies for the following year.

#### 1.12.2.3 Provider Services Call Center Training

The Contractor shall develop a program to train newly hired staff and retrain current Provider Services Call Center staff. This training program shall address topics that include, at minimum:

- The populations covered under the SoonerSelect Dental program;
- SoonerSelect Dental program Covered and non-covered services;
- Prior Authorization requirements and processes;
- Claims submission requirements and processes, including a focus on how to correct claims that have been denied due to Provider submission errors;
- Services for AI/AN Dental Health Plan Enrollees;
- Cultural and linguistic competency;
- Out-of-state services;
- Filing a Provider Complaint; and
- Filing a Grievance or Appeal on behalf of a Dental Health Plan Enrollee.

OHCA reserves the right to amend these requirements as it deems necessary.

### **1.12.3 Provider Website**

#### 1.12.3.1 General Website Requirements

The Contractor shall maintain a website that is accessible to Providers. The Contractor shall:

- Ensure the website is accessible via mobile devices;
- Maintain a separate and distinct section on its website for its SoonerSelect Dental program information if the Contractor markets other lines of business;
- Ensure posted information is current and accurate;
- Review and update website content at least monthly;
- Include a date stamp on each page within the website with the date the page was last updated;



- Clearly label any links;
- Comply with HIPAA requirements and all other State and federal statutory and regulatory privacy requirements when providing Dental Health Plan Enrollee eligibility or Dental Health Plan Enrollee identification on the website, including Provider portal(s); and
- Minimize download and wait times and avoid tools or techniques that require significant memory or special intervention.

#### 1.12.3.2 Website Content

The website shall include all pertinent information including, at least, the following:

- Provider Manual;
- Sample Provider Agreements;
- How to contact the Contractor and its Provider services department;
- Functionality to allow Providers to make inquiries and receive responses from the Contractor regarding care for Dental Health Plan Enrollees, including real-time eligibility information and electronic Prior Authorization request and approval;
- How to track the status of claims online;
- Grievances, Appeals and State Fair Hearing processes; and
- How to file Provider Complaints, including policies and procedures on Provider reconsiderations and appeals.

#### **1.12.4 Provider Manual**

##### 1.12.4.1 General Provider Manual Requirement

The Contractor shall develop, provide, and maintain a written Provider Manual for use by the Contractor's Participating Provider network. The Contractor shall issue a Provider Manual at time of provider application. The Provider Manual shall be made available electronically, and in hard copy format (upon Provider request), to all Participating Providers, without cost.

##### 1.12.4.2 Provider Manual Content

The Provider Manual shall include, at minimum, the following topics:

- Requirements for updating Participating Provider demographic data, including the process and timeframes for updating;
- Expectations for appointment access standards, by Provider type, as outlined in Section 1.11.4: "Time and Distance and Appointment Access Standards" of this Model Contract;
- Requirements for tracking and following-up on referrals for other services (e.g., specialist referrals);
- Benefits provided by the Contractor;
- Coordination of benefits with other Providers, any Subcontractors and OHCA's contractors;
- How and where to access any benefits provided by the State, including any Cost Sharing, and how transportation is provided;
- Prior Authorization, utilization management, second opinion and referral processes, which shall include the Contractor's mechanism to allow Dental Health Plan Enrollees to directly access a specialist as appropriate for a Dental Health Plan Enrollee's condition and identified needs;
- Medical necessity standards and Clinical Practice Guidelines;

- The extent to which, and how, after-hours and emergency coverage are provided;
- Any restrictions on the Dental Health Plan Enrollee's freedom of choice among Participating Providers;
- Cost Sharing and the Contractor's tracking systems for aggregate limits;
- Dental Health Plan Enrollee rights and responsibilities;
- Confidentiality and privacy requirements, including, but not limited to HIPAA, with which the Provider must comply;
- Provider rights for advising and advocating on behalf of Dental Health Plan Enrollees, including the right to file a Grievance or Appeal on behalf of a Dental Health Plan Enrollee as his or her Authorized Representative;
- Provider non-discrimination information;
- The process of selecting and changing the Dental Health Plan Enrollee's PCD Provider;
- Grievance, Appeal and State Fair Hearing procedures and timeframes;
- How to file Provider Complaints, including policies and procedures for filing Provider reconsiderations and appeals;
- How to access auxiliary aids and services, including additional information in alternative formats or languages for patients;
- The Contractor and State contact information, including addresses and phone numbers;
- Information on how to report any potential Fraud, Waste and Abuse;
- Information on how to report any potential cases of neglect, abuse and Exploitation of Dental Health Plan Enrollees;
- Critical Incident reporting;
- Policies and procedures for Third Party Liability and other collections;
- Protocols for Encounter Data reporting and records applicable to Providers for whom the Contractor reimburses via a capitated arrangement;
- Claims submission/filing protocols and standards;
- Payment policies;
- Credentialing/recredentialing information;
- Performance standards; and
- The Contractor's Quality Assessment and Performance Improvement (QAPI) program;

OHCA reserves the right to amend these requirements as necessary.

#### **1.12.5 Provider Education, Training and Technical Assistance**

The Contractor shall establish and maintain a Participating Provider training, education and technical assistance plan. The Contractor shall update the plan annually and shall submit the plan and updates to OHCA. The Contractor shall maintain a record of its training, education and technical assistance activities and shall make this information available to OHCA upon request.

#### 1.12.5.1 Training Frequency

The Contractor shall provide initial and ongoing, at a minimum semi-annual, education and training to its Participating Provider network. The Contractor shall provide trainings in varying geographic locations based on Participating Provider network concentration and need.

#### 1.12.5.2 Training Content

The Contractor shall provide the following information, at minimum, in Participating Provider trainings and educational materials and upon request of a Participating Provider:

- Conditions of participation with the Contractor;
- Participating Provider responsibilities to the Contractor and to Dental Health Plan Enrollees;
- Prior Authorization, utilization management, second opinion and referral processes, including the Contractor's mechanism to allow Dental Health Plan Enrollees to directly access a specialist as appropriate for a Dental Health Plan Enrollee's condition and identified needs;
- How to update the Participating Provider's demographic or facility information with the Contractor and under what timeline;
- Billing requirements, rate structures and amounts;
- Claims submission and dispute resolution processes;
- Encounter submission and encounter rejection remediation process for Providers for whom the Contractor reimburses via a capitated arrangement;
- Cultural and linguistic competency and resources, including AI/AN cultural competency;
- Critical Incident reporting requirements and timeframes;
- Credentialing and recredentialing processes;
- Grievance, Appeals and State Fair Hearing processes;
- Policies and procedures surrounding Provider Complaints;
- Information on how to report any potential cases of abuse, neglect and Exploitation of Dental Health Plan Enrollees;
- Information, as applicable, about the SoonerSelect Dental program and SoonerSelect Dental Provider responsibilities;
- The Contractor's Quality Assessment and Performance Improvement (QAPI) program; and
- Other training and education as required/requested by OHCA or any other State or federal agency.

#### 1.12.5.3 Provider Technical Assistance

The Contractor shall provide technical assistance to Participating Providers when determined necessary by the Contractor or OHCA or as requested by Participating Providers. Technical assistance includes, but is not limited to, in-person and telephonic one-on-one meetings. All technical assistance shall be provided in a culturally competent manner.

#### 1.12.5.4 State Sponsored Provider Outreach Activities

OHCA reserves the right to require that the Contractor coordinate with OHCA for state-sponsored Provider outreach activities.

### **1.12.6 Provider Complaint System**

A Participating or Non-Participating Provider who is not satisfied with the Contractor's policies and procedures or a decision made by the Contractor that does not impact the provision of services to Dental

Health Plan Enrollees may file a Provider Complaint. The Contractor shall have written policies and procedures, approved by OHCA, for receiving, tracking, dating, storing, responding to, reviewing, reporting and resolving Provider Complaints. The Contractor shall establish a Provider Complaint system to track the receipt and resolution of Provider Complaints, including requests for reconsideration or appeals, as detailed in Sections 1.12.6.1: “Provider Reconsiderations” and 1.12.6.2: “Provider Appeals” of this Model Contract, respectively. The Contractor shall:

- Have sufficient ability to receive Provider Complaints by telephone, in writing or in person;
- Have staff designated to receive, process and resolve Provider Complaints;
- Thoroughly investigate each Provider Complaint;
- Ensure an escalation process is in place;
- Furnish the Provider timely written notification of resolution or results; and
- Maintain a tracking system capable of generating reports to OHCA on Provider Complaint volume and resolution, in accordance with reporting requirements specified in Section 1.20: “Reporting.”

#### 1.12.6.1 Provider Reconsiderations

The Contractor shall operate a reconsiderations process whereby Providers may request the Contractor reconsider the decision the Contractor has made or intends to make that is adverse to the Provider. At minimum, this shall include reconsiderations of Program Integrity Provider audit findings and Provider Agreement termination. Such policies and procedures shall be provided in writing:

- In the Provider Manual detailed in Section 1.12.4: “Provider Manual” of this Model Contract;
- On the Contractor’s website detailed in Section 1.12.3: “Provider Website” of this Model Contract;
- At the time the Provider enters into a Provider Agreement or subcontract with the Contractor; and
- Upon Provider request.

The Contractor shall require the Provider to submit a request for reconsideration within the timeframe determined by OHCA. The Contractor shall resolve all requests for reconsideration within the OHCA-determined timeframe. The Contractor shall send a reconsideration resolution notice to the Provider within the timeframe determined by OHCA and including the following, at minimum:

- The date of the notice;
- The action the Contractor has made or intends to make;
- The reasons for the action;
- The date the action was made or will be made;
- If the action is based upon a statute, regulation, policy or procedure, the Contractor shall provide the statute, regulation, policy or procedure supporting the action;
- An explanation of the Provider’s ability to submit an appeal request to the Contractor within 30 Calendar Days of the date of the notice;
- The address and contact information for submission of an appeal;
- The procedures by which the Provider may request an appeal regarding the Contractor’s action;
- The specific change in federal or state law that requires the action, if applicable;
- The Provider’s ability to submit a State Fair Hearing request following completion of the Provider appeal process, or, in cases of an action based on a change in law, the circumstances under which a State Fair Hearing will be granted; and

- Any other information required by Oklahoma statute or regulation, if applicable.

#### 1.12.6.2 Provider Appeals

The Contractor shall implement and operate a system for Provider appeals of the Contractor's audit findings related to Program Integrity efforts and for cause and immediate Provider Agreement termination.

The Contractor shall operate a process whereby Providers may appeal a decision the Contractor has made or intends to make that is adverse to the Provider. Such policies and procedures shall be provided in writing:

- In the Provider Manual detailed in Section 1.12.4: "Provider Manual" of this Model Contract;
- On the Contractor's website detailed in Section 1.12.3: "Provider Website" of this Model Contract;
- At the time the Provider enters into a Provider Agreement or subcontract with the Contractor; and
- Upon Provider request.

The Contractor shall require the Provider to submit an appeal request in writing within the timeframe determined by OHCA. The Contractor shall resolve all appeals within the OHCA-determined timeframe. The Contractor shall send an appeal resolution notice to the Provider within the timeframe determined by OHCA and including the following, at minimum:

- The date of the notice of appeal resolution;
- The results of the resolution process;
- The date of the appeal resolution; and
- For decisions not wholly in the Provider's favor:
  - An explanation of the Provider's ability to request a State Fair Hearing following receipt of the Contractor's notice of appeal resolution;
  - How to request a State Fair Hearing;
  - An explanation that any request for a State Fair Hearing must be requested within 30 Calendar Days of the notice of appeal resolution;
  - The address and contact information for submission of the State fair hearing request;
  - Details on the right to be represented by counsel at the State Fair Hearing;
  - The ability to submit a State Fair Hearing request following completion of the Contractor's Provider appeal process, or, in cases of an action based on a change in law, the circumstances under which a State Fair Hearing will be granted; and
  - Any other information required by Oklahoma statute or regulation, if applicable.

The Contractor shall furnish a litigation summary to OHCA including all information to be specified by OHCA within 15 Calendar Days of a Provider's request for a State Fair Hearing.

### **1.13 Provider Payment**

#### **1.13.1 Provider Payment Rates**

##### 1.13.1.1 Participating Provider Payment

The Contractor shall ensure that rates for Participating Providers are reasonable to ensure Dental Health Plan Enrollee access to services, specified at Section 1.11.4: "Time and Distance and Appointment Access Standards" of this Model Contract, and that they comply with all State and federal provisions regarding

rate setting. The Contractor may adopt the current SoonerCare fee schedule in the absence of a separate payment rate and methodology negotiated with a Participating Provider.

The Contractor shall adhere to State and federal requirements pertaining to payments of specific Provider types as described in Sections 2.13.1.4 through 2.13.1.9 of this Model Contract.

The Contractor's Provider rate setting in the aggregate must align with the provisions of Section 1.21.2: "Performance-Based Contracting" of this Model Contract.

1.13.1.2 Payment to Non-Participating Provider

If the Contractor is unable to provide covered services to a Dental Health Plan Enrollee within the Contractor's network of Participating Providers, the Contractor must adequately and timely arrange for the provision of these services by Non-Participating Providers, in accordance with 42 C.F.R. § 438.206(b)(4). Pursuant to 42 C.F.R. § 438.206(b)(5), the Contractor shall ensure that, if applicable, the cost to the Dental Health Plan Enrollee is no greater than it would have been if the services were furnished by a Participating Provider. Except as otherwise precluded by law and/or specified for IHCPs, FQHCs, and RHCs, the Contractor shall reimburse Non-Participating Providers for covered services provided to SoonerSelect Dental program Health Plan Enrollees at a maximum of 95% of the current Medicaid fee schedule/payment rate, unless the Contractor and the Non-Participating Provider agree to a different reimbursement amount.

1.13.1.3 Balance Billing

In accordance with § 1932(b)(6) of the Act and 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2), the Contractor shall ensure that a Dental Health Plan Enrollee is held harmless by the Provider for the costs of covered services except for any applicable Copayment amount allowed by OHCA. The Contractor shall ensure no balance billing by Providers, referral Providers and Subcontractors to any SoonerSelect Dental program Health Plan Enrollees for services covered under this Model Contract.

1.13.1.4 Payment for Emergency Services

The Contractor shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services is a Participating or Non-Participating Provider, in accordance with federal requirements at § 1932(b)(2) of the Act and 42 C.F.R. § 438.114(c)(1)(i). In accordance with § 1932(b)(2)(D) of the Act, the Contractor shall pay Non-Participating Providers for Emergency Services no more than the amount that would have been paid by OHCA under FFS.

1.13.1.5 Payments to IHCPs

The Contractor shall reimburse IHCPs in accordance with the requirements of Section 1.14.4.3: "Payments to IHCPs" of this Model Contract.

1.13.1.6 Payments to FQHCs and RHCs

Notwithstanding the provisions of Section 1.13.1.1: "Participating Provider Payment," the Contractor shall provide payment for the provision of covered services provided by Participating FQHC and RHC Providers at the Prospective Payment System (PPS) Rate and methodology as employed by OHCA for Eligibles not enrolled in the SoonerSelect Dental program, unless a separate payment rate and methodology is negotiated between the Contractor and the Participating Provider and is approved by OHCA. The Contractor's payment to a Participating FQHC or RHC shall not be less than the level and amount of payment which the Contractor would make for the services if the services were furnished by a Participating Provider that is not a FQHC or RHC, in accordance with § 1903(m)(2)(A)(ix) of the Act.

#### 1.13.1.7 Performance-Based Provider Payments

Performance-based payment arrangements between the Contractor and its network of Participating Providers are essential to advancing SoonerSelect Dental program quality and outcome objectives. The Contractor shall develop and implement performance-based payments that:

- Include mechanisms to advance and encourage both high-quality care and cost savings and that are appropriate to the different components of the Contractor's network; and
- Include, but are not limited to, PCD Providers and other Dental Specialty Providers.

The Contractor's performance-based payments may be made using any combination of the following models:

- Bundled payments, in which the Contractor reimburses Participating Providers for a set of services related to a procedure or health condition rather than for each service separately;
- Pay-for-performance, in which Participating Providers are rewarded for meeting quality or outcome goals, including with respect to service accessibility, service utilization, clinical outcomes, Dental Health Plan Enrollee/patient satisfaction and/or cost of care;
- Payment penalties, for failure to meet quality or outcomes goals, Participating Provider deviation from evidence-based practice standards or when Participating Provider care is connected to sub-standard outcomes such as certain health care acquired conditions;
- Shared savings, in which the Contractor sets a cost target and Participating Providers share in savings of avoided costs if the Contractor meets or exceeds the target(s);
- Shared savings and shared risk, in which the Participating Provider also is put at financial risk if costs exceed the defined target threshold;
- Global capitation in which the Contractor gives a Participating Provider, provider group or health system a single per-patient payment with the intention that the Participating Provider or health system will provide all necessary services to that patient during the Contract period; and/or
- Other models that conform to the objectives and standards of this Section of the Contract.

OHCA reserves the right to develop state-required components the Contractor must implement in its performance-based payment arrangements, such as the following:

- Targeted outcome goals;
- Targeted health conditions; and
- Other components OHCA determines necessary to further the goal of high-quality care or cost savings.

In accordance with 42 C.F.R. § 438.3(i) and Section 1903(m)(2)(A)(x) of the Act, such performance-based payment arrangements, as applicable, must meet the physician incentive plan requirements of 42 C.F.R. §§ 422.208 and 422.210, including:

- The Contractor shall not make a payment, directly or indirectly, to a Participating Provider as an inducement to reduce or limit covered services furnished to a Dental Health Plan Enrollee; and
- If the Contractor's performance-based payment arrangement puts a physician/physician group at substantial financial risk, as determined at 42 C.F.R. § 422.208(d), for services not provided by the physician/physician group, the Contractor must ensure that the physician/physician group has adequate stop-loss protection.

By year three of this Contract, at least 80% of the Contractor's payments to Participating Providers, shall be to Participating Providers whose Provider Agreement includes a performance-based component. The 80% threshold will be calculated using a numerator consisting of total payments to these Participating Providers (performance-based and other) and a denominator consisting of all Participating Provider payments. FQHC and RHC Provider payments, will be excluded from the calculation.

The Contractor shall submit an annual Performance-Based Payment Plan to OHCA in a format and on a schedule to be defined by OHCA. The Performance-Based Payment Plan shall detail the Contractor's strategy and good faith efforts for reaching the 80% target in the third year of this Contract, including specifying the Contractor's intermediate targets in year one and year two of this Contract. The Performance-Based Payment Plan also shall describe the Contractor's methodology or methodologies by type of Participating Provider. The Performance-Based Payment Plan shall be submitted to OHCA for review and approval by OHCA prior to implementation. The Contractor shall submit performance-based payment reports on a quarterly basis to OHCA in a format defined by OHCA and detailing the specific payments for that quarter.

### **1.13.2 Prohibited Payments**

#### **1.13.2.1 Overpayments**

The Contractor shall report Overpayments to OHCA and recover Overpayments the Contractor identifies from its Participating Providers as specified in Section 1.17.6: "Reporting Overpayments" of this Model Contract.

#### **1.13.2.2 Suspension of Payments**

The Contractor shall suspend payments to a Participating Provider for which the State determines there is a credible allegation of Fraud in accordance with Section 1.17.7: "Suspension of Payments for Credible Allegation of Fraud" of this Model Contract and in accordance with 42 C.F.R. § 455.23.

#### **1.13.2.3 Providers Ineligible for Payment**

The Contractor shall ensure that no payments using Medicaid funds are made for services or items as provided in Section 1.17.10: "Prohibited Affiliations and Exclusions" of this Model Contract.

#### **1.13.2.4 Provider-Preventable Conditions**

In accordance with 42 C.F.R. §§ 438.3(g), 434.6(a)(12)(i) and 447.26(b), the Contractor shall not make any payment to a Provider for Provider-preventable Conditions as defined at 42 C.F.R. § 447.26(b). Provider-preventable Conditions for which payment shall not be made include:

- Conditions meeting the following criteria:
  - Is identified in the State Plan;
  - Has been found by OHCA, based upon review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
  - Has a negative consequence for the Dental Health Plan Enrollee;
  - Is auditable; and
  - Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient.



### **1.13.3 Payment Assurance**

Pursuant to 42 C.F.R. § 438.60, OHCA ensures that no payment is made to a Participating Provider other than by the Contractor for services covered under this Contract, except when these payments are specifically required to be made by the State in Title XIX of the Act, Title 42 of the C.F.R., or when OHCA makes direct payments to Participating Providers for graduate medical education costs approved under the Medicaid State Plan. OHCA reserves the right to review any and all Contractor policies and procedures to ensure compliance with this assurance.

### **1.13.4 Claims Processing**

#### 1.13.4.1 Claims Processing System and Methodology

The Contractor shall maintain a claims payment system capable of processing and paying claims in an accurate and timely manner and in full compliance with all State and federal law, including but not limited to HIPAA requirements. The Contractor's claim processing system shall comport with all the information exchange provisions outlined in Section 1.18: "Information Technology" of this Model Contract.

The Contractor shall ensure that either Provider claims submissions or checks/warrants payable be printed, in boldface type, with the language specified in 42 C.F.R. § 455.18 or 42 C.F.R. § 455.19, respectively.

This system shall store claim information in accordance with the record retention requirements at Section 1.1.14: "Inspection and Audit Rights" of this Model Contract. At a minimum, these records shall include:

- The identity of the Provider submitting the claim;
- Date stamp of day received;
- Type of claim;
- Amount billed;
- All adjustments;
- Dates of all relevant action taken on the claim, including payment and denial;
- Amount paid;
- Service code;
- Provider involved in claim, including ordering, referring and rendering;
- Service location;
- Application of coordination of benefits and subrogation of claims; and
- Information on the units of service rendered so that OHCA may collect information for the purposes of utilization management.

The claims processing system used by the Contractor shall be equipped to receive and adjudicate claims submitted electronically and by mail, within a timeframe established by OHCA. The Contractor shall ensure that the electronic claims submission process is usable with a standard internet connection. Providers must be able to track the status of submitted claims online and contact a representative of the Contractor for resolution of claims questions.

The Contractor's and Subcontractors' payment cycle for newly submitted claims shall run at least weekly, on the same day each week, as determined by the Contractor and approved in writing by OHCA.

The claims processing system shall be equipped with system edits for the following, at minimum:

- Confirming Dental Health Plan Enrollee eligibility as claims are submitted on the basis of the eligibility information provided by OHCA applicable to the period in which the charges on the claim were incurred;
- Ensuring that claims are only paid if received from Providers that are eligible to render the services for which the claim was submitted;
- Reviewing for Third Party Liability and reducing claims payment based on payments by a third party for any part of a service;
- Reviewing for duplicate claims and flagging possible duplicate claims for further review or denial;
- Reviewing for PA requirement, and, if applicable to the service(s) for which the claim is submitted, PA approval;
- Reviewing for medical necessity, including that services are appropriate in amount, duration and scope;
- Verifying that the service is a covered service under this Contract and is eligible for payment;
- Ensuring that Dental Health Plan Enrollee benefit limits are factored into the claim adjudication and payment determination;
- Ensuring that the date(s) of service on the claim are valid, including, but not limited to:
  - Date(s) are not in the future; and
  - Date of admission is earlier than date of discharge;
- Identifying missing, invalid, or mismatched Provider NPIs, and/or TINs/EINs.

OHCA reserves the right to add additional minimum required system edits at its discretion.

Each financial adjustment to each claim shall be recorded, including Third Party Liability adjustments, interest and Copayments.

The Contractor's claims processing system shall track the error rates in claims and Encounter Data received from the Provider or a third party prior to a claim or encounter being adjudicated and submitted to OHCA.

#### 1.13.4.2 Timely Claims Filing and Processing

##### 1.13.4.2.1 Timely Claims Filing Requirements

The Contractor shall adjudicate Provider claims in accordance with timely filing limits specified in OAC 317:30-3-11. The Contractor shall require the Provider to submit all claims within six months from the date of service. The Contractor shall require claims to be resubmitted, when applicable, within an additional six months from the date of service. The only exceptions to the resubmission deadline are the following:

- Administrative correction or action by the Contractor taken to resolve a dispute;
- Reversal of eligibility determination;
- Investigation for Fraud or Abuse of the Provider; or
- Court order or hearing decision.

#### 1.13.4.2.2 Timely Payment Requirements

OHCA has set the following timely payment requirements, which have been developed in accordance with the requirements at 42 C.F.R. §§ 447.45(d)(2)-(3) and 447.46 and §§ 1902(a)(37)(A) and 1932(f) of the Act. The Contractor shall observe the following requirements in adjudicating Clean Claims:

- Ensure that 90% of Clean Claims received from all Providers are paid within 14 days of receipt; and
- Ensure that 99% of Clean Claims received from all Providers are paid within 90 days of receipt.

In accordance with 42 C.F.R. § 447.45(d), all claims shall be paid within 12 months of date of receipt by the Contractor, except in the following cases:

- The time limitation does not apply to retroactive adjustments paid to Providers who are reimbursed under a retrospective payment system, as defined in 42 C.F.R. § 447.272;
- The time limitation does not apply to claims from Providers under investigation for Fraud and Abuse; and
- The Contractor may make payments at any time in accordance with a court order, to carry out hearing decisions or OHCA/Contractor corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action or court order to others in the same situation as those directly affected by it.

The Contractor shall develop policies and procedures governing the processing of claims. At minimum, these policies and procedures should cover the format in which claims are to be submitted, the speed with which the Participating Provider or Subcontractor can expect them to be processed and compliance with State and federal law.

The Contractor shall pay its Participating Providers and Subcontractors consistent with Section 1902(a)(37)(A) of the Act.

#### 1.13.4.2.3 Date of Receipt and Date of Payment

The following definitions shall apply for the purpose of determining timely payment of Clean Claims in accordance with §§ 1902(a)(37)(A) and 1932(f) of the Act:

- In accordance with 42 C.F.R. §§ 447.45(d)(5) and 447.46(c)(1), the date of receipt, for purposes of Section 1.13.4.2: “Timely Claims Filing and Processing” of this Model Contract, shall be the date the Contractor received the claim as indicated by its date stamp on the claim.
- In accordance with 42 C.F.R. §§ 447.45(d)(6) and 447.46(c)(1), the date of payment, for purposes of Section 1.13.4.2: “Timely Claims Filing and Processing” of this Model Contract, shall be considered to be the date of the check or other method of payment to the Provider from the Contractor.

#### 1.13.4.2.4 Interest Payment for Delayed Adjudication of Clean Claims

The Contractor shall pay a monthly interest rate of 1.5 percent on all Clean Claims that are not adjudicated within 45 days of receipt by the Contractor, in accordance with 62 O.S. 34.72. This interest rate shall be prorated on a daily basis.

#### 1.13.4.2.5 Treatment of Unclean Claims

If the Contractor receives a claim submission that does not include all the necessary documentation or information to be determined a Clean Claim in order to pay the claim, resulting in a denial or partial denial of the claim, the Contractor may notify the Provider who submitted the claim in writing within seven days of receipt and explain what further documentation is needed for the Contractor to adjudicate the claim. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

#### 1.13.4.2.6 Claim Corrections and Resubmissions

Any corrections or resubmissions of existing, paid claims shall be submitted as adjustments to the existing claim.

#### 1.13.4.3 Claims Format

The Contractor shall accept HIPAA-compliant formats for electronic claims submission. The Contractor shall comply with the following standardized paper billing forms and formats, and any updates thereto:

- Professional claims: CMS 1500 claim form
- Institutional claims: CMS 1450/UB04

The Contractor shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms. These shall include, but not be limited to, HIPAA-based standards and federally required safeguard requirements.

#### 1.13.4.4 Remittance Advice

The Contractor shall send a remittance advice with the claim payment unless payment is executed electronically. If the payment is electronic, the Contractor shall send the remittance advice the same day either electronically in 835 format or via download on the Provider portal.

#### 1.13.4.5 Claims Inquiries and Disputes

The Contractor shall develop policies and procedures governing claims inquiries and disputes. The claims dispute resolution process developed by the Contractor shall include at least two levels for Providers to dispute the nature of medical necessity, with the second level including review by a medical professional with the same or similar specialty to the medical area that is the topic of the dispute. The Contractor shall systematically capture the status and resolution of all claim disputes, as well as all associated documentation.

### **1.14 American Indian/Alaska Native Population and Indian Health Care Providers**

OHCA is committed to preserving the protections afforded to AI/AN Dental Health Plan Enrollees under federal law, while expanding access to person/family-centered care coordination. OHCA is also committed to preventing disruption in payments to Indian Health Care Providers (IHCPs), while encouraging opportunities for creative partnerships between the Contractor and IHCP community.

OHCA and the Contractor will pursue these objectives and maintain open communication with AI/AN stakeholders through the processes outlined in this section and in compliance with the State Plan.

#### **1.14.1 Tribal Government Liaison**

As a part of Key Staff, the Contractor shall employ a full-time Tribal Government Liaison (as described in Section 1.3.6.2) to conduct outreach to the AI/AN community and to serve as a resource for Dental Health Plan Enrollees and Providers with questions or issues. The Tribal Government Liaison will develop policy

and lead tribal consultation with Oklahoma’s tribal governments and tribal health care Providers in Oklahoma. The Contractor shall develop an outreach plan for OHCA’s review and approval for submission during the Readiness Review. The Tribal Government Liaison will also be responsible for communicating with and advising Contractor’s Key Staff on topics regarding issues and concerns raised by IHCPs and AI/AN Dental Health Plan Enrollees including but not limited to reimbursement, claims payments, access to care, and enrollment, etc. The Tribal Government Liaison will also coordinate cultural competency trainings for Contractor’s staff.

#### **1.14.2 OHCA Tribal Government Relations Unit**

OHCA Tribal Government Relations unit acts as an AI/AN liaison between OHCA and CMS, Indian Health Service, Urban Indian facilities and Indian Tribes of Oklahoma for State and national level issues, including (without implied limitation) AI/AN work groups, policy development and compliance, tribal consultation, payment issues and elimination of health disparities. The Contractor’s Tribal Government Liaison shall serve as a single point-of-contact for OHCA Tribal Government Relations Unit and shall attend tribal consultative meetings held by OHCA.

#### **1.14.3 AI/AN Dental Health Plan Enrollees**

##### 1.14.3.1 Enrollment and Disenrollment

OHCA or its designee will provide Choice Counseling and OHCA’s enrollment materials will advise eligible AI/AN Dental Health Plan Enrollees that they have the option to enroll in the SoonerSelect Dental program. Dental Health Plan Enrollees who opt-in will be subject to the enrollment provisions specified in Section 1.5: “Enrollment and Disenrollment” of this Model Contract, except that AI/AN Dental Health Plan Enrollees may disenroll from the SoonerSelect Dental program without cause. If an AI/AN Eligible elects not to enroll or enrolls and then chooses to disenroll from the SoonerSelect Dental program, the AI/AN Eligible shall have a new opportunity to enroll at the next Open Enrollment Period.

##### 1.14.3.2 IHCP as Primary Care Dentist

In accordance with 42 C.F.R. § 438.14(b)(3), unless the Contractor is an Indian Managed Care Entity, the Contractor shall permit AI/AN Dental Health Plan Enrollees to receive services from an IHCP primary care dentist who is a Participating Provider and to choose that IHCP as the Dental Health Plan Enrollee’s PCD, as long as that Provider has capacity to provide the services.

##### 1.14.3.3 Access to Out-of-Network IHCPs and Referrals under Purchase and Referred Care

Pursuant to 42 C.F.R. § 438.14(b)(4), the Contractor shall permit AI/AN Dental Health Plan Enrollees to obtain services covered under the Contract from out-of-network IHCPs from whom the Dental Health Plan Enrollee is otherwise eligible to receive such services. This includes services furnished by an out-of-network IHCP or through referral under purchase and referred care. In accordance with 42 C.F.R. § 438.14(b)(6), the Contractor shall also permit an out-of-network IHCP to refer an AI/AN Dental Health Plan Enrollee to a Participating Provider.

##### 1.14.3.4 Dental Health Plan Enrollee Cost Sharing

AI/AN Dental Health Plan Enrollees are exempt from Cost Sharing in accordance with the requirements of Section 1.16.2: “Cost Sharing Exempt Populations” of this Model Contract.

#### 1.14.4 Indian Healthcare Providers (IHCPs)

##### 1.14.4.1 Sufficient IHCP Participation

In accordance with 42 C.F.R. § 438.14(b)(1), the Contractor shall demonstrate there are sufficient IHCPs participating in the Contractor's network to ensure timely access to services available under the Contract from such Providers for AI/AN Dental Health Plan Enrollees who are eligible to receive services. The Contractor shall provide OHCA with network accessibility reports that are specific to its AI/AN Dental Health Plan Enrollees and IHCP network, in accordance with Reporting Manual requirements.

##### 1.14.4.2 Timely Access to IHCPs

If timely access to covered services cannot be ensured due to few or no IHCPs in the State, the Contractor will be considered to have met the IHCP network requirement if AI/AN Dental Health Plan Enrollees are permitted by the Contractor to access out-of-state contracted IHCPs.

This circumstance shall also be deemed to be good cause for disenrollment from both the Contractor and the SoonerSelect Dental program in accordance with 42 C.F.R. § 438.56(c).

##### 1.14.4.3 Payments to IHCPs

All Contractor payments to IHCPs shall be made in accordance with 42 C.F.R. § 438.14. OHCA will reimburse for services that are eligible for 100% federal reimbursement and are provided by an IHS or 638 tribal facility to AI/AN Dental Health Plan Enrollees who are eligible to receive services through an IHS or 638 tribal facility. Encounters for SoonerCare services billed by IHS or 638 tribal facilities and eligible for 100% federal reimbursement will not be accepted by OHCA or considered in capitation rate development. ~~The Contractor shall make payment to IHCPs for covered services not eligible for 100% federal reimbursement and provided to Dental Health Plan Enrollees who are eligible to receive services through the IHCP regardless of whether the IHCP is a Participating Provider. The Contractor may negotiate a rate for the services provided by an IHCP or, in the absence of a negotiated rate, the Contractor shall reimburse the IHCP for its services at a rate not less than the level and amount the Contractor would pay to the same type of Participating Provider that is not an IHCP.~~

~~The Contractor shall make payment to IHCPs for covered pay for all services not eligible for 100% federal reimbursement and provided to Health Plan Enrollees who are eligible to receive services through the IHCP, regardless of whether the IHCP is a Participating Provider, to all Non-Participating IHCPs enrolled in SoonerCare as an FQHC an amount equal to the amount the Contractor would pay a network FQHC that is not an IHCP, as further described in Section 1.14.1.6: "Payments to FQHCs and RHCs" of this Model Contract, including any supplemental payment from OHCA to make up the difference between the amount the Contractor pays and what the IHCP FQHC would have received under fee-for-service at the applicable encounter rate published annually in the Federal Register by the Indian Health Service (IHS). In the absence of a published encounter rate, the Contractor shall pay, at minimum, the amount the IHCP would receive if the services were provided under the State Plan fee-for-service methodology. In the event the amount the IHCP receives from the Contractor is less than the amount the IHCP would have received under fee-for-service or the applicable encounter rate published annually in the Federal Register by the IHS, the Contractor shall make an additional payment to the IHCP to make up the difference between the amount the Contractor pays and the amount the IHCP would have received under fee-for-service or the applicable encounter rate.~~

~~The Contractor shall pay for all services not eligible for 100% federal reimbursement to an IHCP that is not enrolled in SoonerCare as an FQHC, regardless of network status with the Contractor, at minimum, at the applicable encounter rate published annually in the Federal Register by the Indian Health Service (IHS). In the absence of a published encounter rate, the Contractor shall pay, at minimum, the amount the IHCP would receive if the services were provided under the State Plan fee-for-service methodology. In the event the amount the IHCP receives from the Contractor is less than the amount~~

~~the IHCP would have received under fee-for-service or the applicable encounter rate published annually in the Federal Register by the IHS, the Contractor shall make a supplemental payment to the IHCP to make up the difference between the amount the Contractor pays and the amount the IHCP would have received under fee-for-service or the applicable encounter rate.~~

The Contractor shall timely pay all I/T/U Participating Providers in accordance with the requirements of Section 1.13.4.2: “Timely Claims Filing and Processing” of this Model Contract.

In accordance with CMS State Health Official Letter #16-002, IHS/Tribal facilities may enter into care coordination agreements with non-IHS/Tribal Providers to furnish certain services for AI/AN Eligibles and Health Plan Enrollees and such services are eligible for 100% federal funding. The Contractor shall provide reporting in the timeframe and format required by OHCA to facilitate the state’s collection of 100% federal funding for these services. The Contractor shall also facilitate the development of care coordination agreements between IHCP and other non-IHS/Tribal Providers as necessary to support the provision of services for AI/AN Dental Health Plan Enrollees.

### **1.14.5 Indian Managed Care Entity**

Pursuant to 42 C.F.R. § 438.14(d), an IMCE may restrict its enrollment to AI/ANs in the same manner as Indian Health Programs may restrict the delivery of services to AI/ANs, without being in violation of the requirements in 42 C.F.R. § 438.3(d).

## **1.15 Dental Health Plan Enrollee Grievances and Appeals**

### **1.15.1 General Requirements**

#### 1.15.1.1 Dental Health Plan Enrollee Grievances and Appeals System

In accordance with 42 C.F.R. §§ 438.402 and 438.228(a), the Contractor shall operate a Dental Health Plan Enrollee Grievances and Appeals System to handle Appeals of an Adverse Benefit Determination and Grievances, as well as the processes to collect and track information about them. The Dental Health Plan Enrollee Grievances and Appeals System shall comply with the requirements in all applicable State and federal laws, regulations and guidance. In accordance with the requirements of 42 C.F.R. § 438.402, the Contractor's Grievances and Appeals System shall:

- Have only one level of Appeal for Dental Health Plan Enrollees;
- Allow a Dental Health Plan Enrollee to file a Grievance and request an Appeal with the Contractor, with the ability for the Dental Health Plan Enrollee to request a State Fair Hearing after receiving notice pursuant to 42 C.F.R. § 438.408, and Section 1.15.2: "Adverse Benefit Determinations" of this Model Contract, that the Adverse Benefit Determination is upheld;
- Allow a Dental Health Plan Enrollee to file a Grievance with the Contractor, either orally or in writing, at any time;
- Provide that a Dental Health Plan Enrollee, upon receiving notice of an Adverse Benefit Determination, shall have 60 Calendar Days from the date on an Adverse Benefit Determination notice in which to file a request for an Appeal to the Contractor, which may be filed either orally or in writing;
- Unless the Dental Health Plan Enrollee is requesting an expedited resolution, as described in Section 1.15.4: "Appeals" of this Model Contract, require an oral request for an Appeal to the Contractor to be followed by a written, signed request for an Appeal, with the filing date being the date that the oral request for Appeal was made.

As provided under State law and 42 C.F.R. § 438.402(c)(2)(ii), the Contractor and OHCA shall allow a Provider or an Authorized Representative to request an Appeal, file a Grievance, or request a State Fair Hearing, on behalf of a Dental Health Plan Enrollee with the written consent of the Dental Health Plan Enrollee. When the term "Dental Health Plan Enrollee" is used throughout Section 1.15: "Dental Health



Plan Enrollee Grievances and Appeals” of this Model Contract, it includes Authorized Representatives, and Providers designated as Authorized Representatives for the sole purpose of pursuing Appeals or Grievances on behalf of Dental Health Plan Enrollees. However, Providers shall not be allowed to request continuation of benefits as specified in 42 § 438.420(b)(5) and Section 1.15.6: “Continuation of Benefits Pending Appeal and State Fair Hearing” of this Model Contract.

The Contractor shall maintain written policies and procedures on its Dental Health Plan Enrollee Grievances and Appeals System that shall be approved by OHCA in writing prior to implementation during the Readiness Review.

#### 1.15.1.2 Information about Grievance and Appeals System

The Contractor shall provide information about the Grievances and Appeals System and State Fair Hearing procedures and timeframes to Dental Health Plan Enrollees, Providers and Subcontractors consistent with all applicable State and federal law, regulation and guidance.

##### 1.15.1.2.1 Information to Providers and Subcontractors

In accordance with 42 C.F.R. §§ 438.414 and 438.10(g)(2)(xi) the Contractor shall provide the following information on the following, at minimum, to all Providers and Subcontractors at the time they enter into a contract or Provider Agreement with the Contractor:

- Dental Health Plan Enrollee Grievance, Appeal, and State Fair hearing procedures and timeframes as specified in 42 C.F.R. §§ 438.400 - 438.424 and described in Section 2.15 of this Contract;
- The Dental Health Plan Enrollee’s right to file Grievances and Appeals and the requirements and timeframes for filing;
- The availability of assistance to the Dental Health Plan Enrollee with filing Grievances and Appeals;
- The Dental Health Plan Enrollee's right to request a State Fair Hearing after the Contractor has made a determination on a Dental Health Plan Enrollee’s Appeal which is adverse to the Dental Health Plan Enrollee; and
- The Dental Health Plan Enrollee’s right to request continuation of benefits, as described in Section 1.15.6: “Continuation of Benefits Pending Appeal and State Fair Hearing” of this Model Contract, that the Contractor seeks to reduce or terminate during an Appeal or State Fair Hearing filing, if filed within allowable timeframes, although the Dental Health Plan Enrollee may be liable for the cost of any continued benefits while the Appeal or State Fair Hearing is pending if the final decision upholds the Contractor’s determination that is adverse to the Dental Health Plan Enrollee.

At minimum, the Contractor shall include this information in:

- Provider and Subcontractor contracts with the Contractor;
- The Contractor’s Provider Manual;
- Applicable Provider and Subcontractor training materials; and
- Any other materials as required by State or federal law, regulation and guidance.

##### 1.15.1.2.2 Information to Dental Health Plan Enrollees

In accordance with 42 C.F.R. §438.10(g)(2)(xi), the Contractor’s Dental Health Plan Enrollee Handbook shall include Grievance, Appeal and State Fair Hearing procedures and timeframes, consistent with 42 C.F.R. subpart F, in an OHCA-developed description. At minimum, this information shall include:

- Dental Health Plan Enrollee Grievance, Appeal, and State Fair hearing procedures and timeframes as specified in 42 C.F.R. §§ 438.400 - 438.424 and in Section 1.15 of this Model Contract;
- The Dental Health Plan Enrollee's right to file Grievances and Appeals and the requirements and timeframes for filing;
- The availability of assistance to the Dental Health Plan Enrollee with filing Grievances and Appeals;
- The Dental Health Plan Enrollee's right to request a State Fair Hearing after the Contractor has made a determination on a Dental Health Plan Enrollee's Appeal which is adverse to the Dental Health Plan Enrollee; and
- The Dental Health Plan Enrollee's right to request continuation of benefits, as described in Section 1.15.6: "Continuation of Benefits Pending Appeal and State Fair Hearing" of this Model Contract, that the Contractor seeks to reduce or terminate during an Appeal or State Fair Hearing filing, if filed within allowable timeframes, although the Dental Health Plan Enrollee may be liable for the cost of any continued benefits while the Appeal or State Fair Hearing is pending if the final decision upholds the Contractor's determination that is adverse to the Dental Health Plan Enrollee.

At a minimum, the Contractor shall include this information in:

- Applicable Dental Health Plan Enrollee written notifications;
- The Contractor's Dental Health Plan Enrollee Handbook; and
- Any other materials as required by State or federal law, regulation and guidance.

#### 1.15.1.3 Expedited Review Process

In accordance with 42 C.F.R. 438.410(a), the Contractor shall establish and maintain an expedited review process for Appeals, for cases in which the Contractor determines, or when the Provider as the Dental Health Plan Enrollee's Authorized Representative indicates that taking the time for a standard resolution could seriously jeopardize the Dental Health Plan Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

#### 1.15.1.4 Reasonable Assistance to Dental Health Plan Enrollees

In accordance with 42 C.F.R. § 438.406(a), the Contractor's Grievance and Appeal System shall include provision of reasonable assistance to Dental Health Plan Enrollees in completing Grievance or Appeals forms and taking other procedural steps related to the Grievance or Appeal. The Contractor's reasonable assistance to the Dental Health Plan Enrollee shall include, at minimum:

- Availability of Dental Health Plan Enrollee Care Support Staff;
- Auxiliary aids and services upon request, such as providing interpreter services; and
- Toll-free numbers that have adequate TTY/TDD and interpreter capability.

#### 1.15.1.5 Availability of Alternative Formats

The Contractor shall ensure that all notices related to Grievances and Appeals are available in the prevalent non-English languages required under Section 1.10.1.1: "Prevalent Non-English Languages" of this Model Contract. Pursuant to 42 C.F.R. § 438.10(d)(3), the Contractor shall ensure that the notices are available in alternative formats for persons with special needs, with auxiliary aids and services made available upon request at no cost.

1.15.1.6 Receipt of Grievances and Appeals

The Contractor shall acknowledge receipt of each Grievance and Appeal of an Adverse Benefit Determination, in accordance with 42 C.F.R. § 438.406(b)(1). The process and timeframe by which the Contractor shall meet this requirement shall be determined by OHCA.

1.15.1.7 Decision Makers on Grievances or Appeals

In accordance with 42 C.F.R. § 438.406(b)(2), the Contractor shall:

- Ensure that any individuals making a decision on a Dental Health Plan Enrollee Grievance or Appeal were not involved in, nor a subordinate of any individual involved in, any previous level of review or decision-making; and
- Ensure that any individual making a decision on a Dental Health Plan Enrollee Grievance or Appeal of an Adverse Benefit Determination are individuals with appropriate clinical expertise, as determined by OHCA, in treating the Dental Health Plan Enrollee's condition or disease when the decision involves the following:
  - An Appeal of a denial that is based on lack of Medical Necessity;
  - A Grievance regarding denial of expedited resolution of an Appeal; or
  - A Grievance or Appeal that involves clinical issues.

The Contractor's decision makers on Dental Health Plan Enrollee Grievances or Appeals shall, in accordance with 42 C.F.R. § 438.406(b)(2)(iii), take into account all comments, documents, records and other information submitted by the Dental Health Plan Enrollee or the Dental Health Plan Enrollee's Authorized Representative without regard to whether such information was submitted or considered by the Contractor in the initial Adverse Benefit Determination.

1.15.1.8 Presentation of Evidence

The Contractor shall, in accordance with 42 C.F.R. § 438.406(b)(4), provide Dental Health Plan Enrollees a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor must inform the Dental Health Plan Enrollee of the limited time available for this sufficiently in advance of the resolution timeframes at 42 C.F.R. § 438.408(b)-(c) for Appeals and expedited Appeals.

1.15.1.9 Access to Dental Health Plan Enrollee Case Files

The Contractor shall, in accordance with 42 C.F.R. § 438.406(b)(5), provide Dental Health Plan Enrollees and/or Authorized Representative's the Dental Health Plan Enrollee's Case File, including all medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor, or at the Contractor's direction, in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframes at 42 C.F.R. § 438.408(b)-(c) for Appeals and expedited Appeals.

1.15.1.10 Parties

In accordance with 42 C.F.R. § 438.406(b)(6), the Contractor's Grievance and Appeals System shall include the following as parties to an Appeal:

- The Dental Health Plan Enrollee and the Dental Health Plan Enrollee's Authorized Representative; or
- The legal representative of a deceased Dental Health Plan Enrollee's estate.

#### 1.15.1.11 Recordkeeping

The Contractor shall, in accordance with 42 C.F.R. § 438.416, maintain records of all Grievances and Appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to OHCA quality strategy. The Contractor shall accurately maintain the records in a manner accessible to OHCA and available upon request to the CMS. Except as is established in Section 1.15.5.4, “Contractor State Fair Hearing Support” of this Model Contract, the Contractor shall produce records to OHCA staff no later than three Business Days after the date of request, in the format (electronic or hard copy) requested. The record of each Grievance or Appeal shall contain, at minimum, the following:

- A general description of the reason for the Grievance or Appeal;
- Date the Grievance or Appeal request was received by the Contractor;
- Date of each review or, if applicable, review meeting;
- Resolution at each level of the Grievance or Appeal, if applicable;
- Date of resolution at each level, if applicable; and
- Name of the Dental Health Plan Enrollee for whom the Grievance or Appeal was filed.

### **1.15.2 Adverse Benefit Determinations**

#### 1.15.2.1 General Requirements

The Contractor shall provide Dental Health Plan Enrollees with timely and adequate written notice of an Adverse Benefit Determination consistent with 42 C.F.R. § 438.404(a). The written notice shall include all information required in Section 1.15.2.2: “Notice Content” of this Model Contract and meet the timing requirements set forth in Section 1.15.2.3: “Timeframes for Notice Adverse Benefit Determination” of this Model Contract.

In accordance with 42 C.F.R. § 438.210(c), the Contractor shall notify the requesting Provider, and give the Dental Health Plan Enrollee written notice meeting the requirements of 42 C.F.R. § 438.404, of any decision the Contractor to deny a Service Authorization (PA) request, or to authorize a service in an amount, duration, or scope that is less than requested.

#### 1.15.2.2 Notice Content

OHCA will work with the Contractor after the award of this Contract to develop model notices of Adverse Benefit Determinations. The written notice shall include, at minimum, the following content set forth at 42 C.F.R. § 438.404(b):

- The Adverse Benefit Determination the Contractor has made or intends to make;
- The reasons for the Adverse Benefit Determination, including the Dental Health Plan Enrollee’s right to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Dental Health Plan Enrollee’s Adverse Benefit Determination. Such information shall include necessary criteria, processes, strategies or evidentiary standards in setting coverage limits;
- Information on how to request reasonable access to and copies of all documents, records and other information relevant to the Dental Health Plan Enrollee’s Adverse Benefit Determination;
- The Dental Health Plan Enrollee’s right to request an Appeal of the Contractor’s Adverse Benefit Determination, including information and procedures for exhausting the Contractor’s one level of Appeal and the right to request a State Fair Hearing;
- The circumstances under which an Appeal process can be expedited and how to request it;

- The Dental Health Plan Enrollee’s right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued and the circumstances, consistent with OHCA’s policy, under which the Dental Health Plan Enrollee may be required to pay the costs of these services; and
- The procedures for exercising all rights set for in this Section and in 42 C.F.R. § 438.404(b).

The notice shall comply with all information requirements at 42 C.F.R. § 438.10 and, consistent with 42 C.F.R. § 438.10(d)(3) and Section 1.10.1.5: “Taglines” of this Model Contract, contain taglines in each state-established prevalent non-English language as well as large print explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the entity providing customer service.

#### 1.15.2.3 Timeframes for Notice Adverse Benefit Determination

The Contractor shall mail the written notice of an Adverse Benefit Determination within the following timeframes set forth in Sections 1.15.2.3.1 through 1.15.2.3.5 of this Contract, in accordance with 42 C.F.R. § 438.404(c):

##### 1.15.2.3.1 Termination, Suspension or Reduction of Previously Authorized Covered Services

When the action for which the notice of Adverse Benefit Determination is being provided is a termination, suspension or reduction of previously authorized Medicaid-covered services, the Contractor shall send the written notice at least ten days before the date of action, in accordance with 42 C.F.R. §§ 431.211 and 438.404(c)(1). The Contractor shall also send the written notice of an Adverse Benefit Determination at least ten days before the date of action when the Dental Health Plan Enrollee’s location and address is unknown based on returned mail with no forwarding address, in accordance with OAC 317:35-5-67.

Exceptions to the ten day advance written notice requirement for termination, suspension or reduction of previously authorized Medicaid-covered services shall be, as follows:

- *Notice Timeframe for Probable Dental Health Plan Enrollee Fraud:* In accordance with 42 C.F.R. §§ 431.214 and 438.404(c)(1), the Contractor may shorten the written notice of Adverse Benefit Determination to as few as five (5) days before the date of action if the Contractor has facts that have been verified, if possible, through secondary sources, indicating that action should be taken because of probable Dental Health Plan Enrollee Fraud.
- *Notice Timeframe for Voluntary or Involuntary Dental Health Plan Enrollee Eligibility or Service Reduction:* In accordance with 42 C.F.R. §§ 431.213 and 438.404(c)(1), the Contractor shall provide Dental Health Plan Enrollees with written notice of an Adverse Benefit Determination no later than the date of the action in the notice in any of the following circumstances:
  - The Contractor has factual information confirming the Dental Health Plan Enrollee’s death;
  - The Dental Health Plan Enrollee submits a signed written statement requesting service termination;
  - The Dental Health Plan Enrollee submits a signed written statement including information that requires service termination or service reduction and indicates that the Dental Health Plan Enrollee understands that service termination or service reduction will result from supplying the information;

- The Dental Health Plan Enrollee has been admitted to an institution in which he or she is ineligible for further services; or
- The Contractor has information establishing that the Dental Health Plan Enrollee has been accepted for Medicaid services by another local jurisdiction, state, territory or commonwealth.

#### 1.15.2.3.2 Payment Denial

In accordance with 42 C.F.R. § 438.404(c)(2), when the action for which the notice of Adverse Benefit Determination is being provided is denial of payment, the Contractor shall provide the notice at the time of any action affecting the claim.

#### 1.15.2.3.3 Standard Service Authorization Denial or Limitation

In accordance with 42 C.F.R. §§ 438.404(c)(3) and 438.210(d)(1), when the action for which the notice of Adverse Benefit Determination is being provided is standard Service Authorization (PA) decisions that deny or limit services, the Contractor shall provide the notice as expeditiously as the Dental Health Plan Enrollee's condition requires and not to exceed 14 days following receipt of the request for service. The Contractor may extend the 14-day Service Authorization notice timeframe up to 14 additional calendar days if the Dental Health Plan Enrollee or Provider as Authorized Representative requests an extension.

If the timeframe is extended based upon the Contractor justification of a need for additional information and how the extension is in the Dental Health Plan Enrollee's interest, the Contractor shall, in accordance with 42 C.F.R. § 438.404(c)(4), provide the Dental Health Plan Enrollee written notice of the reason for the decision to extend the timeframe, inform the Dental Health Plan Enrollee of the right to file a Grievance if the Dental Health Plan Enrollee disagrees with that decision and issue and carry out its determination as expeditiously as the Dental Health Plan Enrollee's health condition requires and no later than the date the extension expires.

#### 1.15.2.3.4 Expedited Service Authorization Denial

In accordance with 42 C.F.R. §§ 438.404(c)(6) and 438.210(d)(2), for cases in which a Provider indicates, or the Contractor determines, that following the standard authorization timeframe could seriously jeopardize the Dental Health Plan Enrollee's life or health or Dental Health Plan Enrollee's ability to attain, maintain or regain maximum function, the Contractor shall make an expedited authorization decision and provide oral notice as expeditiously as the Dental Health Plan Enrollee's health condition requires and provide written notice no later than 72 hours after receipt of the request for service. The Contractor may extend the 72-hour time period for written notice by up to 14 days if:

- The Dental Health Plan Enrollee or Provider as Authorized Representative requests an extension; or
- The Contractor justifies (to OHCA upon request) a need for additional information and how the extension is in the Dental Health Plan Enrollee's interest.

#### 1.15.2.3.5 Untimely Service Authorization Decisions

In accordance with 42 C.F.R. § 438.404(c)(5), the Contractor shall give notice on the date that the timeframes expire, when Service Authorization decisions are not reached within the applicable timeframes for either standard or expedited Service Authorizations as set forth in Sections 1.15.2.3.3 and 1.15.2.3.4 of this Contract.

### **1.15.3 Grievances**

#### **1.15.3.1 Authority, Format and Timeframe for Filing Grievance**

As detailed in Section 1.15.1.1: “Dental Health Plan Enrollee Grievances and Appeals System” of this Model Contract, a Dental Health Plan Enrollee may file a Grievance with the Contractor, either orally or in writing at any time.

#### **1.15.3.2 Requirement to File Grievance with Contractor**

The Dental Health Plan Enrollee shall be required to file a Grievance directly with the Contractor and shall not file with OHCA, in accordance with OHCA’s policy as allowed under 42 C.F.R. §438.402(c)(3).

#### **1.15.3.3 Timeframe for Resolution of Grievance**

The Contractor shall resolve each Grievance and provide notice, as expeditiously as the Dental Health Plan Enrollee’s health condition requires, which shall be within 30 Calendar Days from the date the Contractor receives the Grievance, in accordance with 42 C.F.R. § 438.408(a) and (b)(1).

In accordance with 42 C.F.R. § 438.408(c)(1), the resolution timeframe may be extended by the Contractor by up to 14 Calendar Days if:

- The Dental Health Plan Enrollee or Provider as Authorized Representative requests an extension; or
- The Contractor shows (to the satisfaction of OHCA, upon request) that there is a need for additional information and how the delay is in the Dental Health Plan Enrollee’s interest.

If the Contractor extends the timeframe for resolution of a Grievance, pursuant to the preceding language and 42 C.F.R. § 438.408(c)(1), and such extension was not at the request of the Dental Health Plan Enrollee, the Contractor must complete the following in accordance with 42 C.F.R. §438.408(c)(2)(i)-(ii):

- Make reasonable efforts to give the Dental Health Plan Enrollee prompt oral notice of the delay; and
- Give the Dental Health Plan Enrollee written notice of the reason for the decision to extend the timeframe within two Calendar Days and inform the Dental Health Plan Enrollee of the right to file a Grievance if the Dental Health Plan Enrollee disagrees with that decision.

#### **1.15.3.4 Grievance Resolution Notice Format and Content**

The Contractor shall provide written notice of resolution of a Grievance to the impacted Dental Health Plan Enrollee within three calendar days of the resolution of the Grievance. In accordance with 42 C.F.R. § 438.408(d)(1) and Section 1.10.4: “OHCA Developed Dental Health Plan Enrollee Materials” of this Model Contract OHCA shall establish the content the Contractor must include in the notice. The notice shall be in a format and language that, at a minimum, meet the requirements of 42 C.F.R. § 438.10, including taglines in each State-established prevalent non-English language as well as large print explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the entity providing customer service.

### **1.15.4 Appeals**

#### **1.15.4.1 Authority and Format for Requesting Appeal**

As detailed in Section 1.15.1.1: “Dental Health Plan Enrollee Grievances and Appeals System” of this Model Contract, a Dental Health Plan Enrollee may file an Appeal with the Contractor orally or in writing.

In accordance with 42 C.F.R. § 438.402(c)(3), an oral request must be followed by a signed, written request unless the Dental Health Plan Enrollee is requesting an expedited resolution.

1.15.4.2 Timeframe for Requesting Appeal

In accordance with 42 C.F.R. § 438.402(c)(2)(ii), the Contractor shall allow the Dental Health Plan Enrollee to file an Appeal to the Contractor within 60 Calendar Days from the date on the Adverse Benefit Determination notice.

1.15.4.3 Timeframe for Standard Appeal Resolution

The Contractor shall resolve each Appeal and provide notice, as expeditiously as the Dental Health Plan Enrollee's health condition requires, which shall be within 30 Calendar Days from the date the Contractor receives the Appeal, in accordance with 42 C.F.R. § 438.408(a) and (b)(2).

In accordance with 42 C.F.R. § 438.408(c)(1), the resolution timeframe may be extended by the Contractor by up to 14 Calendar Days if:

- The Dental Health Plan Enrollee or Provider as Authorized Representative requests an extension; or
- The Contractor shows (to the satisfaction of OHCA, upon its request) that there is a need for additional information and how the delay is in the Dental Health Plan Enrollee's interest.

If the Contractor extends the timeframe for resolution of an Appeal, pursuant to the preceding language and 42 C.F.R. § 438.408(c)(1), and such extension was not at the request of the Dental Health Plan Enrollee, the Contractor must complete the following in accordance with 42 C.F.R. § 438.408(c)(2)(i)-(iii):

- Make reasonable efforts to give the Dental Health Plan Enrollee prompt oral notice of the delay;
- Give the Dental Health Plan Enrollee written notice of the reason for the decision to extend the timeframe within two Calendar Days and inform the Dental Health Plan Enrollee of the right to file a Grievance if the Dental Health Plan Enrollee disagrees with that decision; and
- Resolve the Appeal as expeditiously as the Dental Health Plan Enrollee's health condition requires and no later than the date the extension expires.

1.15.4.4 Timeframe for Expedited Resolution

The Contractor shall resolve each expedited Appeal and provide notice, as expeditiously as the Dental Health Plan Enrollee's health condition requires, which shall be within 72 hours from the date the Contractor receives the Appeal, in accordance with 42 C.F.R. § 438.408(a) and (b)(3).

In accordance with 42 C.F.R. § 438.408(c)(1), the resolution timeframe may be extended by the Contractor by up to 14 Calendar Days if:

- The Dental Health Plan Enrollee or Provider as Authorized Representative requests an extension; or
- The Contractor shows (to the satisfaction of OHCA, upon its request) a need for additional information and how the delay is in the Dental Health Plan Enrollee's interest.

If the Contractor extends the timeframe for resolution of an expedited Appeal, pursuant to the preceding language and 42 C.F.R. § 438.408(c)(1), and such extension was not at the request of the Dental Health Plan Enrollee, the Contractor must complete the following in accordance with 42 C.F.R. § 438.408(c)(2)(i)-(iii):



- Make reasonable efforts to give the Dental Health Plan Enrollee prompt oral notice of the delay;
- Give the Dental Health Plan Enrollee written notice of the reason for the decision to extend the timeframe within two calendar days and inform the Dental Health Plan Enrollee of the right to file a Grievance if the Dental Health Plan Enrollee disagrees with that decision; and
- Resolve the Appeal as expeditiously as the Dental Health Plan Enrollee's health condition requires and no later than the date the extension expires.

#### 1.15.4.5 Appeal Resolution Notice Format and Content

For all Appeals, the Contractor shall provide written notice of resolution to the impacted Dental Health Plan Enrollee, in accordance with 42 C.F.R. § 438.408(d)(2), in a format and language that, at a minimum, meet the standards described at 42 C.F.R. § 438.10. The notice shall contain taglines in each state-established prevalent non-English language as well as large print explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the entity providing customer service.

In accordance with 42 C.F.R. § 438.408(d)(2)(ii), the Contractor, in addition to the written notice requirements of the preceding paragraph, shall also make reasonable efforts, as determined by OHCA, to provide oral notice to the Dental Health Plan Enrollee for resolution of an expedited Appeal.

OHCA intends to work with the Contractor to develop model notices upon award of this Contract. In accordance with 42 C.F.R. § 438.408(e)(1)-(2), the notice shall include the results of the resolution process and the date it was completed, and for Appeals not resolved wholly in favor of the Dental Health Plan Enrollee, the notice shall include the following:

- The right to request a State Fair Hearing;
- How to request a State Fair Hearing;
- The right to request and receive benefits while the State Fair Hearing is pending, as detailed in 1.15.6: "Continuation of Benefits Pending Appeal and State Fair Hearing" of this Model Contract;
- How to request benefits while the State Fair Hearing is pending; and
- Notice that the Dental Health Plan Enrollee may, consistent with OHCA policy, be held liable for the cost of those benefits if the State Fair Hearing decision upholds the Contractor's Adverse Benefit Determination.

### **1.15.5 Access to State Fair Hearings and Contractor Role**

#### 1.15.5.1 Authority and Timeline for State Fair Hearing Request

Pursuant to 42 C.F.R. §§ 438.402(c)(1)(i) and 438.408(f)(1), a Dental Health Plan Enrollee may request a State Fair Hearing under Subpart E of 42 C.F.R. Part 431 only after receiving notice from the Contractor upholding an Adverse Benefit Determination. The Dental Health Plan Enrollee shall have 120 days from the date of the Adverse Benefit to request a State Fair Hearing.

#### 1.15.5.2 Deemed Exhaustion of Appeals Process

If the Contractor fails to adhere to any timing or notice requirements as detailed in 42 C.F.R. § 438.408, the Dental Health Plan Enrollee is deemed to have exhausted the Contractor's Appeal process and the Dental Health Plan Enrollee may initiate a State Fair Hearing, pursuant to 42 C.F.R. §§438.402(c)(1)(i)(A) and 438.408(f)(1)(i).

#### 1.15.5.3 Parties to State Fair Hearing

In accordance with 42 C.F.R. § 438.408(f)(3), parties to the State Fair Hearing shall include the Contractor and the Dental Health Plan Enrollee and the Dental Health Plan Enrollee's representative or the representative of a deceased Dental Health Plan Enrollee's estate.

#### 1.15.5.4 Contractor State Fair Hearing Support

The Contractor shall maintain a sufficient level of trained staff to provide support in the State Fair Hearing process, including all of the following, at minimum:

- The Contractor shall provide the State with a summary setting forth the following information:
  - Name and address of the Dental Health Plan Enrollee, which includes the Dental Health Plan Enrollee's Authorized Representative, if applicable;
  - A summary statement concerning why the Dental Health Plan Enrollee is filing a request for a State Fair Hearing;
  - A brief chronological summary of the Contractor's action in relationship to the Dental Health Plan Enrollee's request for a State Fair Hearing;
  - A statement of the basis of the Contractor's decision;
  - A citation of the applicable policies relied upon by the Contractor;
  - A copy of the notice which notified Dental Health Plan Enrollee of the decision in question;
  - Any applicable correspondence; and
  - The name and title of the Contractor's staff who will serve as witnesses at the State Fair Hearing.
- This summary must be received by OHCA within 15 Calendar Days after notification of the request for a State Fair Hearing.
- Summarizing the arguments presented by the Dental Health Plan Enrollee, which includes the Dental Health Plan Enrollee's Authorized Representative, if applicable, and the Contractor in summaries for State Fair Hearings to ensure the dispute and actions by the Dental Health Plan Enrollee and Contractor are clearly identified. The Contractor shall state the legal basis upon which any dismissal requests are based and include regulations or statutes in support.
- Ensuring timely delivery to the Dental Health Plan Enrollee, which includes the Dental Health Plan Enrollee's Authorized Representative, if applicable, the State and the Office of Administrative Hearings of State Fair Hearing documentation, as required.

OHCA reserves the right to amend the Contractor State Fair Hearing responsibilities, including setting performance targets for State Fair Hearing requests that are resolved upholding the Contractor's original determination, as it deems necessary and appropriate under this Model Contract.

### **1.15.6 Continuation of Benefits Pending Appeal and State Fair Hearing**

#### 1.15.6.1 When the Contractor Shall Continue Benefits

In accordance with 42 C.F.R. § 438.420 and OAC 317:2-1-2.6, the Contractor shall continue a Dental Health Plan Enrollee's benefits under the Contract when all of the following occur:

- The Dental Health Plan Enrollee files the request for an Appeal timely in accordance with § 438.402(c)(1)(ii) and (c)(2)(ii);
- The Appeal involves the termination, suspension, or reduction of previously authorized services;
- The services were ordered by an authorized Provider;
- The period covered by the original authorization has not expired; and

- The Dental Health Plan Enrollee timely files for continuation of benefits, meaning on or before the later of the following:
  - Within ten Calendar Days of the Contractor sending the notice of Adverse Benefit Determination; or
  - The intended effective date of the Contractor's proposed Adverse Benefit Determination.

If the Dental Health Plan Enrollee fails to indicate a preference as to continuation or reinstatement of services in a written request for hearing made within ten Calendar Days of the Adverse Benefit Determination, services shall be continued or reinstated. Notwithstanding the foregoing, continuation or reinstatement of benefits shall not occur under the following circumstances:

- The Dental Health Plan Enrollee has exceeded the limit applicable to the services; or
- When a Provider has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested.

#### 1.15.6.2 Duration of Continued or Reinstated Benefits

If the Contractor continues or reinstates the Dental Health Plan Enrollee's benefits at the Dental Health Plan Enrollee's request while the Appeal or State Fair Hearing is pending, the benefits must be continued until one of following occurs:

- The Dental Health Plan Enrollee withdraws the Appeal or request for State Fair Hearing;
- The Dental Health Plan Enrollee fails to request a State Fair Hearing and continuation of benefits within ten Calendar Days after the Contractor sends the notice of an adverse resolution to the Dental Health Plan Enrollee's Appeal under 42 C.F.R. § 438.408(d)(2); or
- A State Fair Hearing officer issues a hearing decision adverse to the Dental Health Plan Enrollee.

#### **1.15.7 Contractor Recovery**

The Contractor may, in accordance with 42 C.F.R. § 438.420(d), recover from the Dental Health Plan Enrollee costs of services furnished to the Dental Health Plan Enrollee while an Appeal or State Fair Hearing was pending, to the extent the services were continued solely due to the requirements set forth in 42 C.F.R. §§ 438.420 or § 431.230(b) and the final resolution of the Appeal or State Fair Hearing upholds the Contractor's Adverse Benefit Determination.

#### **1.15.8 Effectuation of Reversed Dental Health Plan Enrollee Appeal Resolutions**

##### 1.15.8.1 Authorization of Services Not Furnished While Dental Health Plan Enrollee Appeal is Pending

In accordance with 42 C.F.R. § 438.424(a), when services are not furnished to the Dental Health Plan Enrollee while the Dental Health Plan Enrollee's Appeal or State Fair Hearing is pending, and the Contractor or State Fair Hearing officer reverses the decision to deny, limit or delay services, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Dental Health Plan Enrollee's health condition requires. This shall be no later than 72 hours from the date the Contractor receives notice reversing the initial determination to deny, limit or delay the services.

##### 1.15.8.2 Payment for Services Furnished While Dental Health Plan Enrollee Appeal is Pending

In accordance with 42 C.F.R. § 438.424(b), the Contractor shall pay for disputed services received by the Dental Health Plan Enrollee while the Dental Health Plan Enrollee's Appeal or State Fair Hearing was pending and the Contractor or State Fair Hearing officer reverses the initial decision to deny authorization of the services. Payment shall be made in accordance with the terms of this Model Contract.

## **1.16 Cost Sharing**

### **1.16.1 Compliance with State Plan Requirements**

Any Cost Sharing imposed by the Contractor shall be in accordance with Medicaid FFS requirements as outlined in the OHCA State Plan and 42 C.F.R. §§ 447.50 through 447.56.

### **1.16.2 Cost Sharing Exempt Populations**

The Contractor shall not impose premiums on any Dental Health Plan Enrollees. In accordance with 42 C.F.R. § 447.56, the Contractor shall not impose Cost Sharing upon any of the following:

- Dental Health Plan Enrollees under age 21;
- Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age;
- Pregnant Women;
- Any Dental Health Plan Enrollee whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs;
- Dental Health Plan Enrollees receiving hospice care, as defined in section 1905(o) of the Act;
- An American Indian/Alaskan Native who is eligible to receive or has received an item or service furnished by an Indian Health Care Provider or through referral under purchase and referred care is exempt from cost sharing requirements. American Indian/Alaskan Natives who are currently receiving or have ever received an item or service furnished by an Indian Health Care Provider or through referral under purchase and referred care are exempt from all Cost Sharing; and
- Dental Health Plan Enrollees receiving Medicaid due to a diagnosis of breast or cervical cancer in accordance with 42 C.F.R. § 435.213.

### **1.16.3 Cost Sharing Exempt Services**

In accordance with 42 C.F.R. § 447.56, the Contractor shall implement processes to ensure Cost Sharing is not imposed on any of the following services:

- Emergency Services;
- Preventive Services; and
- Provider-Preventable Services.

### **1.16.4 Claims Payment Reductions**

The Contractor shall reduce the payment made to a Provider by the amount of the Dental Health Plan Enrollee's Cost Sharing obligation, regardless of whether the Provider has collected the payment or waived the Cost Sharing. Notwithstanding the foregoing, the Contractor shall not reduce payments to Providers, including IHCPs, for items and services provided to AI/ANs who are exempt from Cost Sharing.

### **1.16.5 Five Percent Cost Sharing Limit**

In accordance with 42 C.F.R. § 447.56, Dental Health Plan Enrollee's total Cost Sharing shall not exceed five percent of the Dental Health Plan Enrollee's household income applied on a monthly basis. The Contractor shall report Dental Health Plan Enrollee Cost Sharing to the MMIS according to a process defined by OHCA. The MMS will aggregate the Contractor's Cost Sharing data with household Cost Sharing and Dental Health Plan Enrollee Cost Sharing incurred for any Excluded Benefits and will notify the Contractor via the ANSI ASC X 12 834 electronic transaction when a Dental Health Plan Enrollee has met the five percent aggregate limit. Upon receipt of the ANSI ASC X 12 834 electronic transaction, the

Contractor shall ensure that Copayments are not deducted from Provider claims reimbursement through the end of the month. The Contractor shall notify the Dental Health Plan Enrollee and Providers when the aggregate limit has been met and that Cost Sharing will not apply for the remainder of the month. The Contractor shall reinstate Dental Health Plan Enrollee Cost Sharing effective the first of the following month for any Dental Health Plan Enrollees who exceeded the aggregate limit in the previous month.

## **1.17 Program Integrity**

### **1.17.1 General Program Integrity and Compliance Requirements**

The Contractor and its Subcontractors shall comply with all State and federal laws and regulations related to program integrity, compliance and disclosure requirements. This includes all current State and federal laws and regulations as well as any future laws and regulations that may be required.

#### 1.17.1.1 Administrative and Management Arrangements and Procedures

The Contractor and its Subcontractors shall implement and maintain administrative and management arrangements or procedures that are designed to detect and prevent Fraud, Waste and Abuse. The Contractor's Fraud, Waste and Abuse policies and procedures shall be coordinated with those of OHCA's Program Integrity and Accountability Unit. In accordance with 42 C.F.R. § 438.408(a), the arrangements, policies and procedures must include, but not be limited to, the following, as further detailed in this Section of this Contract:

- A compliance program, as described in Section 1.17.2: "Compliance Program" of this Model Contract;
- Prompt referral of any potential Fraud, Waste or Abuse to OHCA's Program Integrity and Accountability Unit and Legal Unit, in writing using a form as prescribed by OHCA, as described in Section 1.17.1.2: "Referral to OHCA Program Integrity and Accountability Unit or Oklahoma Medicaid Fraud Control Unit (MFCU)" of this Model Contract;
- Prompt notification to OHCA regarding changes in a Dental Health Plan Enrollee's circumstances that may affect SoonerSelect Dental program eligibility, as described in Section 1.17.3.1: "Reporting Dental Health Plan Enrollee Changes in Circumstance" of this Model Contract;
- Notification to OHCA regarding changes in a Provider's circumstances that may affect SoonerSelect Dental program eligibility, as described in Section 1.17.3.2: "Reporting Provider Changes in Circumstance" of this Model Contract;
- Method to verify Dental Health Plan Enrollees' receipt of covered services, as described in Section 1.17.4: "Verifying Delivery of Services" of this Model Contract;
- Written policies and procedures to prevent Fraud, Waste and Abuse and employee whistleblower protections, as described in Section 1.17.5: "False Claims Act Policies and Whistleblower Protection" of this Model Contract;
- Prompt reporting of all Overpayments, as described in Section 1.17.6: "Reporting Overpayments" of this Model Contract; and
- Suspending payments to Participating Providers where there is a credible allegation of Fraud, as described in Section 1.17.7: "Suspension of Payments for Credible Allegation of Fraud " of this Model Contract.

1.17.1.2 Referral to OHCA Program Integrity and Accountability Unit or Oklahoma Medicaid Fraud Control Unit (MFCU)

In accordance with 42 C.F.R. § 438.608(a)(7), the Contractor shall make a prompt referral of any potential Fraud, Waste, or Abuse that the Contractor, or a Subcontractor to the extent that a Subcontractor is delegated responsibility for coverage of services and payment of claims, identifies to OHCA's Program Integrity and Accountability Unit and Legal Unit, in writing using a form as prescribed by OHCA. The referral shall be made within three Business Days of the Contractor's identification of the activity at issue.

1.17.1.3 Collaboration with OHCA and MFCU

The Contractor shall collaborate with the Oklahoma Medicaid Fraud Control Unit (MFCU) and OHCA as necessary to ensure integrity of the SoonerSelect Dental program. At minimum, the Contractor shall:

- Participate in good faith at monthly program integrity meetings held jointly with the MFCU and OHCA;
- Provide responses to specific requests made by the MFCU within three Business Days of receipt of the request; and
- Provide the MFCU access to the Contractor's claims payment data and other applicable records.

OHCA reserves the right to amend these requirements or timeframes as necessary to address program integrity concerns identified by OHCA, MFCU or the Contractor.

1.17.1.4 Audit Requirements and Provider Rights

The Contractor shall cooperate in any audit activity performed by OHCA, OHCA's Program Integrity and Accountability Unit, Medicaid recovery audit contractor, the CMS and/or Payment Error Rate Management and the CMS audit Medicaid integrity contractors. The Contractor, its Subcontractors and Participating Providers shall, upon request, make available any and all administrative, financial and medical records relating to the delivery of items or services for which State or federal monies are expended, unless otherwise provided by law.

**1.17.2 Compliance Program**

In accordance with 42 C.F.R. § 438.608(a)(1)(i)-(vii) and OHCA policy, the Contractor, as well as its Subcontractors that are delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall have a compliance program that includes, at minimum, all of the following elements:

- Written policies, procedures and standards of conduct that articulate the Contractor or Subcontractor's commitment to comply with all applicable requirements and standards under this Contract and all applicable State and federal requirements;
- The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of this Contract and who reports directly to the Chief Executive Officer and the Board of Directors;
- The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Contractor or Subcontractor's compliance program and its compliance with requirements under this Model Contract;
- At a minimum, the Contractor shall utilize a full-time, single Lead Investigator based in Oklahoma to identify risk and guard against Fraud, Waste, and Abuse, monitor aberrant

Providers, and refer potential Fraud, Waste, and Abuse to OHCA by conducting Fraud, Waste, and Abuse investigations, and preparing investigatory reports.

- The Lead Investigator shall be dedicated solely to OHCA program integrity work and meet the following qualifications
  - A minimum of two years in health care field working in Fraud, Waste, and Abuse investigations and audits;
  - A Bachelor's degree or an Associate's degree with an additional two years working in health care Fraud, Waste, and Abuse investigations and audits. OHCA will accept experience and certifications commensurate with the educational requirements. OHCA will evaluate the experience and certifications in lieu of educational requirements; and
  - Ability to understand and analyze health care claims and coding.
- The Lead Investigator shall collaborate with OHCA Program Integrity and Accountability Unit and OHCA Legal Unit in areas such as Fraud referrals, audits and investigations, overpayments, Provider terminations, as well as attend any required meetings as prescribed by OHCA, including, but not limited to, OHCA's monthly Program Integrity meeting with MFCU.
- In addition to the Lead Investigator, the Contractor shall, at a minimum, utilize one full-time investigator for every 75,000 enrolled SoonerSelect Dental Health Plan Enrollees. These investigators shall be based in Oklahoma to identify risk and guard against Fraud, Waste, and Abuse, monitor aberrant Providers, and refer potential Fraud, Waste, and Abuse to OHCA by conducting Fraud, Waste, and Abuse investigations, and preparing investigatory reports.
- A system for training and education for the Compliance Officer and Lead Investigator, the organization's senior management and the organization's employees for the State and federal standards and requirements under this Contract, as described in Section 1.17.2.2: "Compliance Education and Training" of this Model Contract;
- Effective lines of communication between the Compliance Officer and the organization's employees;
- Enforcement of standards through well-publicized disciplinary guidelines; and
- The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Contract;
- The establishment and implementation of procedures for proactive specific controls in place to detect Fraud, Waste and Abuse and erroneous payments, including review of Provider records and technology used to identify:
  - Aberrant billing patterns,
  - Pre/post-payment claims edits,
  - Post-processing review of claims,
  - Provider profiling and credentialing used to aid program and payment integrity reviews,

- Surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of covered services,
  - Provisions in Subcontractor and Provider Agreements that ensure integrity of Provider credentials, and
  - Dental Health Plan Enrollee record reviews;
- The establishment of policies and procedures for reporting all allegations of Fraud, Waste and Abuse to OHCA's Program Integrity and Accountability Unit and Legal Unit, in writing using a form as prescribed by OHCA, including:
  - Designating the Contractor's staff Dental Health Plan Enrollees responsible for reporting Fraud to OHCA's Program Integrity and Accountability Unit,
  - Providing a process for timely, complete and consistent exchange of information and collaboration with OHCA's Program Integrity and Accountability Unit, designated agents and contracted EQRO;
- The development of policies and implementation of a process to:
  - Timely suspend all Provider payments, as outlined in Section 1.17.7: "Suspension of Payments for Credible Allegation of Fraud" of this Model Contract when notified by the OHCA Legal Unit and other State/federal agencies to suspend payments because of credible allegation(s) of Fraud,
  - Comply with requests from the OHCA Program Integrity and Accountability Unit, OHCA Legal Unit, and other State/federal agencies to access and receive copies of any records kept by the Contractor;
- Staff that are qualified and adequate in number and training to effectively monitor this Contract;
- Development and implementation of a process for the confidential reporting of Contractor violations, including:
  - Hotline and/or electronic method for reporting violations, as described in Section 1.17.2.3: "Compliance Hotline" of this Model Contract;
  - Designation of an individual to receive reports of violations;
  - Independent reporting paths for the reporting of violations so that such reports cannot be diverted by any supervisors or other personnel;
- Establishment of protections to ensure that:
  - No individual who reports cases or suspected cases of a program integrity violation, Fraud, Waste or Abuse is retaliated against by anyone who is employed by or contracted with the Contractor,
  - The identity of the individual(s) reporting violations or suspected violations be kept confidential to the extent possible;
- Development and implementation of an internal and external process for conducting investigations and follow-up of any suspected or confirmed Fraud, Waste or Abuse or compliance violations;
- Coordination with OHCA and other MCOs and DBMs contracted with OHCA on proactive detection of Fraud, Waste and Abuse and erroneous payments, including:



- Providing a monthly and quarterly list of audit activities to OHCA , in writing in a form as prescribed by OHCA, in order to reduce or prevent overlap;
- Participating in monthly meeting with OHCA Program Integrity and Accountability Unit to discuss all active referrals, investigations, and audits;
- Reporting audit activities and audit outcomes to OHCA in order to facilitate OHCA follow-up on the audit activity as needed;
- Timely correspondence necessary with MCOs and DBMs contracted with OHCA as directed by OHCA to prevent or detect potential Fraud, Waste, or Abuse of Medicaid funds under the SoonerSelect Dental program; and
- Monthly check for exclusions of the Contractor’s employees, owners and agents and database to capture identifiable information.

#### 1.17.2.1 Compliance Plan

The Contractor shall have a written compliance plan that addresses, at minimum, the items described in Section 1.17.2: “

Compliance Program” of this Model Contract. The Contractor shall submit a copy of the compliance plan to OHCA’s Program Integrity and Accountability Unit for review and approval a minimum of 60 days prior to the Contract start date and annually thereafter annually by July 1st. The initial compliance plan must be approved by OHCA’s Program Integrity and Accountability Unit prior to implementation by the Contractor.

The Contractor shall submit any request(s) for revision(s) to the compliance plan for review to OHCA’s Program Integrity and Accountability Unit a minimum of 60 days prior to the requested implementation date of the revision(s). Revisions must be approved by OHCA’s Program Integrity and Accountability Unit prior to implementation by the Contractor.

#### 1.17.2.2 Compliance Education and Training

The Contractor shall educate and train all employees, including management, and any Subcontractors/agents about:

- Provisions of 42 C.F.R. § 438.610 regarding prohibited Contractor affiliations and all relevant State and federal laws, regulations, policies procedures and guidance, including updates and amendments to these documents or any such standards;
- The Contractor’s compliance program, as described in Section 1.17.2: “
- Compliance Program” of this Model Contract;
- The Contractor’s code of conduct; and
- Privacy and security, including but not limited to HIPAA.

The Contractor shall conduct training for new hires within 30 days of employment and conduct training annually for all employees. The Contractor shall maintain evidence of completed education and training efforts. The Contractor shall provide such evidence upon request by OHCA.

#### 1.17.2.3 Compliance Hotline

The Contractor shall maintain a toll-free compliance hotline number. The Contractor’s hotline and OHCA’s hotline shall be accessible by employees, Subcontractors/agents, Participating Providers and Dental Health Plan Enrollees to report compliance concerns, including suspected Fraud, Waste and Abuse. The

Contractor shall ensure that the Contractor's hotline number and OHCA's hotline number, as well as an explanatory statement, are distributed to its employees, Subcontractors/agents, Participating Providers and staff.

### **1.17.3 Reporting Changes in Circumstance**

#### **1.17.3.1 Reporting Dental Health Plan Enrollee Changes in Circumstance**

The Contractor shall promptly notify OHCA, in a notification manner approved by OHCA, when the Contractor, or the Subcontractor to the extent the Subcontractor is delegated responsibility for coverage of services and payment of claims, receives information about changes in a Dental Health Plan Enrollee's circumstances that may affect the Dental Health Plan Enrollee's SoonerSelect Dental program eligibility, in accordance with 42 § C.F.R. 438.608(a)(3) and in accordance with the provisions of Section 1.5.8: "Dental Health Plan Enrollee Status Changes" of this Model Contract. Changes required to be promptly reported include, at minimum, all of the following:

- Changes in the Dental Health Plan Enrollee's residence or notification of the Dental Health Plan Enrollee's mail that is returned as undeliverable and
- Death of the Dental Health Plan Enrollee.

For purposes of meeting this requirement, prompt notification to OHCA is defined as within five Business Days of the Contractor's receipt of the information.

#### **1.17.3.2 Reporting Provider Changes in Circumstance**

In accordance with 42 C.F.R. § 438.608(a)(4), the Contractor shall promptly notify OHCA, in a notification manner approved by OHCA, when the Contractor, or its Subcontractor to the extent the Subcontractor is delegated responsibility for coverage of services and payment of claims, receives information about a change in a Provider's circumstances that may affect the Provider's eligibility to participate in the SoonerSelect Dental program, including termination of the Provider Agreement with the Contractor.

For purposes of meeting this requirement, prompt notification to OHCA is defined as within three Business Days of the Contractor's receipt of the information. The Contractor shall provide the information required under this Section inclusive of, at minimum, the Provider's name, address and NPI to an OHCA designated email.

### **1.17.4 Verifying Delivery of Services**

#### **1.17.4.1 General Requirement**

In accordance with 42 C.F.R. § 438.608(a)(5), the Contractor, or its Subcontractor to the extent the Subcontractor is delegated responsibility for coverage of services and payment of claims, shall have a method to verify whether services that have been represented to have been delivered by Participating Providers were actually received by Dental Health Plan Enrollees. The Contractor may conduct verification by telephone, electronic correspondence or writing. The Contractor shall report the results of this monitoring to OHCA on a quarterly basis in a manner prescribed by OHCA.

#### **1.17.4.2 Explanation of Benefits (EOBs)**

The Contractor shall develop and distribute EOBs to verify the delivery of services consistent with the requirements of 42 C.F.R. § 438.608(a)(5). The EOBs shall be distributed using a methodology approved by OHCA that ensures all services and Provider types are sampled regularly.

The EOB developed and distributed by the Contractor shall conform to all requirements of 42 C.F.R. §§ 455.20 and 433.116. The Contractor shall ensure that EOBs are accessible electronically via the Dental Health Plan Enrollee Portal as set forth at Section 1.10.6.3: “Dental Health Plan Enrollee Website Portal” of this Model Contract and shall also ensure telephonic, written or other electronic EOB access for Dental Health Plan Enrollee’s unable to access the Dental Health Plan Enrollee Portal. The EOB should list the services delivered, name of the Provider claiming the service, date on which it was claimed to have been delivered, service location and amount of payment. A Dental Health Plan Enrollee shall be instructed to call the listed phone number if the services are incorrect. In the event the Contractor receives notice from a Dental Health Plan Enrollee that services listed on the EOB were not received, the Contractor shall follow the requirements of this Section 2.17: “Program Integrity” to determine if referral due to potential Fraud is necessary.

The Contractor shall oversample if a specific service or class of provider justifies closer oversight.

#### **1.17.5 False Claims Act Policies and Whistleblower Protection**

In accordance with 42 C.F.R. § 438.608(a)(6), the Contractor shall establish and implement written policies for all employees, including management, and any Subcontractor or agent of the Contractor’s that provide detailed information about preventing and detecting Fraud, Waste and Abuse in federal health care programs. This information shall include, at minimum:

- The False Claims Act;
- Other federal and state laws described in §1902(a)(68) of the Act and 42 U.S.C. 1396a;
- Administrative remedies for false claims and statements;
- State laws pertaining to civil or criminal penalties for false claims and statements, including 63 O.S. § 5053 through 63 O.S. § 5054 ;
- Whistleblower protection under such laws, including the rights of employees to be protected as whistleblowers; and
- The Contractor’s policies and procedures for detecting and preventing Fraud, Waste and Abuse.

In addition, the Contractor shall include this information in its employee handbook. These policies shall be made available to OHCA upon request and reviewed during Readiness Review.

#### **1.17.6 Reporting Overpayments**

In accordance with 42 C.F.R. § 438.608(a)(2), the Contractor, or its Subcontractor to the extent the Subcontractor is delegated responsibility for coverage of services and payment of claims, shall promptly report all Overpayments identified or recovered, specifying the Overpayments due to potential Fraud, to OHCA in a manner and format to be specified by OHCA.

For purposes of meeting this requirement, prompt notification to OHCA is defined as within three Business Days of the Contractor’s identification or recovery of the Overpayment.

#### **1.17.7 Suspension of Payments for Credible Allegation of Fraud**

The Contractor, or its Subcontractor to the extent the Subcontractor is delegated claims payment responsibility, shall timely suspend payments to a Participating Provider for which OHCA determines there is a credible allegation of Fraud in accordance with 42 C.F.R. §§ 438.608(a)(8) and 455.23. OHCA shall determine whether payments should be suspended or if an exception is appropriate. OHCA shall notify the Contractor of payment suspensions, and the Contractor must then immediately suspend further

payments to the Provider. The Contractor must ensure that no Medicaid dollars are received by a Provider whose payments have been suspended or that has been terminated by OHCA.

After a credible allegation of Fraud, unless prior written approval is obtained from OHCA, the Contractor may not take any of the following actions:

- Contact the subject of the investigation concerning any matter related to the investigation;
- Institute any interventions, sanctions or remedial procedures towards the subject of the investigation, including but not limited to hearings, suspension or termination;
- Take any actions to recoup or withhold improperly paid funds already paid or potentially due to the Provider;
- File any civil action based upon the suspected Fraud against the subject of the investigation;
- Enter into or attempt to negotiate any settlement or agreement regarding the suspected Fraud; or
- Accept any money or other thing of value offered by the subject of the investigation in connection with suspected Fraud.

If the Contractor thinks that it is appropriate to initiate a recoupment or withholding action against a Provider under these circumstances, the Contractor shall consult with OHCA and OHCA's Program Integrity and Accountability Unit to ensure whether such action is permissible. In the event that the Contractor obtains funds from an action when recoupment or withholding is prohibited, the Contractor shall return the funds to the Provider.

#### **1.17.8 Provider Screening and Enrollment**

In accordance with 42 C.F.R. § 438.608(b), the Contractor shall ensure that all of the Contractor's Participating Providers are enrolled with OHCA as a Medicaid Provider and periodically revalidated consistent with the Provider disclosure, screening and enrollment requirements of 42 C.F.R. §§ 438.602, 455.100-106 and 455.400 - 470.

#### **1.17.9 Written Disclosures**

The Contractor shall submit the following disclosures and reports, as set forth at 42 C.F.R. § 438.608(c):

- Written disclosure of any prohibited affiliation under 42 C.F.R. § 438.610, as detailed in Section 1.17.10: "Prohibited Affiliations and Exclusions" of this Model Contract;
- Written disclosures of information on ownership and control required under 42 C.F.R. § 455.104, as detailed in Section 1.17.9.1: "Required Ownership, Controlling Interest and Managing Employee Disclosures" of this Model Contract;
- Report to OHCA within 30 Calendar Days when the Contractor has identified the Capitation Payments or other payments in excess of amounts specified in this Contract, as detailed in Section 1.2.3: "Report of Capitation Overpayment" of this Model Contract.

##### 1.17.9.1 Required Ownership, Controlling Interest and Managing Employee Disclosures

In accordance with the requirements at 42 C.F.R. §§ 438.604(a)(6), 438.608(c)(2) and 455.104, the Contractor shall submit to OHCA the following information:

- The name of any Person with an Ownership or Control Interest in the Contractor or its Subcontractors;

- The address of a Person with an Ownership or Control Interest in the Contractor or its Subcontractors, which, for corporations shall include, as applicable, the following:
  - Primary business address,
  - Every business location, and
  - Post Office box address;
- The date of birth of any individual Person with an Ownership or Control interest in the Contractor or its Subcontractors;
- The Social Security Number of any individual Person with an Ownership or Control Interest in the Contractor or its Subcontractors;
- Other tax identification number of any corporate Person with an Ownership or Control Interest in the Contractor or its Subcontractors;
- Tax identification number of any Subcontractor in which the Contractor has a five percent or more interest;
- Information on whether a Person with an Ownership or Control Interest in any Subcontractor in which the Contractor has a five percent or more interest is related to another person with Ownership or Control interest in the Contractor as a spouse, parent, child, or sibling;
- The name of any Other Disclosing Entity in which an owner of the Contractor is a Person with an Ownership or Control Interest; and
- The name, address, date of birth, and Social Security Number of any Managing Employee of the Contractor.

#### 1.17.9.1.1 Persons with an Ownership or Control Interest

In accordance with requirements at 42 C.F.R. §§ 438.608(c)(2) and 455.100-455.104, as well as §§ 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Act, the Contractor and its Subcontractors shall disclose to OHCA, and OHCA shall review the submitted disclosures, any Persons with an Ownership or Control Interest in the Contractor that:

- Has a Direct Ownership Interest, Indirect Ownership Interest, or combined Direct/Indirect Ownership Interest of five percent or more of the Contractor's equity;
- Owns five percent or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least five percent of the value of the Contractor's assets;
- Is an officer or director of the Contractor if the Contractor is organized as a corporation;
- Is a partner in the Contractor if the Contractor is organized as a partnership; or
- Is a member or manager of the Contractor if the Contractor is organized as a limited liability company.

#### 1.17.9.1.2 When Disclosures of Persons with An Ownership or Control Interest Are Required

In accordance with requirements at 42 C.F.R. §§ 438.608(c)(2), 455.100-455.103 and 42 C.F.R. 455.104(c)(3), as well as §§ 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Act, the Contractor and its Subcontractors shall make the disclosures required in Section 1.17.9.1: "Required Ownership, Controlling Interest and Managing Employee Disclosures" of this Model Contract at the following times:

- When the Contractor submits a Proposal in accordance with the State's procurement process;
- When the Provider or Disclosing Entity submits a Provider application;
- When the Provider or Disclosing Entity executes a Provider Agreement with OHCA;
- Upon request of the State during revalidation of Provider enrollment;

- When the Contractor executes a Contract with OHCA;
- When OHCA renews or extends this Contract; and
- Within 35 days after any change in ownership of the Contractor or of the Disclosing Entity.

#### **1.17.10 Prohibited Affiliations and Exclusions**

##### 1.17.10.1 Providers Excluded from Participation in Federal Health Care Programs

The Contractor, in accordance with 42 C.F.R. § 438.214(d)(1), shall not employ or contract with Providers excluded from participation in federal health care programs.

##### 1.17.10.2 Sanctioned Individual

The Contractor shall not allow a sanctioned individual under § 1128(b)(8) of the Act to have Control Interest in the Contractor, in accordance with 42 C.F.R. § 438.808 and § 1903(i)(2) of the Act.

##### 1.17.10.3 Other Prohibited Affiliations

The Contractor:

- Shall not contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly:
  - with an individual convicted of crimes described in § 1128(b)(8)(B) of the Act, in accordance with 42 C.F.R. § 438.808(a), 438.808(b)(2) and § 1903(i)(2) of the Act;
  - with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, pursuant to 42 C.F.R. § 438.808(a), 438.808(b)(2), 438.610(a) and § 1903(i)(2) of the Act; or
  - with any individual or entity that is excluded from participation in any Federal health care program under § 1128 or 1128A of the Act, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2), 438.610(b) and 1903(i)(2) of the Act.
- Shall not employ or contract, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services:
  - with any individual or entity that is (or is affiliated with a person/entity that is), or would provide those services through an individual or entity that is, debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, in accordance with 42 C.F.R. §§ 438.808(a), 438.808(b)(3)(i)-(ii), 438.610(a) and § 1903(i)(2) of the Act; or
  - with any individual or entity that is excluded, or would provide those services through an individual or entity who is excluded, from participation in any Federal health care program under § 1128 or 1128A of the Act, in accordance with 42 C.F.R. §§ 438.808(a), 438.808(b)(3)(i)-(ii), 438.610(b); and § 1903(i)(2) of the Act.

#### 1.17.10.4 Written Disclosure

In accordance with 42 C.F.R. § 438.608(c), the Contractor shall provide written disclosure of all prohibited relationships between the Contractor and any individual, entity or Affiliate identified in Section 1.17.10: “Prohibited Affiliations and Exclusions” of this Model Contract.

#### 1.17.10.5 State Identification of Prohibited Relationships

In accordance with 42 C.F.R. § 438.610(d), if OHCA finds that the Contractor is not in compliance with the requirements for prohibited affiliations at 42 C.F.R. § 438.610(a)-(c), set forth in this Section of the Contract, OHCA shall notify the Secretary of DHHS of the Contractor’s noncompliance. OHCA, may continue an existing agreement with the Contractor unless the Secretary directs otherwise. OHCA shall not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary of DHHS provides to OHCA and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the Contractor’s prohibited affiliations.

### **1.17.11 Overpayments to Providers**

#### 1.17.11.1 Treatment of Recoveries Made by Contractor of Overpayments to Providers

The Contractor shall provide with the following policies, procedures, timelines and documentation requirements of the Contractor prior to the Contractor’s Readiness Review.:

- Retention policies for the treatment of recoveries of all Overpayments from the Contractor to a Provider, including specifically the retention policies for the treatment of recoveries of Overpayments due to Fraud, Waste or Abuse;
- The process, timeframes and documentation required for reporting the recovery of all Overpayments; and
- The process, timeframes and documentation required for payment of recoveries of Overpayments to OHCA in situations where the Contractor is not permitted to retain some or all of the recoveries of Overpayments.

This Subsection does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

If an Overpayment to a Provider made by the Contractor is identified by OHCA rather than by the Contractor, OHCA may recover the Overpayment directly from the Provider, or OHCA may require the Contractor to recover and send the Overpayment to OHCA as directed by OHCA Program Integrity and Accountability Unit.

If a Fraud referral from the Contractor generates an investigation and/or legal action results in a recovery, the Contractor will be entitled to share in recovery following final resolution of the action (settlement agreement/final court judgment) and payment of recovered funds to OHCA. The State shall retain its costs of pursuing the action and its actual documented loss. The State will pay the remainder of the recovery, not to exceed the Contractor’s actual documented loss, to the Contractor. If the state determines it is in its best interest to resolve the matter under a settlement agreement, the State has final authority concerning the settlement. If final resolution of a matter does not occur until after this Contract has expired, these policies shall survive expiration.

If OHCA makes a recovery where the Contractor has sustained a documented loss, but the case did not result from a referral made by the Contractor, OHCA shall not be obligated to repay any monies recovered to the Contractor, but may do so at its discretion.

1.17.11.2 Overpayment Reporting Mechanism for Participating Providers

In accordance with 42 C.F.R. § 438.608(d)(2), the Contractor shall have a mechanism for a Participating Provider to report to the Contractor when the Participating Provider has received an Overpayment, to return the Overpayment to the Contractor within 60 days after the date on which the Overpayment was identified and to notify the Contractor in writing of the reason for the Overpayment. The Contractor shall require Participating Providers to use this reporting mechanism.

**1.17.12 Fraudulent or Abusive Dental Health Plan Enrollee Conduct**

Fraudulent or abusive Dental Health Plan Enrollee conduct may include, but is not limited to, the following:

- Overutilization, such as:
  - Concurrently obtaining services from two or more Providers of the same specialty, not in the same group practice, with no referrals;
  - Concurrently using two or more prescribing physicians and/or dentists to obtain drugs from the same therapeutic class of medication;
  - Using two or more emergency facilities for non-emergent diagnosis;
  - Two or more occurrences of having prescriptions for the same therapeutic class of medication filled two or more times on the same or subsequent day by the same or different Providers; or
  - Concurrently using two or more pharmacies to obtain quantity of drugs from the same therapeutic class of medication which exceed the manufacturer's maximum recommended dosage as approved by the Food and Drug Administration (FDA);
- Fraud, such as:
  - Purchasing drugs on a forged prescription;
  - Loaning the Dental Health Plan Enrollee's SoonerSelect Dental card to another individual to obtain Medicaid-reimbursed services; and
- Engaging in threatening or abusive conduct to Providers.

Dental Health Plan Enrollees may be identified through utilization management, chart review or by referral from Participating Providers. The Contractor shall notify OHCA of Dental Health Plan Enrollees who have been identified as participating in fraudulent or abusive conduct within three Business Days of the Contractor identifying or being informed of the Dental Health Plan Enrollee's conduct.

The Contractor shall also take also additional steps in accordance with OHCA's guidance. OHCA shall work with the Contractor and the Dental Health Plan Enrollee based on the specific circumstances of the fraudulent or abusive activity.

The Contractor, with OHCA's approval, shall provide the Dental Health Plan Enrollee with written notification and supporting documentation of the identified fraudulent or abusive behavior. The Contractor shall provide education to the Dental Health Plan Enrollee regarding the Dental Health Plan Enrollee's behavior. The Contractor shall document all efforts.

The Contractor may request initiation of Disenrollment of Dental Health Plan Enrollees for fraudulent behavior in accordance with the provisions of Section 1.5.7.1: "Contractor Request" of this Model Contract.



### **1.17.13 Transactions with Parties in Interest**

#### **1.17.13.1 Reporting Transactions**

In accordance with §1903(m)(4)(A) of the Act, the Contractor shall report to OHCA and, upon request, to the Secretary of DHHS, the Inspector General of DHHS, and the Comptroller General a description of transactions between the Contractor and a Party in Interest, as defined in §1318(b) of the Public Health Service Act, (Party in Interest) the following transactions:

- Sale or exchange, or leasing of any property between the Contractor and a Party in Interest;
- Furnishing for consideration of goods, services (including management services), or facilities between the Contractor and a Party in Interest, not including salaries paid by the Contractor to employees for services provided in the normal course of employment; and
- Lending of money or an extension of credit between the Contractor and any Party in Interest.

#### **1.17.13.2 Availability of Reports**

In accordance with § 1903(m)(4)(B) of the Act, the Contractor shall make any reports of transactions identified in Section 1.17.13.1: “Reporting Transactions” of this Model Contract between the Contractor and Parties in Interest that are provided to OHCA, the Secretary, the Inspector General of DHHS, or the Comptroller General or other agencies available to Dental Health Plan Enrollees upon reasonable request.

### **1.18 Information Technology**

#### **1.18.1 General Requirements**

The Contractor shall maintain a management information system in full compliance with all requirements of the Health Insurance Portability and Accountability Act (HIPAA), requirements set forth in the Health Information Technology for Economic and Clinical Health Act (HITECH) in 42 U.S.C. 17931, § 6504(a) of the Affordable Care Act and all other applicable state and federal laws and regulations.

In accordance with 42 C.F.R. § 438.242, the Contractor’s information system shall collect, analyze, integrate and report data as set forth in this Contract. The Contractor shall make all information and data collected by the Contractor’s information system available (in usable format specified) to OHCA and, upon request, to the CMS, in accordance with 42 C.F.R. § 438.242(b)(4). Pursuant to 42 C.F.R. § 438.242(b)(1), the Contractor shall comply with Section 6504(a) of the Affordable Care Act, which requires the state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of Section 1903(r)(1)(F) of the Act.

At minimum, the Contractor’s management information system shall:

- Collect data on Dental Health Plan Enrollee and Provider characteristics as specified in Section 2.18 and any subsequent OHCA requirements, and on all services furnished to Dental Health Plan Enrollees through an Encounter Data system, described in Section 1.18.4: “Dental Health Plan Enrollee Encounter Data ” of this Model Contract;
- Ensure that data received from Providers is accurate and complete by:
  - Verifying the accuracy and timeliness of reported data, including data from Participating Providers the Contractor is compensating on the basis of capitation payments;
  - Screening the data for completeness, logic, and consistency; and

- Collecting data from Participating Providers in a standardized format or formats, to the extent feasible and appropriate, including secure information exchanges and technologies utilized for SoonerSelect Dental program quality improvement and care coordination efforts.
- Implement an Application Programming Interface (API) as specified in 42 C.F.R. § 431.60 as if such requirements applied directly to Contractor and include all encounter data, including encounter data from any network providers Contractor is compensating on the basis of capitation payments and adjudicated claims and encounter data from any subcontractors.
- Implement and maintain a publicly accessible standards-based API described in 42 C.F.R. § 431.70, which must include all information specified in 42 C.F.R. § 438.10(h)(1) and (2).
- The Contractor shall conform to HIPAA-compliant standards for information exchange and shall demonstrate this capability at Readiness Review. Batch and online transaction types are as follows:
  - Batch transaction types:
    - ASC X12N 820 Premium Payment
    - ASC X12N 834 Benefit Enrollment and Maintenance
    - ASC X12N 835 Claims Payment Remittance Advice
    - ASC X12N 837D Health Care Claim: Dental
  - Online transaction types:
    - ASC X12N 270/271 Eligibility Coverage or Benefit Inquiry/Response
    - ASC X12N 274 Healthcare Provider Information
    - ASC X12N 276/277 Health Care Claim Status Inquiry/Response
    - ASC X12N 278 Health Care Services Review Inquiry/Response

As a part of its management information system solution, the Contractor shall provide for an electronic document management system, ensuring that documents received from Dental Health Plan Enrollees or Providers maintain logical relationships to certain key data such as Dental Health Plan Enrollee identification and Provider identification numbers when the Contractor houses indexed images of documents used by Dental Health Plan Enrollees and Providers to transact with the Contractor.

The Contractor shall also be required to demonstrate sufficient data analysis and ability to interface with OHCA systems. The Contractor shall ensure medical information will be kept confidential at all times, through security protocol, and with heightened sensitivity as data relates to personal identifiers and sensitive services.

The Contractor shall ensure that its management information system is compliant with any future State or federal regulations within the timeframe stipulated by the respective regulatory body. This includes, but is not limited to, all requirements for Medicaid Managed Care Plans from the “21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program” final rule (ONC 21st Century Cures Act final rule), by the Office of the National Coordinator for Health Information Technology, published in the Federal Register on May 1, 2020.

In accordance with 42 C.F.R. §438.242(c)(3), the Contractor shall collect and submit all data required for state T-MSIS reporting and other CMS required reporting.

#### 1.18.1.1 Ongoing Maintenance of IT Solutions

The Contractor shall maintain its management information system as reviewed and approved during the Readiness Review process described at Section 1.3.10: “Readiness Review” of this Model Contract during the life of this Model Contract. The Contractor shall timely correct any defects identified and will notify

OHCA if the defects impact Provider or Dental Health Plan Enrollee portals or any functionality that supports the delivery of Dental Health Plan Enrollee or Provider services. The Contractor shall submit a report of such defect corrections to OHCA monthly, at minimum. During Readiness Review, the Contractor shall submit an IT Maintenance and Operations plan for OHCA review and approval.

The Contractor shall develop and maintain an IT Roadmap, which shall show any planned upgrades to any component of the IT solution proposed. The IT Roadmap shall be delivered to OHCA at a minimum twice per year. The Contractor shall notify OHCA at least 60 days in advance of: 1) any proposed release upgrades for any Commercial Off the Shelf (COTS) products in use and 2) any changes to non-COTS products requiring custom coding to address a system issue or enhance existing system functionality. The notification shall include an impact statement including what the upgrade will provide and the risks associated with the implementation. OHCA reserves the right to require a delay of no more than 60 days in the implementation of any planned upgrades.

The Contractor shall participate in OHCA Information Technology Defect resolution meetings with OHCA-contracted MMIS vendor(s) as required by OHCA.

### **1.18.2 Operations**

The Contractor's management information system shall integrate information and data components across the Contractor's operations, ensuring all data collection and exchange capabilities are in compliance with the requirements of 42 C.F.R. § 438.242.

The Contractor's management information system shall support all aspects of a managed care operation, which shall include modules/subsections that capture and provide information on the following operational areas, at minimum, as determined by OHCA and in accordance with 42 C.F.R. § 438.242(a):

- Dental Health Plan Enrollee/Enrollee information, including:
  - Disenrollment for reasons other than the loss of Medicaid eligibility; and
  - Grievances and Appeals;
- Third Party Liability;
- Provider;
- Reference;
- Encounter processing;
- Claims processing;
- Financial;
- Utilization Management;
- Quality Improvement;
- Reporting; and
- Program Integrity.

The Contractor shall have the ability to process, receive and send data on these areas, and any other areas necessary for SoonerSelect Dental program operations in a HIPAA-compliant format where applicable.

The Contractor's data management and records system shall have protocols for managing duplicative records for individual Dental Health Plan Enrollees or specific SoonerSelect Dental program populations.

In accordance with 42 C.F.R. 438.242(b) and Section 1.18.1: "General Requirements" of this Model Contract, the Contractor shall ensure the accuracy and completeness of all data submitted to OHCA,

including data from Participating Providers receiving compensation from the Contractor, and all data shall be screened for completeness, logic, consistency and be collected from Providers in standardized formats to the extent feasible and appropriate.

### **1.18.3 Communications with OHCA**

The Contractor shall transmit all data directly to OHCA in accordance with 42 C.F.R. § 438.242. If the Contractor utilizes Subcontractors for services, the Contractor shall ensure all data from the Subcontractors is provided to the Contractor and the Contractor shall transmit the Subcontractors' data to OHCA in a format specified by OHCA. The Contractor's management information system shall be capable of utilizing formats specified by OHCA and shall be capable of sharing information directly with OHCA's systems. The Contractor shall be responsible for ensuring a working interface between OHCA's and the Contractor's system to facilitate exchange of relevant Dental Health Plan Enrollee and Provider data.

The Contractor shall operate a functional email server that is compatible with the systems maintained by OHCA and OHCA's contracted fiscal agent. This server shall be capable of sending and receiving confidential encrypted messages.

The Contractor shall have the ability to meet OHCA's security standards in all communication, including encryption of confidential data and materials.

### **1.18.4 Dental Health Plan Enrollee Encounter Data**

In accordance with the terms of this Contract, 42 C.F.R. § 438.242(c), and all applicable State and federal laws, the Contractor shall collect and maintain sufficient Dental Health Plan Enrollee Encounter Data to identify the Provider who delivers any item(s) or service(s) to Dental Health Plan Enrollees under this Contract. In accordance with 42 C.F.R. § 438.818(a)(1), the Contractor shall have a comprehensive automated and integrated Encounter Data system that complies with HIPAA standards and is capable of meeting the requirements in the subsections below.

#### **1.18.4.1 Encounter Data Detail and Format**

The Contractor shall submit complete, accurate and timely HIPAA-compliant Encounter Data in the level of detail and format to be specified by OHCA. The Contractor's Encounter Data shall be submitted to the State MMIS in the standard HIPAA transaction formats, including the ASC X12N 837D. Contractor paid amounts shall be provided.

The Contractor shall collect, and submit to the State MMIS, Dental Health Plan Enrollee service level Encounter Data for all covered, not covered, and denied services. Encounter data will include servicing Provider data.

The Contractor shall be held responsible for errors or noncompliance resulting from its actions or the actions of an agent authorized to act on its behalf for all submission of data including Encounter Data.

Encounter Data shall be certified and submitted in accordance with 42 C.F.R. § 438.606 and Section 1.20.1.3: "Certification Requirements" of this Contract. The Encounter Data shall include fully adjudicated claims from the previous seven days as well as any corrections from previous encounter submissions. OHCA reserves the right to alter the level of detail or format in which the Encounter Data is submitted. Should this occur, the Contractor shall comply with any such changes. The Contractor's Dental Health Plan Enrollee Encounter Data submitted to OHCA shall meet all requirements and include all information that

the State is required to report to the CMS under 42 C.F.R. § 438.818 and shall be submitted to OHCA in the Accredited Standards Committee (ASC) X12N 837, National Council for Prescription Drug Programs (NCPDP) formats and the ASC X12N 835 format, as appropriate. Collection, maintenance, submission and specifications of Dental Health Plan Enrollee Encounter Data shall be compliant with 42 C.F.R. §438.242.

The Contractor and its Provider network shall accept and use the State assigned Provider IDs for Encounter Data submissions. The Contractor and its Provider network shall accept and use state eMPI/ Medicaid IDs for SoonerCare Eligibles. The Contractor will provide unique MCO identifiers for Encounter Data submission.

#### 1.18.4.2 Timely Submission and Reconciliation

The Contractor shall require all Providers and any delegated Subcontractors to submit Encounter Data and claims data in sufficient detail to support detailed utilization tracking and financial reporting. The Contractor shall submit all Encounter Data to OHCA and the State HIE. The Contractor shall collect and submit Encounter Data to the state HIE within three Business Days of adjudication. All adjusted encounters must be submitted within three Business Days of adjustment. OHCA reserves the right to alter the frequency of required data submission. Should this occur, the Contractor shall comply with any such changes.

The Encounter Data submitted by the Contractor to OHCA shall include the Encounter Data from all Subcontractors and be sufficient to determine which Provider provided a service(s) or item(s) to a Dental Health Plan Enrollee. Data submitted regarding a Provider interaction shall include the appropriate NPI and service location code. Encounter Data shall be submitted for all of the following types of claims processed by the Contractor or Subcontractors:

- Paid;
- Denied;
- Corrected;
- Voided; and
- Zero dollars paid.

The Contractor shall submit Encounter Data for 100% of encounters within three Business Days of adjudication. This includes all claim types indicated in the immediately preceding paragraph.

#### 1.18.4.3 OHCA Review of Encounter Data

In accordance with 42 C.F.R. § 438.242(d), OHCA shall review and validate that the Encounter Data collected, maintained, and submitted to OHCA by the Contractor meets the requirements of 42 C.F.R. § 438.242. If OHCA determines that the Contractor Encounter Data submission does not meet accuracy and completeness standards or is denied by OHCA for another reason, it shall require the Contractor to correct the Encounter Data and resubmit it to OHCA within 30 days. OHCA may audit the data for accuracy at any time. The Contractor shall support OHCA's Encounter Data Validation activities.

The Contractor acknowledges that complete and validated Encounter Data is critical for OHCA to meet the CMS' reporting and rate setting requirements. The Contractor shall collaborate with OHCA and OHCA's designated technology vendor(s) to make adjustments to the Contractor's Encounter Data processing system to meet the requirements of the technology vendor(s).

#### 1.18.4.4 Health Information Exchange

As required by OHCA, the Contractor shall participate in the State's designated health information exchange (HIE) initiatives for submission of Encounter Data and exchange of clinical information in order to improve the quality and efficiency of health care delivery in numerous ways, including: reducing medical errors; decreasing duplicative or unnecessary services; improving data quality for public health research; promoting population health management, reducing manual, labor-intensive monitoring and oversight; and reducing Fraud and Abuse.

The Contractor shall develop, implement and participate in health information technology (HIT) and data sharing initiatives in order to improve the quality, efficiency and safety of health care delivery in the State. The Contractor shall assign staff to participate in a technical workgroup as scheduled by OHCA and the State HIE vendor. The workgroup's purpose is to enhance the data submission requirements and improve the accuracy, quality, and completeness of the Encounter Data submission to the State HIE.

The Contractor shall be required to enter into data sharing agreements with any health information technology entity that the state enters into data sharing agreement with to operate the statewide HIE.

The Contractor's participation shall include bi-directional interfaces to gather and send clinical data to the HIE. The Contractor shall require its Providers with CMS certified Electronic Health Records (EHR) systems to connect to the state HIE for the purpose of bi-directional health data exchange. Providers who do not have a certified EHR shall be required to use the state HIE provider portal to query patient data for enhanced patient care.

If the Provider does not have an EHR, they must still sign a participation agreement with the state HIE and sign up for direct secure messaging services and portal access so that clinical information can be shared securely with other Providers in their community of care.

The Contractor's Participating Providers shall sign a participation agreement with the Oklahoma state HIE within one month of contract signing. Providers shall engage with the state HIE for the purpose of connecting their EHR system to the HIE to share their patient electronic records. The ultimate objective is to facilitate improved care coordination resulting in higher quality care and better outcomes.

The Contractor shall submit a monthly report to OHCA regarding Contractor(s) Provider Network and Provider EHR, HIE connectivity status.

The Contractor shall be responsible for establishing connectivity to the state-wide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable state policies, standards and guidelines.

The Contractor shall collect, and submit to the state HIE, Dental Health Plan Enrollee service level Encounter Data for all covered, not covered, and denied services. Encounter Data will include servicing Provider data as required by 42 C.F.R. § 242(c)(1). The Contractor's Encounter Data shall be submitted to the state HIE in the standard HIPAA transaction formats, including the ASC X12N 837D transaction format. Contractor paid amounts shall be provided.

The Contractor 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-electronic compliant formats.

The Contractor and their network of Participating Providers shall accept and use the state assigned Provider IDs for Encounter Data submissions.

The Contractor and their network of Participating Providers shall accept and use state eMPI/ Medicaid IDs for SoonerCare Eligibles. The Contractor(s) will provide unique DBM identifiers for their Encounter Data submissions.

The Contractor shall collect and submit Encounter Data to the state HIE within three Business Days of adjudication. All adjusted encounters must be submitted within three Business Days of adjustment.

#### **1.18.5 Enrollment Data**

The Contractor shall maintain an eligibility and enrollment subsystem that is continuously updated with information both received from OHCA and received directly from a Dental Health Plan Enrollee. This subsystem shall have the ability to interface with the Contractor's claims processing and care management systems and maintain information at a detail level to be specified by OHCA. The Contractor shall be responsible for verifying Dental Health Plan Enrollee eligibility data and reconciling with Capitation Payments for each eligible Dental Health Plan Enrollee. The Contractor shall reconcile its eligibility and capitation records monthly. OHCA shall determine the terms for reconciling eligibility and underpayments of capitation back to the Contractor. The Contractor shall be financially responsible for the Dental Health Plan Enrollee's SoonerSelect Dental program covered benefits that are the responsibility of the Contractor under this Contract if the Contractor receives either enrollment information or a Capitation Payment. OHCA reserves the right to alter the frequency of required eligibility and capitation record reconciliation. Should this occur, the Contractor shall comply with any such changes.

The Contractor shall accept enrollment data in electronic format, via secure file transfer protocol ("SFTP"), as directed by OHCA and as detailed in OHCA Program Companion Guide – 834 Contractor Benefit Enrollment and Maintenance Transaction (834 Companion Guide), which shall be updated by OHCA or its designated third party MMIS vendor. OHCA reserves the right to amend the 834 Companion Guide. The Contractor shall be responsible for loading all eligibility information into its system within one Business Day of receipt.

The Contractor's database shall have the capability to identify an individual Dental Health Plan Enrollee across multiple demographic and clinical data sets. The system must also be able to utilize a unique Oklahoma based Master Patient Index (MPI).

The Contractor shall develop and maintain policies and procedures to ensure the accuracy and completeness of the data submitted to OHCA. The Contractor shall continuously update the subsystem with data submitted by OHCA and the Dental Health Plan Enrollee. OHCA reserves the right to audit data submitted by the Contractor for validity and completeness at any time. The Contractor shall screen the data for completeness, logic and consistency. The Contractor's system shall maintain audit trails for this purpose.

#### **1.18.6 System Security**

The Contractor shall maintain systems, policies and procedures that ensure state and federal standards for compliance and security are met and to protect the integrity of all business and technical components of the Contractor's operations under this Contract. This includes, but is not limited to, a requirement that Contractor must comply with the most current version of the suite of documents entitled the Minimum Acceptable Risk Standards for Exchanges ("MARS-E"). Alternatively, Contractor agrees to implement and

maintain standards that at all times meet or exceed the most current MARS-E requirements. For example NIST 800-53 rev 4 (moderate system) would meet the requirements of the current MARS-E. Contractor further agrees to maintain a level of security that is commensurate with the risk and magnitude of the harm that could result from the loss, misuse, disclosure, or modification of the information contained on the system with the highest security levels. If at any time, Contractor plans to implement and maintain security standards other than MARS-E or the most current applicable NIST standards, Contractor must submit the specific details of the planned change to OHCA for approval not later than 60 days before the date of planned implementation. Contractor is prohibited from implementing different security standards that would reduce the level of protection provided or that would cause OHCA to fall out of compliance with any applicable laws, regulations, or requirements of government agencies with jurisdiction or enforcement authority over OHCA.

The Contractor shall ensure access to data systems is restricted by employing an access management function that restricts individual access to data in a tiered structure based on the security clearance of the individual accessing the data. The Contractor shall ensure access to information is based on job function with the overarching concept of access to information on the minimum basis required for adequate performance of the job function (e.g., users permitted inquiry privileges only will not be permitted to modify information if not applicable to the requirements of the job the individual is performing).

The Contractor shall ensure every point of data receipt and processing has appropriate security and data integrity protocols in place. The Contractor shall be responsible for providing physical safeguards to its data processing center, operations center and any related information or systems. These safeguards shall remain in place for the duration of the Contractor's relationship with OHCA. The Contractor shall grant authorized OHCA and CMS personnel and any designees access to its facilities upon request.

Contractor shall maintain data online for no less than three years; and shall retain additional archive history for no less than ten years and the Contractor shall ensure such data is retrievable within 48 hours.

The Contractor shall provide OHCA with a list of all staff with access to identifying Dental Health Plan Enrollee data upon request from OHCA.

The Contractor shall make available identifying Dental Health Plan Enrollee data to authorized and designated State and federal employees and designees.

The Contractor shall immediately (in any event, not later than within one hour of Discovery) notify OHCA in the event of an information security breach, including unintentional security issues caused by the Contractor's employees. The Contractor shall maintain audit trails on individual Dental Health Plan Enrollee documentation and have the ability to determine who has accessed or viewed a Dental Health Plan Enrollee's personal medical information.

The Contractor shall abide by the current State of Oklahoma Security Standards at: <https://www.ok.gov/cio/documents/InfoSecPPG.pdf> and any updates thereto. Contractor recognizes that it may be necessary for OHCA to require Contractor to adhere additional or modified security standards which may be more stringent than the State of Oklahoma Security Standards, in order to maintain compliance with applicable laws, rules, regulations, legal requirements, and industry best practices. In the event OHCA determines additional or modified security standards to be necessary, it will give Contractor at least sixty (60) days advance written notice of any changes in requirements, and Contractor agrees to timely implement and comply with the same.



In addition, the Contractor shall complete and attest to meeting all Security Specifications in Form 8070001235-P-DBM Security Specifications located in the Bidder's Library. An annual SOC 2 Type II of the Dental Benefit Manager system is required as is annual penetration testing of the system conducted by independent pen test practitioner. Contractor will provide copies of the annual SOC 2 Type II Report, all penetration testing reports, and any additional independent assessment or audit completed to attest to Contractor's security controls upon OHCA's request. The Contractor shall require Multi-Factor-Authentication (MFA) for all privileged users, defined as those users that have access to PHI across all of the Contractor's systems.

Contractor shall complete Form 8070001235-Q-OMES Cloud Computing Certification located in the Bidder's Library, based on proposed system environment as a part of Proposal submission.

To the extent Contractor requests to use a third-party hosting vendor, that vendor is subject to OHCA's approval and must satisfactorily complete the State's Certification and Accreditation Review and any supplemental requests by OHCA. Contractor agrees not to migrate OHCA's data or otherwise utilize a different third-party hosting vendor in connection with key business functions that are Contractor's obligations under the Contract until OHCA approves the third-party hosting vendor's State Certification and Accreditation Review. In the event the third-party hosting vendor is not approved by OHCA, Contractor acknowledges and agrees it may not utilize such third-party vendor in connection with key business functions that are Contractor's obligations under the Contract, until such third party meets OHCA requirements.

#### **1.18.7 Disaster Preparation and Data Recovery**

The Contractor shall submit a plan that addresses disaster recovery and business continuity related to emergency situations to OHCA for review and approval during Readiness Review detailed in Section 1.3.10: "Readiness Review" of this Model Contract and on an annual basis thereafter.

The plan shall include the following aspects of disaster recovery, at minimum:

- Communications;
- Physical plant security;
- Data security; and
- Fire/disaster prevention and recovery procedures.

Each aspect included within the disaster recovery plan must describe both the Contractor and OHCA's responsibilities. For purposes of this requirement, "disaster" means an occurrence of any kind that adversely affects, in whole or in part, the error-free and continuous operation of the Contractor's or its Subcontractors' IS or affects the performance, functionality, efficiency, accessibility, reliability or security of the system. Disasters may include natural disasters, human error/malfeasance/neglect, computer virus or malfunctioning hardware or electrical supply.

The Contractor shall take all steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. OHCA and the Contractor will jointly determine when unscheduled system downtime will be elevated to a "disaster" status.

The Contractor shall notify OHCA, at a minimum, within two hours of discovery of a disaster or other disruptions in its normal business operations. Such notification shall include a detailed explanation of the impact of the disaster, particularly related to mission critical business processes, such as claims

processing, eligibility and enrollment processing, Service Authorization (PA) management, Provider enrollment and data management, Encounter Data management, and any other processing affecting the Contractor's capability to interface with OHCA or OHCA's contractors. If all information required herein is not available within the required time frame for reporting, Contractor shall not delay the initial report, but shall provide as much information as is available at the time and shall continue to update OHCA with additional information at least every four hours until complete information is provided. OHCA, in its discretion, may require the Contractor to provide a detailed plan for resuming operations.

The Contractor shall develop Information system contingency planning in accordance with the requirements of this Section and with 45 C.F.R. § 164.308, which relates to administrative safeguards. Contingency plans shall include: data backup plans, disaster recovery plans and emergency mode of operation plans. Application and Data Criticality analysis and testing and revisions procedures shall also be addressed within the Contractor's contingency plan documents. The Contractor shall be responsible for executing all activities needed to recover and restore operation of information systems, data and software at an existing or alternative location under emergency conditions within 24 hours of identification of a disaster. The Contractor shall protect against hardware, software and human error. The Contractor shall maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups and disaster recovery. The Contractor shall maintain full and complete back-up copies of data and software and shall back up on tape or optical disk and store its data in an off-site location approved by OHCA.

The Contractor shall have the capability to continue receiving, processing and disseminating data and reports within 24 hours of a disaster situation. In the event of a catastrophic or natural disaster, including, but not limited to: fire, flood, earthquake, storm, hurricane, war, invasion, act of foreign enemies, or terrorist activities, the Contractor shall resume normal business functions at the earliest possible time, not to exceed 30 Calendar Days from the date of the catastrophic event or natural disaster. In the event of any other disasters or system unavailability caused by the failure of systems and technologies within the Contractor's scope of control including, but not limited to, system failures caused by criminal acts, human error, malfunctioning equipment or electrical supply, the Contractor shall resume normal business functioning at the earliest possible time, not to exceed ten Calendar Days.

The Contractor may include resources outside Oklahoma but within the United States as part of this plan. If applicable, the plan must satisfy all requirements for federal certification.

The plan shall be maintained and updated by the Contractor throughout the term of this Contract and shall be available for review by State or federal officials on request. The Contractor shall certify to OHCA that the disaster recovery plan has been tested at least annually and has passed all aspects of testing.

The Contractor shall have a disaster preparation and recovery plan specific to operating information systems in a disaster situation.

The data system shall be accessible remotely and offsite. The offsite system shall be capable of providing basic system functions in the event of a disaster incapacitating another system site.

The Contractor and its Subcontractors' responsibilities include, but are not limited to:

- Supporting immediate restoration and recovery of lost or corrupted data or software;

- Establishing and maintaining, in an electronic format, a weekly back-up and a daily back-up that are adequate and secure for all computer software and operating programs; database tables; files; and system, operations and user documentation;
- Demonstrating an ability to meet back-up requirements by submitting and maintaining data backup and disaster recovery plans that address:
  - Checkpoint and restart capabilities and procedures;
  - Retention and storage of back-up files and software;
  - Hardware back-up for the servers;
  - Hardware back-up for data entry equipment;
  - Network back-up for telecommunications; and
  - Developing coordination methods for disaster recovery activities with OHCA and its contractors to ensure continuous eligibility, enrollment and delivery of services; and
- Providing OHCA with business resumption documents, reviewed and updated at least annually, but not limited to:
  - Disaster recovery plans;
  - Business continuity and contingency plans;
  - Facility plans; and
  - Any other related documents as identified by OHCA.

At no additional charge to OHCA, the Contractor shall be required to have in a place a comprehensive, fully tested IT business continuity/disaster recovery plan (BCDR) with respect to the system and services it provides to OHCA under this Model Contract. The BCDR plan will, at a minimum, meet the requirements of National Institute of Standards and Technology (NIST) SP800-34 and its successor publications once made final.

The State and the Contractor will mutually agree on reasonable Recovery Point Objectives and Recovery Time Objectives reflective of the State's business requirements and the critical nature of the Contractor's systems and services in support of the associated State business operations:

- At a minimum, the Recovery Time Objectives will be no more than 48 hours; and
- At a minimum, the Recovery Point Objectives will be no more than 24 hours.

These Objectives will be reviewed and, as necessary, modified on an annual basis.

The Contractor shall coordinate its BCDR plan with OHCA's IT business continuity/disaster recovery plans, including other State solutions with which the Contractor's system interfaces to assure appropriate, complete, and timely recovery.

The Contractor agrees to coordinate the development, updating, and testing of its BCDR plan with the State in the State's development, updating, and testing of its Continuity of Operations Plan (COOP), as required by State policy and Homeland Security Presidential Directive (HSPD) 20.

The BCDR plan will be based on the agreed upon Recovery Point Objectives and Recovery Time Objectives, and a comprehensive assessment of threat and risk to be performed by the Contractor, with such threat and risk assessment updated no less than annually by the Contractor, reflecting technological changes, Contractor business changes, OHCA business operations changes and other appropriate factors agreed upon by the Contractor and OHCA.

The Contractor shall test its BCDR plan no less than annually, with such testing being comprehensive in nature and scope assuring point-to-point testing in meeting the agreed upon Recovery Point Objectives and Recovery Time Objectives.

The first test of the Contractor's BCDR plan shall be performed within 90 Calendar Days of the award of this Contract.

The Contractor will provide the State with an annual report regarding the Contractor's annual, at minimum, testing and updating of its BCDR plan, including the results of the test, failure points and corrective action plans.

OHCA retains the right to veto, change or request revisions to all plans required under this Section 1.19.9.

#### **1.18.8 Back-up Plan**

The Contractor shall develop a back-up plan for maintaining provisional functionality of the information technology and data management systems in the event of any failure that incapacitates main systems. The plan shall articulate the data management strategy in place to ensure the Contractor can meet the Recovery Point Objectives mentioned in the BCDR plan as required pursuant to Section 1.18.7: "Disaster Preparation and Data Recovery" of this Model Contract.

The Contractor shall submit this back-up plan to OHCA for review during the Readiness Review at Section 1.3.10: "Readiness Review" of this Model Contract. OHCA retains the right to veto, change or request revisions to the back-up plan.

#### **1.18.9 Accessibility**

The Contractor shall ensure that Dental Health Plan Enrollees and Providers have continuous access to information to be designated by OHCA. Internet accessibility shall comply with requirements in Section 1.10: "Dental Health Plan Enrollee Services" of this Model Contract, Section 508 of the Rehabilitation Act of 1973, Pub. L. No. 93-112, and the Oklahoma Electronic and Information Technology Accessibility law, 2004 HB 2197. The Contractor shall ensure Information is available 24 hours a day, seven days per week via the Dental Health Plan Enrollee portal, Provider portal, and/or toll-free phone-based functions and including, but not limited to: confirmation of enrollment, electronic claims management, Dental Health Plan Enrollee services and Provider services. The exceptions to this requirement include during periods of scheduled system unavailability for maintenance or updates during specific time periods agreed upon by OHCA and the Contractor and unavailability caused by events outside of the Contractor's scope of control.

The Contractor shall ensure that all system functions used for enrollment, disenrollment, claims or transaction submission/receipt/processing, transaction viewing or searches, and interfacing/exchanging data for Dental Health Plan Enrollees, providers and State staff are accessible between 7:00 am and 7:00 pm Central Time, Monday through Friday with the exception of State Holidays.

The URL for the Contractor's public website shall be submitted to OHCA to embed in agency websites. The URL may not be changed without OHCA's approval.

The Contractor shall maintain a point of contact with OHCA should OHCA staff require assistance interfacing/exchanging data with Contractor's system.

#### 1.18.9.1 System Performance Requirements

The Contractor shall ensure that the average response time that is controllable by the Contractor is no greater than the requirements set forth below, between 7:00 am and 7:00 pm Central Time, Monday through Friday for all applicable system functions except for the following:

- During periods of scheduled downtime agreed upon by OHCA and the Contractor;
- During periods of unscheduled unavailability caused by systems and telecommunications technology outside of the Contractor's scope of control; or
- Dental Health Plan Enrollee and Provider portal and phone-based functions, such as Dental Health Plan Enrollee eligibility and enrollment and electronic claims submission that are expected to be available 24 hours a day, seven days a week.

##### 1.18.9.1.1 Record Search Time

The response time shall be within three seconds for 98% of the record searches as measured from a representative sample of OHCA System Access Devices.

##### 1.18.9.1.2 Record Retrieval Time

The retrieval time shall be within three seconds for 98% of the records retrieved as measured from a representative sample of OHCA System Access Devices.

##### 1.18.9.1.3 On-line Adjudication Response Time

The response time shall be within five seconds 99% of the time as measured from a representative sample of user System Access Devices.

##### 1.18.9.1.4 Screen Display Time

The system screen display time shall be within two seconds for 95% of the time as measured from a representative sample of user System Access Devices. Screen Display Time is the time elapsed after the last field is filled on the screen with an enter command until all field entries are edited with errors highlighted on the monitor.

##### 1.18.9.1.5 New Screen Page Time

The new screen page time shall be within two seconds for 95% of the time as measured from a representative sample of user System Access Devices. New screen page time is the time elapsed from the time a new screen is requested until the data from the screen appears or loads to completion on the monitor.

#### 1.18.9.2 System Performance Notification and Reporting

The Contractor shall develop an automated method of monitoring the online performance and responsiveness of all systems, including web portals. The monitoring method shall separately monitor for availability and performance/response time each component of the systems named in Section 1.18.2: "Operations" of this Model Contract.

Upon discovery of any issues within its scope of control that may jeopardize system availability and performance as defined in this Section 1.18, the Contractor shall notify OHCA Business Enterprises in person, via phone and electronic mail, followed by surface mail notification.

The Contractor shall deliver notification as soon as possible, but no later than two hours after the problem occurs.

The Contractor shall resolve unscheduled system unavailability, caused by the failure of systems and telecommunications technologies within the Contractor's scope of control, and shall implement the restoration of services, within 30 minutes of the Contractor's discovery of system unavailability. The Contractor shall resolve unscheduled system unavailability to all other Contractor system functions caused by systems and telecommunications technologies outside of the Contractor's scope of control and shall implement the restoration of services within four hours of the Contractor's discovery of system unavailability.

Cumulative system unavailability caused by systems and telecommunications technologies within the Contractor's scope of control shall not exceed one hour during any continuous five Calendar Day period.

Where the operational problem results in delays in report distribution or problems in on-line access during the Business Day, the Contractor shall notify OHCA within 15 minutes of discovery of the problem, in order for the applicable work activities to be rescheduled or be handled based on system unavailability protocols.

The Contractor shall provide to OHCA, information on system unavailability events, as well as status updates on problem resolution. These updates shall be provided on an hourly basis and made available via electronic mail, telephone and the Contractor's website.

## **1.19 Financial Standards and Third Party Liability**

### **1.19.1 Financial Stability**

The Contractor shall maintain a financially stable operation in accordance with all State and federal laws, regulations and guidance. The Contractor shall meet and comply with all policies and administration of these processes. The Contractor shall maintain a fiscally solvent operation per federal regulations and Oklahoma Insurance Department (OID) requirements for a minimum net worth and risk-based capital including the following requirements:

- Initial and continuing net worth;
- Paid-in capital;
- Determination of liabilities;
- Risk-based capital investments; and
- Additional reserve or surplus protections as may be required by the OID.

OHCA and the OID will monitor the Contractor's financial performance. OHCA will include OID findings in its monitoring activities. The Contractor shall copy OHCA on required filings with the OID and shall provide separate financial information pertaining to this Contract upon submission. Further responsibilities may also be required following the Contract award date.

#### **1.19.1.1 Insolvency Protection**

The Contractor shall comply with state and federal requirements for protection against insolvency, including 42 C.F.R. § 438.106 and Section 1932(b)(6) of the Act. The Contractor shall develop and maintain an Insolvency Plan pursuant to 36 O.S. § 6913(E) and have a process in place to review and authorize contracts established for reinsurance and third-party liability, as applicable. Unless the Contractor is a federally qualified HMO (as defined in Section 1310 of the Public Health Service Act), the Contractor shall comply with 42 C.F.R. § 438.116, which requires the Contractor:

- Provide satisfactory assurances to OHCA showing that its provision against the risk of insolvency is adequate to ensure that Dental Health Plan Enrollees will not be liable for the Contractor's debts should it become insolvent; and
- Meet the solvency standards established by the HMO Act of 2003, 36 O.S. § 6901, *et. seq.* (OSCN 2016).

In accordance with 42 C.F.R. § 438.106, the Contractor shall also ensure Dental Health Plan Enrollees are not held liable for any of the following:

- The Contractor's debts in the event of the Contractor's insolvency;
- Covered services provided to the Dental Health Plan Enrollee for which OHCA does not pay the Contractor, or for which OHCA or the Contractor does not pay the Provider that furnished the service under a contractual, referral, or other arrangement; and
- Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the Dental Health Plan Enrollee would owe if the Contractor covered the services directly.

#### 1.19.1.2 Eligible Investments

The Contractor shall invest in or loan their funds on the security of, and shall hold as assets, only eligible investments as prescribed in 36 O.S. § 1601, *et seq.*

#### 1.19.1.3 Modified Current Ratio

The Contractor must maintain current assets, plus long term investments that can be converted to cash within five Business Days without incurring a penalty of more than 20% that equal or exceed current liabilities.

If a penalty for conversion of long term investments is applicable, only the value excluding the penalty may be counted for the purpose of compliance with this requirement. Provided they are not issued by or include an interest in an Affiliate, the types of long term investments that may be counted, consistent with above requirements, are prescribed in 36 O.S. § 1601, *et seq.*

#### 1.19.1.4 Prior Approval of Payments to Affiliates

The Contractor shall not pay money or transfer any assets to an Affiliate without prior approval from OHCA except for payment of a claim for a medical product or service that was provided to a Dental Health Plan Enrollee and paid in accordance with a written Provider contract and this Contract. To obtain authorization, the Contractor must demonstrate to OHCA that the Contractor:

- Meets specified risk-based capital requirements as of the close of the most recent year for which the due date for filing the annual unaudited OID financial report has passed;
- Complies with the Contract financial stability and solvency protection requirements as of the last day of the most recent quarter for which the due date for filing OID financial reports has passed; and
- Would remain in compliance with the Contract's financial stability and solvency protection requirements following the proposed transaction.

OHCA may require repayment of amounts involved in the transaction if subsequent audit or other adjustments determine that the Contractor did not comply with the Contract's financial stability and solvency protection requirements after the transaction took place.

### 1.19.2 Medical Loss Ratio

The Contractor shall calculate and report to OHCA its medical loss ratio (MLR) for each MLR Reporting Year in accordance with 42 C.F.R. § 438.8 and the following methodology:

- The MLR is the ratio of the numerator (as defined in accordance with 42 C.F.R. § 438.8(e)) to the denominator (as defined in accordance with 42 C.F.R. § 438.8(f)).
- Each Contractor expense shall be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis.
- Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.
- Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.
- Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.
- The Contractor may add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is Partially Credible.
- The Credibility Adjustment is added to the reported MLR calculation before calculating any remittances.
- The Contractor may not add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is Fully Credible.
- If the Contractor's experience is Non-Credible, it is presumed to meet or exceed the MLR calculation standards.
- The Contractor shall aggregate data for all Medicaid eligibility groups covered under the Contract, with the exception that the Contractor shall separately report the MLR for Expansion Adults.

The Contractor shall submit an MLR report to OHCA in accordance with the Reporting Manual requirements, which shall be within 12 months of the end of the MLR Reporting Year, and that includes for each MLR Reporting Year, the following, in accordance with 42 C.F.R. § 438.8:

- Total incurred claims.
- Expenditures on quality improving activities.
- Expenditures related to activities compliant with program integrity requirements.
- Non-claims costs.
- Premium revenue.
- Taxes.
- Licensing fees.
- Regulatory fees.
- Methodology(ies) for allocation of expenditures.
- Any Credibility Adjustment applied.
- The calculated MLR.
- Any remittance owed to OHCA, if applicable.
- A comparison of the information reported with the audited financial report.



- A description of the aggregation method used to calculate total incurred claims.
- The number of Member months.

The Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR Reporting Year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

In the event OHCA makes a retroactive change to the Capitation Payments for an MLR Reporting Year where the MLR report has already been submitted to OHCA, the Contractor shall re-calculate the MLR for all MLR Reporting Years affected by the change and submit a new MLR report.

The Contractor shall attest to the accuracy of the calculation of the MLR when submitting the MLR Report in accordance with the MLR standards delineated in this section and 42 C.F.R. § 438.8.

1.19.2.1 MLR Corridor and MLR Remittance

The Contractor’s total annual Capitation Payments shall be evaluated against a minimum 85% MLR, calculated in accordance with 42 C.F.R. § 438.8. The Contractor’s gains and losses shall be evaluated according to the table below. Note for illustrative purposes the table below uses a Capitation Rate priced-for (target) MLR of 90%. As the Capitation Rates have not yet been developed, this illustrated 90% is subject to change. The corridor will be symmetric. The 85% minimum MLR will not change and neither will the share factors. However, given the change in the priced-for MLR, the 88%, 92%, and 95% will be adjusted to provide a symmetrical corridor. The MLR calculation will be done across all population groups except a separate calculation will be done for the Medicaid Expansion population for federal match claiming purposes.

The following table has been provided for illustrative purposes only:

Medical Loss Ratio Corridor	Contractor Share of Gain/Loss in the Corridor	OHCA/CMS Share of the Gain/Loss in the Corridor
MLR of less than 85%	0%	100%
MLR equal to or greater than 85% and less than 88%	50%	50%
MLR equal to or greater than 88% and less than 92%	100%	0%
MLR equal to or greater than 92% and less than 95%	50%	50%
MLR equal to or greater than 95%	0%	100%

OHCA reserves the right to modify the target MLR and associated corridor in future Contract years, in accordance with Section 1.1.9: “Amendments or Modifications” of this Model Contract. OHCA and the Contractor shall remit to OHCA or the Contractor all applicable refunds in the manner and timeframe specified by OHCA. This provision shall survive expiration of the Contractor’s other duties under the SoonerSelect Dental program, in the event the Contractor is terminated or not renewed.

### **1.19.3 Third Party Liability**

The Contractor will be notified of known Dental Health Plan Enrollee third party resources via the ANSI ASC X 12 834 electronic transactions. Dental Health Plan Enrollee third party resource information provided to the Contractor will be based upon information obtained or made available to OHCA at the time of an Applicant's or Eligible's eligibility determination or re-determination.

Medicaid shall be the payer of last resort for all covered services in accordance with federal regulations, including 42 C.F.R. 433 Subpart D and 42 C.F.R. § 447.20. The Contractor shall make every reasonable effort to:

- Determine the liability of third parties to pay for services rendered to Dental Health Plan Enrollees;
- Avoid costs which may be the responsibility of third parties; and
- Recover any liability from responsible third party sources, except for estate recovery and third party subrogation. Contractor shall calculate amount to be recovered by using their fee schedule for the specific service.

The Contractor shall treat funds recovered from third parties as reductions to claims payment as required under Section 1.13.4.1: "Claims Processing System and Methodology" of this Model Contract and shall report all TPL collections in the manner and timeframe required by OHCA.

#### 1.19.3.1 Third Party Liability Procedures

The Contractor shall develop and implement policies and procedures to meet its obligations regarding Third Party Liability cost avoidance and recovery when the third party pays a benefit to a Dental Health Plan Enrollee.

#### 1.19.3.2 Third Party Payment to Subcontractors

If Third Party Liability exists for part or all of the services provided to a Dental Health Plan Enrollee by a Subcontractor or a Provider, and the third party will make payment within a reasonable time, the Contractor may pay the Subcontractor or Provider only the amount, if any, by which the Subcontractor's or Provider's allowable claim exceeds the amount of Third Party Liability.

#### 1.19.3.3 Determination of Third Party Payment

If probable existence of Third Party Liability has been established at the time a claim is filed, the Contractor must reject the claim and return it to the Provider for a determination of the amount of any Third Party Liability. The Contractor shall provide Third Party Liability data to any Provider having a claim denied by the Contractor based upon Third Party Liability.

Notwithstanding the forgoing, in accordance with 42 C.F.R. § 433.139(b), the Contractor shall pay claims for the following and then bill the responsible third party:

- Preventive pediatric services, including EPSDT; and
- For a service provided to a Dental Health Plan Enrollee on whose behalf child support enforcement is being carried out if the third party coverage is through an absent parent and the Provider certifies that, if the Provider has billed a third party, the Provider has waited 100 days from the date of service without receiving payment before billing Medicaid.

#### 1.19.3.4 Third Party Payment Denial

The Contractor shall deny payment on a claim that has been denied by a third party payer when the reason for denial is the Provider or Dental Health Plan Enrollee's failure to follow claims and payment procedures

specified by the third party. The basis for such denials may include the failure to obtain Prior Authorization, receive care from a Participating Provider and timely submit claims for payment according to submission procedures.

#### 1.19.3.5 Third Party Payment Recovery

The Contractor shall retain third party payment recoveries, except as otherwise specified in this section. The Contractor shall post all third party payments to claim level detail by Dental Health Plan Enrollee.

#### 1.19.3.6 Estate Recovery Activities

OHCA shall be solely responsible for estate recovery activities and shall retain any funds recovered through these activities.

#### 1.19.3.7 Third Party Subrogation and Recovery

The Contractor shall identify potential subrogation cases using a list of OHCA-approved diagnosis and treatment codes. When subrogation is identified, the Contractor shall notify OHCA in the timeframe and manner required by OHCA. OHCA will be responsible for pursuing subrogation and will retain all subrogation recoveries.

#### 1.19.3.8 Third Party Payment Exclusions

The Contractor shall not consider allowable Dental Health Plan Enrollee Cost Sharing and Dental Health Plan Enrollee payment responsibilities as permitted under the Contract as a Third Party Liability source.

#### 1.19.3.9 Third Party Payment Resource Information

The Contractor must cooperate with OHCA or its cost-recovery vendor, in recovering benefits provided by Dental Health Plan Enrollee's access to other insurance.

OHCA may require a contracted Third Party Liability vendor to review paid claims that are over 90 days old and pursue Third Party Liability (excluding subrogation) for those claims that do not indicate recovery amounts in the Contractor's reported Encounter Data. OHCA has sole right of recovery after 365 Calendar Days. In accordance with 63 O.S. § 5051.2(E), the Contractor shall make appropriate payments to OHCA provided the claim is submitted for consideration within three years from the date the service was furnished. Any action by OHCA to enforce the payment of the claim shall be commenced within six years of the submission of the claim by OHCA.

If the Contractor operates or administers any non-Medicaid health plan or other lines of business, the Contractor shall assist OHCA in a manner to be specified with identification of Dental Health Plan Enrollees with access to other insurance.

## **1.20 Reporting**

### **1.20.1 General Reporting Obligations**

In accordance with 42 C.F.R. § 438.604(b), the Contractor shall submit any data, documentation or information relating to the Contractor's performance as required by OHCA or the Secretary. OHCA intends to publish a Reporting Manual outlining the Contractor's performance reporting obligations. The Contractor shall comply with all Reporting Manual requirements and submit all requested data completely and accurately within the timeframes and format prescribed by OHCA.

Failure to comply with reporting requirements as outlined in the Reporting Manual, or via ad hoc request from OHCA, may subject the Contractor to Non-Compliance Remedies. At any time that a submitted report is rejected for non-compliance other than timeliness, the Contractor shall revise the report and

cure the reason for rejection within five days of notification from OHCA or as otherwise specified. Any revisions to previously submitted reports must be re-submitted in the format specified by OHCA.

If the Contractor delegates any activities or obligations under the Contract, the Subcontractor, individual or entity accepting delegation shall also perform the Contractor's reporting responsibilities and obligations in compliance with the Contract and Reporting Manual.

The Contractor shall provide access to OHCA, upon request, of all source data utilized to generate reports required under the Contract to permit OHCA to validate reports.

#### 1.20.1.1 Modifications to Reporting Requirements

OHCA reserves the right to modify the Reporting Manual at its sole discretion. Additionally, OHCA may, at its discretion, require the Contractor to submit additional reports, both ad hoc and recurring.

#### 1.20.1.2 Initial Program Implementation Reporting

OHCA will require more frequent Contractor reporting during Initial Program Implementation to:

- Monitor SoonerSelect Dental program implementation;
- Permit adequate OHCA oversight and corrections of any identified problems as necessary; and
- Ensure satisfactory levels of Dental Health Plan Enrollee and Provider services.

#### 1.20.1.3 Certification Requirements

In accordance with 42 C.F.R. § 438.606(a), all data, documentation, or information submitted by the Contractor to OHCA under 42 C.F.R. § 438.604 shall be certified by one of the following:

- The Contractor's Chief Executive Officer (CEO);
- The Contractor's Chief Financial Officer (CFO); or
- An individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

The Contractor shall submit this certification concurrently with the data, documentation or information submission. The certifying officer must attest that, based on the certifying officer's best information, knowledge, and belief, the data, documentation and information submitted are accurate, complete and truthful.

#### 1.20.1.4 Audit Rights and Remedies

OHCA reserves the right to audit the Contractor's self-reported data at any time and may require corrective action or other remedies as specified in Section 1.22: "Non-Compliance Remedies" of this Model Contract for Contractor non-compliance.

#### 1.20.1.5 Continuous Process Improvement

The Contractor shall review all reports submitted to OHCA to identify instances and patterns of non-compliance, determine and analyze the reasons for non-compliance, identify and implement actions to correct non-compliance and identify and implement quality improvement activities to improve performance and ensure ongoing compliance.

### **1.20.2 Required Data Collection and Reports**

In accordance with 42 C.F.R. § 438.66(c), and as further delineated in the following subsections, the Contractor shall submit data to OHCA on the following:

- Enrollment and Disenrollment data;
- Dental Health Plan Enrollee Grievance and Appeal logs;
- Provider complaint and appeal logs;
- Results of Dental Health Plan Enrollee satisfaction surveys conducted by the Contractor;
- Results of Provider satisfaction surveys conducted by the Contractor;
- Performance on required quality measures;
- Medical management committee reports and minutes;
- Annual quality improvement plan;
- Audited financial and Encounter Data;
- MLR summary reports; and
- Customer service performance data.

OHCA will utilize findings from this data collection to improve the performance of the SoonerSelect Dental program.

#### 1.20.2.1 Contractor Payment Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.2: “Payments to Contractor” of this Model Contract. Contractor payment reports shall include, at minimum:

- *Capitation Reconciliation*: Monthly reconciliation of enrollment and Capitation Payments.
- *Capitation Overpayment*: Report of Capitation Payment Overpayments.

#### 1.20.2.2 Administrative Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.3: “Administrative Requirements” of this Model Contract. Administrative reports shall include, at minimum:

- *Accreditation*: Status reports while undergoing accreditation and copy of accreditation review findings in accordance with requirements of 42 C.F.R. § 438.332(b).
- *Subcontractor Compliance*: Reports documenting known or anticipated value of contracted or subcontracted services, the Contractor’s oversight of its Subcontractors and any applicable performance issues or corrective actions.
- *Implementation plan*: Status reports on key implementation activities prior to initial Dental Health Plan Enrollee enrollment.
- *Hiring and Staffing Plan*: Contractor’s plan to meet staffing requirements and ongoing reporting of changes in Key Staff.
- *Board of Directors*: Notification of changes in Board of Directors.

#### 1.20.2.3 Enrollment and Disenrollment Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.5: “Enrollment and Disenrollment” of this Model Contract. Enrollment and Disenrollment reports shall include, at minimum:

- *Dental Health Plan Enrollee Disenrollment Requests*: Reports documenting volume of and reason for Dental Health Plan Enrollee requests for Disenrollment.

#### 1.20.2.4 Covered Benefits Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.6: “Covered Benefits” of this Model Contract. Benefits reports shall include, at minimum:

- *EPSDT*: Data required to comply with CMS EPSDT performance on the Form CMS-416.
- *Value-Added Benefits*: Report documenting all Value-Added Benefits offered by the Contractor and the utilization rates of each.

#### 1.20.2.5 Dental Management Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.7: “Dental Services Utilization Management” of this Model Contract. Dental management reports shall include, at minimum:

- *Prior Authorization*: Report documenting PA processing timeliness, approvals, pending requests and denial rates.
- *Dental Management Program*: Report documenting the Contractor’s Dental Management Program description, work plan and program evaluation.
- *Utilization Reports*: Reports documenting elements such as preventive, restorative, prosthetic, orthodontic, and oral surgery services. The Contractor may be required to provide breakout by Dental Health Plan Enrollees based on the Contractor’s Risk Stratification Level Framework.
- *Out of State Services*: Report documenting approved out of state services to include detailed verification of unavailability of in-state services.

#### 1.20.2.6 Transition of Care Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.8: “Transition of Care” of this Model Contract. Transition of care reports shall include, at minimum, Contractor activity surrounding the following transitions:

- Age transitions; and
- Transitions between Dental Benefit Managers.

#### 1.20.2.7 Quality Improvement Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.9: “Quality” of this Model Contract. The Contractor shall be capable of providing reports broken out by race, ethnicity, or other relevant demographics as directed by OHCA .Quality reports shall include, at minimum:

- *Quality Rating System*: Reporting necessary to comply with the quality rating system required in accordance with 42 C.F.R. § 438.334.
- *Annual QAPI Plan*: An annual QAPI program description and work plan addressing the Contractor’s strategies for performance improvement and quality management activities, which addresses all elements in Section 1.9.3: “Quality Assessment and Performance Improvement (QAPI) Program” of this Model Contract.
- *CAHPS*: Annual reports for each of the audited CAHPS survey required under Section 1.9.4.1: “Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys” of this Model Contract.

- *Provider Satisfaction Survey*: Annual report documenting the results of the annual Participating Provider Survey as described in Section 1.9.4.2: “Provider Satisfaction Surveys” of this Model Contract.
- *Quality Performance Measures*: Reporting on all required measures as described in Section 1.9.5: “Quality Performance Measures” of this Model Contract.
- *Performance Improvement Projects*: Reports on the Contractor’s PIPs as required under Section 1.9.6: “Performance Improvement Projects (PIPs)” of this Model Contract.
- *Provider Profiling*: Provider performance monitoring reports in accordance with Section 1.9.8: “Provider Profiling” of this Model Contract.

#### 1.20.2.8 Dental Health Plan Enrollee Services Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.10: “Dental Health Plan Enrollee Services” of this Model Contract. Dental Health Plan Enrollee Services reports shall include, at minimum:

- *Failure to Contact Dental Health Plan Enrollee*: Report documenting Dental Health Plan Enrollees the Contractor failed to reach following initial Dental Health Plan Enrollee enrollment with the Contractor in accordance with Section 1.10.5: “New Dental Health Plan Enrollee Materials and Outreach” of this Model Contract.
- *Dental Health Plan Enrollee Services Call Center*: Report documenting the performance of the Dental Health Plan Enrollee Services Call Center, such as call volume, call reasons, call abandonment rate, live-voice answer rate, average wait time, blocked call rate and overflow call center data. Also includes annual evaluation and planned improvement activities.
- *Dental Health Plan Enrollee Services Call Center Training*: Report documenting the training received by Dental Health Plan Enrollee Services Call Center staff.
- *Advisory Board*: Reports on activities of the quarterly Advisory Board meetings.
- *PCD Provider Assignments*: Reports on PCD Provider assignment rates, differentiated by Dental Health Plan Enrollee selection versus Contractor assignment.
- *PCD Provider Changes*: Reports on the volume of PCD Provider changes and reasons.
- *Website*: Reports documenting website utilization data.
- *Marketing*: Documents the Contractor’s Marketing plan and activities.

#### 1.20.2.9 Provider Network Development Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.11: “Provider Network Development” of this Model Contract. Provider network development reports shall include, at minimum:

- *Network Adequacy*: In accordance with 42 C.F.R. § 438.604, the Contractor shall submit documentation for which OHCA will base its certification that the Contractor has complied with requirements for availability and accessibility of services, including adequacy of the Participating Provider network, as set forth in 42 C.F.R. § 438.206.
- *Geo-Access Reports*: Showing compliance with time and distance standards to Participating Providers as outlined in Section 1.11.4: “Time and Distance and Appointment Access Standards” of this Model Contract.

- *Provider Network Development and Management Plan*: As required in accordance with the requirements of Section 1.11.1.5: “Provider Network Development and Management Plan” of this Model Contract.
- *Provider Enrollment and Disenrollment*: Showing Participating Providers, including enrollments and disenrollments.
- *Provider Application Denials*: Showing all Providers for whom the Contractor has denied request to become a Participating Provider.
- *Credentialing*: Showing the timeliness of all Provider credentialing and recredentialing activities.
- *24-Hour Availability Audit*: Showing Participating Provider’s compliance with requirement to be accessible to Dental Health Plan Enrollees 24 hours per day, seven days per week and corrective actions implemented for Participating Providers failing to meet the requirement.
- *Network Adequacy Exceptions Report*: In accordance with Section 1.11.5: “Network Adequacy Exception Process” of this Model Contract, including date of approval, description of the exception, how the Contractor is assuring Dental Health Plan Enrollees residing in the applicable geographic area are receiving the necessary care and Contractor efforts and progress in addressing the deficiency.

#### 1.20.2.10 Provider Services Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.12: “Provider Services ” of this Model Contract. Provider services reports shall include, at minimum:

- *Provider Services Call Center*: Report documenting the performance of the Provider Services Call Center, such as call volume, calls handled, average call handle time, call reasons, call abandonment rate, live-voice answer rate, average wait time, blocked call rate, overflow call center data and customer satisfaction indicators. Also includes annual evaluation and planned improvement activities.
- *Provider Services Call Center Training*: Documents the training received by Provider Services Call Center staff.
- *Participating Provider Training, Education and Technical Assistance Plan*: Documents the training provided including details such as training topics covered, the date of the trainings and the participants, by the Contractor to its Participating Providers, in accordance with Section 1.12.5: “Provider Education, Training and Technical Assistance” of this Model Contract.
- *Provider Complaints*: Report documenting the type, volume, timely processing and resolution status of Provider Complaints, reconsiderations and appeals.

#### 1.20.2.11 Provider Payment Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.13: “Provider Payment” of this Model Contract. Provider payment reports shall include, at minimum:

- *Performance-Based Provider Payments*: Documents the plan, volume of and details surrounding performance-based payments made by the Contractor to Participating Providers.
- *Provider-Preventable Conditions*: The Contractor shall require Providers to report Provider-Preventable Conditions associated with claims for payment or Dental Health Plan Enrollee



treatments for which payment would otherwise be made. The Contractor shall report all identified Provider-Preventable conditions to OHCA as required under the Reporting Manual.

- *Claims Activity*: Report on claims activities, including the number of claims received, denied and paid, total amount paid and any adjustments or edits to claims.
- *Claims Payment Accuracy*: Report documenting claims payment and denial accuracy by claim type and Provider type. The report shall be compiled by the Contractor through an audit of the accuracy of a random sample of claims payments processed in the relevant reporting period. The report shall document the results of the audit, including the number and percentage of claims and dollars that were paid accurately.
- *Claims Timeliness*: Report on the timeliness of claims paid by claim type and Provider type. The report shall include the number and percentage of claims processed for the reporting period that were paid within 30 days of service date, within 60 days of service date, within 90 days of service date, those left pending, those that were submitted in previous quarters but paid in the reporting quarter and suspended claims.

#### 1.20.2.12 AI/AN Population and Indian Health Care Providers Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.14: “American Indian/Alaska Native Population and Indian Health Care Providers” of this Model Contract. These reports shall include, at minimum:

- *Network Accessibility*: Reports documenting network accessibility specific to the Contractor’s AI/AN Dental Plan Enrollee membership and the IHCP network.

#### 1.20.2.13 Grievances and Appeals Reports

The Contractor shall submit monthly reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.15: “Dental Health Plan Enrollee Grievances and Appeals” of this Model Contract. Dental Health Plan Enrollee Grievances and Appeals reports shall include, at minimum:

- *Dental Health Plan Enrollee Grievances*: Documents the volume, timely processing and reasons for Dental Health Plan Enrollee Grievances.
- *Dental Health Plan Enrollee Appeals*: Documents the volume, timely processing, decision overturn rate and reasons for Dental Health Plan Enrollee Appeals.
- *State Fair Hearings*: Documents the volume of Appeals escalating to the State Fair Hearing process and the rate of Contractor decisions overturned.

#### 1.20.2.14 Cost Sharing Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.16: “Cost Sharing” of this Model Contract. Cost Sharing reports shall include, at minimum:

- *Five Percent Limit*: Reports documenting the volume of Dental Health Plan Enrollees reaching the five percent Cost Sharing limit described in Section 1.16.5: “Five Percent Cost Sharing Limit” of this Model Contract.

#### 1.20.2.15 Program Integrity Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.17: “Program Integrity” of this Model Contract. Program integrity reports shall include, at minimum:

- *Compliance Plan*: The plan developed in accordance with the requirements of Section 1.17.2.1: “Compliance Plan” of this Model Contract and all associated reporting.
- *Verifying Delivery of Services*: Reports documenting the activities of the Contractor to verify service delivery in accordance with Section 1.17.4: “Verifying Delivery of Services.” in this Model Contract. Report shall detail the number of EOBs distributed, Dental Health Plan Enrollee responses and resolution of Dental Health Plan Enrollee responses.
- *Overpayments*: In accordance with 42 C.F.R. § 438.608(d)(3), the Contractor shall report monthly to OHCA on recoveries of Overpayments. Prompt reporting of all Overpayments to occur in accordance with Section 1.17.6: “Reporting Overpayments” of this Model Contract.
- *Transactions with Parties in Interest*: Reporting in accordance with the requirement of Section 1.17.13: “Transactions with Parties in Interest” of this Model Contract.
- *Investigations Opened*: Provides documentation on the program integrity investigations initiated and cases ultimately referred to the State.

#### 1.20.2.16 Information Technology Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual and Section 1.18: “Information Technology” of this Model Contract, to demonstrate compliance with Contract requirements. Information Technology reports shall include, at minimum, the following:

- Encounter Data;
- Encounter Data and Financial Summary Reconciliation;
- Information Security Breach;
- System Performance Reports;
- System Unavailability Reports;
- Disaster Preparation and Recovery Plan;
- BCDR Incidence Reports;
- Back-up Plan;
- Initial and Bi-annual IT Roadmap; and
- Maintenance and Operations Plan.

#### 1.20.2.17 Financial Performance Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.19: “Financial Standards and Third Party Liability” of this Model Contract. Reports shall include, at minimum:

- *Base Data*: In accordance with 42 C.F.R. § 438.604, the Contractor shall submit data on the basis of which OHCA certifies the actuarial soundness of Capitation Rates, including base data generated by the Contractor.
- *Insurance Department Filings*: Copy of all OID required filings provided to OHCA.
- *Audited Financial Reports*: In accordance with 42 C.F.R. § 438.3(m), the Contractor shall submit audited financial reports specific to the Contract on an annual and quarterly basis. The Contractor

shall ensure the audit is conducted in accordance with generally accepted accounting principles and standards.

- *Change in Independent Actuary or Independent Auditor:* The Contractor must provide OHCA with notice within ten days of expiration of the Contractor's contract with an independent auditor or actuary. The notice must include: the date and reason for the change or termination; the name of the replacement auditor or actuary; and if the change or termination resulted from a disagreement or dispute, the nature of the disagreement or dispute at issue.
- *Disclosure of Fiduciary Relationships and Bonding Reports:* The Contractor shall disclose each person who qualifies as a fiduciary as defined by 36 O.S. § 6906(A). The Contractor shall provide OHCA with evidence of the Contractor's Fidelity Bond or Certificate of Fidelity Insurance in the manner prescribed by 36 O.S. § 6906(A). The Contractor shall not make payment regarding amounts expended for home health care services provided by any agency or organization, unless the agency or organization provides OHCA with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.
- *Third Party Payments:* Reports documenting cost avoidance values, recoveries from third parties, potential subrogation cases and third party resource information.
- *Rate Cell Financial Reports:* Certified financial reports as specified by OHCA reflecting cost experience at the rate cell level.
- *MLR Reports:* Data on the basis of which OHCA will determine the Contractor's compliance with the MLR requirements described in 42 C.F.R. § 438.8 and Section 1.19.2: "Medical Loss Ratio" of this Model Contract.
- *Insolvency Protection:* Data on the basis of which OHCA will determine the Contractor has made adequate provision against the risk of insolvency, as required under 42 C.F.R. § 438.116.

## **1.21 Contractor Performance Standards**

### **1.21.1 Full Compliance**

The performance standards for the Contractor are defined as full compliance with the participation requirements specified in this Model Contract. The Contractor shall be subject to the penalties described in Section 2.22: "Non-Compliance Remedies" of this Model Contract for failure to meet performance standards.

### **1.21.2 Performance-Based Contracting**

The Contractor and OHCA agree that the SoonerSelect Dental program shall be administered in accordance with the tenets of performance-based contracting, including:

- Defining quality of care, quality of life and health outcomes objectives for Dental Health Plan Enrollees;
- Measuring the Contractor's progress in meeting performance objectives; and
- Rewarding the Contractor for achievement of performance objectives and penalizing the Contractor for failure to achieve performance objectives, through the methods described in this section and Section 1.22: "Non-Compliance Remedies" of this Model Contract.

OHCA, the Contractor and other Dental Benefit Managers shall collaborate in development of a uniform performance monitoring data set starting no later than 180 days after the Contract start date. The data set shall incorporate mandatory reports as described in Section 1.20: "Reporting" of this Model Contract

and shall include performance benchmarks related to service accessibility and utilization, quality improvement and non-clinical functions. OHCA shall have sole authority for establishing final benchmarks.

### **1.21.3 Monitoring and Evaluation of Contractor Performance**

#### 1.21.3.1 OHCA Monitoring Methods

The Contractor shall cooperate fully to support OHCA's performance of monitoring activities. OHCA will monitor the Contractor's performance and compliance with Contract participation requirements through multiple methods, including but not limited to:

- The Readiness Review;
- Ongoing operational and financial reviews, to be conducted onsite at the Contractor's Oklahoma-based office required under Section 1.3.5: "Oklahoma Presence" of this Model Contract and through desk audits;
- Review of the Contractor's reports required under Section 1.20: "Reporting" of this Model Contract and the Reporting Manual;
- Review of the Contractor's quality improvement measures and performance improvement project outcomes, as described in Section 1.9: "Quality" of this Model Contract;
- Assessment of the Contractor's performance against uniform performance monitoring benchmarks;
- Findings from the annual EQR as described in Section 1.9.2: "External Quality Review" of this Model Contract;
- Quarterly meetings with OHCA and Contractor Key Staff; and
- Additional data concerning the Contractor's performance gathered directly by OHCA from Dental Health Plan Enrollees, Providers and other SoonerSelect Dental program stakeholders.

#### 1.21.3.2 Contractor Internal Monitoring Methods

The Contractor shall have an internal monitoring process for ensuring compliance with all Contract requirements.

The Contractor shall report to OHCA monthly on its compliance monitoring activities, in a format to be specified by OHCA in the Reporting Manual. The Contractor shall document any self-identified area of non-compliance with Contract requirements and shall describe the actions being taken to correct the deficiency. At its discretion, OHCA may request additional information or require submission of a formal corrective action plan, in accordance with the provisions of Section 1.22: "Non-Compliance Remedies" of this Model Contract.

#### 1.21.3.3 Treatment of Self-Reported Deficiencies in Assessment of Damages

In the event that the Contractor identifies and reports an area of non-compliance (deficiency) that falls within a category for which civil monetary damages apply, as described in Section 1.22: "Non-Compliance Remedies" of this Model Contract, OHCA, at its sole discretion, may waive the damages subject to the Contractor remedying the deficiency in a manner and on a schedule acceptable to OHCA.

OHCA's standard policy shall be not to waive monetary damages, if applicable, when an area of non-compliance (deficiency) is identified by OHCA without first being reported by the Contractor.

#### 1.21.3.4 Consideration of Contractor Performance in Auto Assignments

It is OHCA's intent to modify the assignment algorithm in future contract years of the SoonerSelect Dental program to take into consideration the Contractor's performance on improving health outcomes. The revised algorithm will be included as part of a Contract amendment to be issued in accordance with Section 1.1.9: "Amendments or Modifications" of this Model Contract.

#### 1.21.3.5 Consideration of Contractor Performance in Re-Contracting

It is OHCA's intent to include data on the Contractor's performance in any future procurement conducted prior to the expiration of the current Contract, including any extension periods.

### **1.22 Non-Compliance Remedies**

The Non-Compliance Remedy imposed by OHCA will be dependent upon the nature, severity and duration of the Contractor's non-compliance. OHCA shall only impose those Non-Compliance Remedies it determines, in its sole discretion, to be appropriate for the deficiencies identified. If OHCA elects not to exercise a Non-Compliance Remedy in a particular instance of Contractor non-compliance, this decision shall not be construed as a waiver of OHCA's right to pursue future assessment of that performance requirement and associated Non-Compliance Remedy(s), including those that, under the terms of the Contract, may be retroactively assessed.

OHCA may take one or more of the following actions in response to the Contractor's non-compliance with Contract requirements:

- Require the Contractor to develop a formal corrective action plan submitted to OHCA under signature of the Contractor's chief executive. The corrective action plan is subject to OHCA approval.
- Suspend full or partial Capitation Payments.
- Suspend auto-assignment of Eligibles to the Contractor. At its sole discretion, OHCA may suspend all auto-assignments or may selectively suspend auto-assignments for a region, county or SoonerCare eligibility group.
- Impose Intermediate Sanctions in accordance with 42 C.F.R. § 438.702 and Section 1.22.3: "Intermediate Sanctions" of this Model Contract.
- Impose other Non-Compliance Remedies in accordance with Section 1.22.6: "Other Non-Compliance Remedies" of this Model Contract.
- Terminate the Contract in accordance with Section 1.23: "Termination" of this Model Contract.

#### **1.22.1 Notification of Non-Compliance Findings**

OHCA shall notify the Contractor of any findings of Contract non-compliance in writing and in accordance with Section 1.1.5: "Notices" of this Model Contract. The notice will:

- Describe the nature of the Contract non-compliance;
- Outline required steps to be taken by the Contractor to remedy the non-compliance, including Contractor filing of a corrective action plan, if applicable;
- Provide a date by which the non-compliance must be remedied;
- Describe the method by which the Contractor shall demonstrate it has remedied the area of non-compliance;

- Identify the basis and nature of the Non-Compliance Remedy(s) to be imposed by OHCA, if applicable; and
- Contractor appeal rights as described in Section 1.22.2: “Appeal of Finding of Non-Compliance” of this Model Contract.

### **1.22.2 Appeal of Finding of Non-Compliance**

The Contractor may challenge a finding of non-compliance that results in an Intermediate Sanction, through appeal to OHCA Administrative Law Judge. Such an appeal must be filed in writing with the Administrative Law Judge Docket Clerk within 30 days of the Contractor’s receipt of notice of the Intermediate Sanction. The appeal will be adjudicated in accordance with OHCA’s administrative rules.

### **1.22.3 Intermediate Sanctions**

#### **1.22.3.1 Civil Monetary Penalties**

##### **1.22.3.1.1 Failure to Provide Medically Necessary Services**

If the Contractor fails to substantially provide Medically Necessary services to a Dental Health Plan Enrollee that the Contractor is required to provide under law or the Contract, OHCA may impose a Civil Monetary Penalty of up to \$25,000 for each failure to provide services. OHCA may also impose sanctions in accordance with Section 1.22.3.2: “Other Intermediate Sanctions” of this Model Contract.

##### **1.22.3.1.2 Imposition of Excess Premiums**

If the Contractor imposes premiums or charges on Dental Health Plan Enrollees that are in excess of those permitted in the Medicaid program, OHCA may impose a Civil Monetary Penalty of up to \$25,000 or double the amount of the excess premiums or charges, whichever is greater. OHCA may also impose sanctions in accordance with Section 1.22.3.2: “Other Intermediate Sanctions” of this Model Contract. If OHCA imposes a Civil Monetary Penalty under this section, OHCA will deduct the amount of the overcharge from the penalty and return it to the affected Dental Health Plan Enrollee in accordance with 42 C.F.R. § 438.704(c).

##### **1.22.3.1.3 Discrimination on the Basis of Health Status**

If the Contractor discriminates among Dental Health Plan Enrollees on the basis of their health status or need for dental services, OHCA may impose a Civil Monetary Penalty of up to \$100,000 for each determination of discrimination. OHCA may impose a Civil Monetary Penalty of up to \$15,000 for each Eligible the Contractor did not enroll because of a discriminatory practice, up to the \$100,000 maximum. OHCA may also impose sanctions in accordance with Section 1.22.3.2: “Other Intermediate Sanctions” of this Model Contract.

##### **1.22.3.1.4 Misrepresentation or Falsification of Information to OHCA or CMS**

If the Contractor misrepresents or falsifies information that it furnishes to CMS or to OHCA, OHCA may impose a Civil Monetary Penalty of up to \$100,000 for each instance of misrepresentation. OHCA may also impose sanctions in accordance with Section 1.22.3.2: “Other Intermediate Sanctions” of this Model Contract.

##### **1.22.3.1.5 Misrepresentation or Falsification of Information to Dental Health Plan Enrollees, Eligibles or Providers**

If the Contractor misrepresents or falsifies information that it furnishes to a Dental Health Plan Enrollee, Eligible, or health care Provider, OHCA may impose a Civil Monetary Penalty of up to \$25,000 for each

instance of misrepresentation. OHCA may also impose sanctions in accordance with Section 1.22.3.2: “Other Intermediate Sanctions” of this Model Contract.

#### 1.22.3.1.6 Provider Incentive Plan Non-Compliance

If the Contractor fails to comply with the provider incentive plan requirements as described in Section 1.13.1.7: “Performance-Based Provider Payments” of this Model Contract, OHCA may impose a Civil Monetary Penalty of up to \$25,000 for each failure to comply. OHCA may also impose sanctions in accordance with Section 1.22.3.2: “Other Intermediate Sanctions” of this Model Contract.

#### 1.22.3.1.7 Improper Distribution of Marketing Materials

If the Contractor distributes Marketing Materials that have not been approved by OHCA or that contain false or misleading information, either directly or indirectly through any agent or independent contractor, OHCA may impose a Civil Monetary Penalty of up to \$25,000 for each distribution.

### 1.22.3.2 Other Intermediate Sanctions

In accordance with 42 C.F.R. § 438.702, OHCA may impose the following Intermediate Sanctions if it determines the Contractor acts or fails to act in accordance with Sections 1.22.3.1.1 through 1.22.3.1.6.

- Appoint temporary management to the Contractor in accordance with Section 1.22.5: “Appointment of Temporary Management” of this Model Contract.
- Grant Dental Health Plan Enrollees the right to disenroll without cause and notify them of their right to disenroll.
- Suspend all new Enrollments to the Contractor after the date the Secretary or OHCA notifies the Contractor of a determination of a violation of any requirement under §§ 1903(m) or 1932 of the Act.
- Suspend Capitation Payments for new enrollments to the Contractor until CMS or OHCA is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

### 1.22.3.3 Additional Social Security Act Violations

If the Contractor violates any applicable requirements of §§ 1903(m), 1932, or 1905(t) of the Act, or any implementing regulations, other than those violations addressed in Section 1.22.3.1: “Civil Monetary Penalties” of this Model Contract, OHCA may impose the following sanctions:

- Grant Dental Health Plan Enrollees the right to disenroll without cause.
- Suspend all new Enrollments to the Contractor after the date the Secretary or OHCA notifies the Contractor of a determination of a violation of any requirement under §§ 1903(m) or 1932 of the Act.
- Suspend Capitation Payments for new Enrollments to the Contractor until CMS or OHCA is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

### **1.22.4 Denial of Payment for New Dental Health Plan Enrollees**

Capitation Payments to the Contractor will be denied for new Dental Health Plan Enrollees when, and for so long as, payment for those Dental Health Plan Enrollees is denied by CMS under 42 C.F.R. § 438.730(e). The CMS may deny payment to OHCA for new Dental Health Plan Enrollees if its determination is not contested timely by the Contractor. OHCA will define in writing to the Contractor the conditions for lifting the payment denials.

**1.22.5 Appointment of Temporary Management**

In accordance with 42 C.F.R. § 438.706, OHCA may impose temporary management of the Contractor when OHCA finds through ongoing monitoring activities such as onsite surveys, Dental Health Plan Enrollee or other complaints, review of the Contractor’s financial status, or any other source:

- There is continued egregious behavior by the Contractor;
- There is substantial risk to Dental Health Plan Enrollee health; or
- The sanction is necessary to ensure the health of the Contractor’s Dental Health Plan Enrollees while improvements are made to remedy violations that require sanctions, or until there is an orderly termination or reorganization of the Contractor.

OHCA must impose temporary management if it finds the Contractor has repeatedly failed to meet substantive requirements in §§ 1903(m) or 1932 of the Act. In accordance with 42 C.F.R. § 438.706(c), OHCA may not delay the imposition of temporary management to provide a hearing. OHCA will not terminate temporary management until it determines, at its sole discretion that the Contractor can ensure the sanctioned behavior will not recur.

When temporary management is imposed, OHCA will notify and grant Dental Health Plan Enrollees the right to terminate enrollment with the Contractor without cause, as described in 42 C.F.R. § 438.702(a)(3). If temporary management is imposed, the Contractor shall cooperate fully in the transition process to ensure any disruption to Dental Health Plan Enrollees and Providers is minimized.

OHCA or its designees shall have full and exclusive power of management and control of the Contractor as necessary to ensure the uninterrupted care to Dental Health Plan Enrollees pending the Contractor’s termination from the SoonerSelect Dental program or remedying of the underlying deficiency. OHCA shall have the authority to hire staff, execute any instrument in the name of the Contractor and to commence, defend and conduct in its name any action or proceeding in which the Contractor may be a party during the temporary management period.

The Contractor shall be responsible for all reasonable expenses related to the direct operation of the health plan, including but not limited to attorney fees, cost of preliminary or other audits of the Contractor and expenses related to the management of any office or other assets of the Contractor.

**1.22.6 Other Non-Compliance Remedies**

In accordance with 42 C.F.R. § 438.702(b), OHCA may impose Non-Compliance Remedies, in addition to those outlined in Section 1.22.3: “Intermediate Sanctions” of this Model Contract. Additional Non-Compliance Remedies are outlined in the table below. The Contractor understands and agrees that the liquidated damages described herein are not construed as penalties. OHCA retains authority to seek other remedies and take other actions as appropriate to ensure compliance, satisfy contractual obligations and/or safeguard Dental Health Plan Enrollees’ rights and interests.

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
Section 1.2.2: “Capitation Reconciliation”	The Contractor fails to perform monthly reconciliation of enrollment roster data against Capitation Payments.	<ul style="list-style-type: none"> <li>• Refund of any detected overpayments or duplicate payments as identified through OHCA or federal review and resulting from the</li> </ul>



Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
		<p>Contractor’s failure to properly perform reconciliation.</p> <ul style="list-style-type: none"> <li>Liquidated damages of \$5,000 per day that the Contractor remains out-of-compliance with reconciliation requirement.</li> </ul>
<p>Section 1.18.4: “Dental Health Plan Enrollee Encounter Data</p>	<p>The Contractor fails to submit weekly Encounter Data timely.</p>	<ul style="list-style-type: none"> <li>For failure to submit Encounter Data by the deadline established by OHCA, liquidated damages equal to 15% of capitation paid for the month previous to month in which encounter data was due.</li> </ul>
<p>Section 1.18.4: “Dental Health Plan Enrollee Encounter Data</p>	<p>The Contractor fails to submit Encounter Data in accordance with OHCA accuracy standards, as determined through encounter Validation studies conducted by OHCA or its designee.</p>	<ul style="list-style-type: none"> <li>For error rate of 5.1 to 7.0 percent: five percent of capitation paid in Validation study period.</li> <li>For error rate of 7.1 to 10 percent: ten percent of capitation paid in Validation study period.</li> <li>For error rate of 10.1 percent or greater: 15% of capitation paid in Validation study period.</li> </ul>
<p>Section 1.17.1.3: “Collaboration with OHCA and MFCU”</p>	<p>The Contractor fails to allow OHCA, MFCU, or other authorized State and federal authorities access to claims payment data and other applicable records.</p>	<ul style="list-style-type: none"> <li>Liquidated damages of \$500 per day.</li> </ul>
<p>Section 1.17.1.3: “Collaboration with OHCA and MFCU”</p>	<p>Contractor fails to provide information responsive to specific requests made by OHCA, MFCU, or other authorized State and federal authorities (including, but not limited to, requests for records of Dental Health Plan Enrollee and Provider interviews), within three Business Days of said request, unless otherwise agreed upon by OHCA.</p>	<ul style="list-style-type: none"> <li>Liquidated damages of \$1,000 per day.</li> </ul>
<p>Section 1.17.1.2: “Referral to OHCA Program Integrity and Accountability</p>	<p>The Contractor fails to refer credible allegations of Fraud to OHCA’s Legal Division in writing</p>	<ul style="list-style-type: none"> <li>Liquidated damages of \$1,000 per day.</li> </ul>

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
Unit or Oklahoma Medicaid Fraud Control Unit (MFCU)"	within three Business Days of discovery.	
Section 1.17.7: "Suspension of Payments for Credible Allegation of Fraud"	If credible allegation of Fraud exists, the Contractor fails to immediately suspend all payments to the Provider as instructed by OHCA within 24 hours of receipt of said instruction.	<ul style="list-style-type: none"> <li>• Liquidated damages of \$1,000 per day</li> </ul>
Section 1.17.1.3: "Collaboration with OHCA and MFCU"	The Contractor fails to participate in good faith at monthly Program Integrity meetings held jointly with MFCU and OHCA.	<ul style="list-style-type: none"> <li>• Liquidated damages of \$10,000 per meeting.</li> </ul>
Section 1.17.2: "Compliance Program"	The Contractor fails to participate in good faith at monthly meetings with OHCA Program Integrity and Accountability Unit.	<ul style="list-style-type: none"> <li>• Liquidated damages of \$10,000 per day</li> </ul>
Section 1.17.9.1.2: "When Disclosures of Persons with An Ownership or Control Interest Are Required"	The Contractor fails to disclose any change in ownership and control information to OHCA within 35 Calendar Days in accordance with 42 C.F.R. § 455.104 and Subcontractors as governed by 42 C.F.R. § 438.230.	<ul style="list-style-type: none"> <li>• Liquidated damages of \$1,000 per day</li> </ul>
Section 1.17.9.1.2: "When Disclosures of Persons with An Ownership or Control Interest Are Required"	<p>As required by 42 C.F.R. § 455.105, the Contractor fails to submit to OHCA or DHHS, within 35 Calendar Days of request, full and complete information about:</p> <p>The ownership of any Subcontractor with whom the Contractor has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and</p> <p>Any significant business transactions between the Contractor and any wholly owned supplier, or between the Provider</p>	<ul style="list-style-type: none"> <li>• Liquidated damages of \$1,000 per day</li> </ul>

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
	and any Subcontractor, during the five-year period ending on the date of request.	
Section 1.17.2: “ Compliance Program”	By close of the last Calendar Day of each month, the Contractor fails to provide a monthly report of all open program integrity related audits and investigations related to Fraud, Waste, and Abuse activities for identifying and collecting potential overpayments, utilization review, and Provider compliance. The report shall include, but is not limited to, audits and investigations performed, overpayments identified, overpayments recovered, and other program integrity actions taken; such as, corrective action plans, Provider education, financial sanctions, and sanctions against a Provider.	<ul style="list-style-type: none"> <li>• Liquidated damages of \$1,000 per day</li> </ul>
Section 1.20: “Reporting”	The Contractor fails to submit a required report timely and/or accurately.	<ul style="list-style-type: none"> <li>• Liquidated damages of \$2,500 per Business Day per report that has not been submitted correctly, complete, on time and in the OHCA-defined format.</li> <li>• If reporting non-compliance impacts OHCA’s ability to monitor the Contractor’s solvency, and the Contractor’s financial position requires OHCA to transfer Dental Health Plan Enrollees to another Contractor, the Contractor shall pay any difference between the Capitation Rates that would have been paid to the Contractor and the actual rates being paid to the replacement Dental Benefit Manager as a result of the Dental Health Plan Enrollee transfer.</li> </ul>

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
		<p>Additionally, the Contractor shall pay any costs OHCA incurs to accomplish the transfer of Dental Health Plan Enrollees.</p>
<p>Section 1.10.5: “New Dental Health Plan Enrollee Materials and Outreach”</p>	<p>The Contractor fails to distribute a Dental Health Plan Enrollee Handbook or ID Card in the required timeframe.</p>	<ul style="list-style-type: none"> <li>• Liquidated damages of \$500 for each instance where the Contractor fails to distribute a Dental Health Plan Enrollee’s Enrollment with the Contractor.</li> <li>• Liquidated damages of \$500 for each instance where the Contractor fails to distribute a Dental Health Plan Enrollee ID Card within seven days of a Dental Health Plan Enrollee’s Enrollment with the Contractor.</li> </ul>
<p>Section 1.10.7: “Dental Health Plan Enrollee Services Call Center”</p>	<p>The Contractor fails to meet Dental Health Plan Enrollee Call Center performance standards.</p>	<ul style="list-style-type: none"> <li>• For any calendar month where the call abandonment rate is equal to or greater than five percent, liquidated damages of \$10,000 for each full percentage point equal to or greater than five percent.</li> <li>• For any calendar month where less than 85% of calls are answered by a live voice within 30 seconds of the first ring, liquidated damages of \$10,000 for each full percentage point below 85%.</li> <li>• For any calendar month where the average wait time exceeds two minutes, liquidated damages of \$10,000.</li> <li>• For any calendar month where the blocked call rate exceeds one percent, liquidated damages of \$10,000 for each percentage point above one percent.</li> </ul>

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
<p>Section 1.12.2: “Provider Services Call Center”</p>	<p>The Contractor fails to meet Provider Services Call Center performance standards.</p>	<ul style="list-style-type: none"> <li>• For any calendar month where the call abandonment rate is equal to or greater than five percent, liquidated damages of \$10,000 for each full percentage point equal to or greater than five percent.</li> <li>• For any calendar month where less than 85% of calls are answered by a live voice within 30 seconds of the first ring, liquidated damages of \$10,000 for each full percentage point below 85%.</li> <li>• For any calendar month where the average wait time exceeds two minutes, liquidated damages of \$10,000.</li> <li>• For any calendar month where the blocked call rate exceeds one percent, liquidated damages of \$10,000 for each percentage point above one percent.</li> </ul>
<p>Section 1.11.3: “Credentialing”</p>	<p>The Contractor fails to meet timeliness standards for Provider credentialing.</p>	<ul style="list-style-type: none"> <li>• Liquidated damages of \$500 per Calendar Day where the Contractor fails to credential a Provider within 45 days of receipt of a complete application.</li> </ul>
<p>Section 1.13.4.2: “Timely Claims Filing and Processing”</p>	<p>The Contractor fails to meet timely claims payment standards.</p>	<ul style="list-style-type: none"> <li>• Liquidated damages of \$10,000 for any calendar month where the Contractor fails to pay 90% or more of clean claims within 14 days for each deficient claim type.</li> <li>• Liquidated damages of \$10,000 for any calendar month where the Contractor fails to pay 99% or more of clean claims within 90 days for each deficient claim type.</li> <li>• For the purposes of this requirement, there are six claims types: professional paper claims,</li> </ul>

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
		professional electronic claims, facility paper claims, facility electronic claims, pharmacy paper claims and pharmacy electronic claims.
Section 1.11.4: “Time and Distance and Appointment Access Standards”	The Contractor fails to meet time and distance standards for network adequacy for any of the following Provider types: <ul style="list-style-type: none"> <li>• General Dentistry Providers;</li> <li>• Pediatric Specialty Dental Providers</li> <li>• Specialty Dental Providers;</li> <li>• Essential Community Providers</li> </ul>	<ul style="list-style-type: none"> <li>• Liquidated damages of \$10,000 for each calendar month, for each Provider type, where the Contractor fails to meet the time and distance standards.</li> <li>• Submission of corrective action plan to OHCA.</li> <li>• More frequent submission of network adequacy reports at the direction of OHCA until Contractor compliance is demonstrated for 60 consecutive days.</li> <li>• OHCA may require the Contractor to maintain an open network for the Provider type(s) for which the Contractor demonstrates non-compliance.</li> <li>• Non-compliance with network adequacy standards for three consecutive months shall result in auto-assignment suspension until such time as the Contractor successfully demonstrates compliance.</li> </ul>
Section 1.15: “Dental Health Plan Enrollee Grievances and Appeals”	The Contractor fails to resolve 98% of Dental Health Plan Enrollee Grievances within 30 Calendar Days from the date the Grievance is received.  The Contractor fails to resolve 100% of Dental Health Plan Enrollee Grievances within 60 Calendar Days from the date the Grievance is received.	<ul style="list-style-type: none"> <li>• Liquidated damages of \$10,000 for each quarter the Contractor is non-compliant.</li> </ul>

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
<p>Section 1.15: “Dental Health Plan Enrollee Grievances and Appeals”</p>	<p>The Contractor fails to resolve 100% of Dental Health Plan Enrollee Appeals within 30 Calendar Days from the date the Appeal is received.</p> <p>The Contractor fails to resolve 100 percent of expedited Appeal requests within 72 hours of when the request was received or within the additional 14 Calendar Days if the timeframe is extended.</p>	<ul style="list-style-type: none"> <li>Liquidated damages of \$10,000 for each quarter the Contractor is non-compliant.</li> </ul>
<p>Section 1.15: “Dental Health Plan Enrollee Grievances and Appeals”</p>	<p>The Contractor fails to send 100% of notice of standard Service Authorization decisions to the requesting Provider, and the Dental Health Plan Enrollee or the Dental Health Plan Enrollee’s Authorized Representative, within 14 Calendar Days from request for the service, or within 28 Calendar Days, if extended.</p> <p>The Contractor fails to send 100% of notices of expedited service authorizations within 72 hours from the date of request for the service, or within the additional 14 Calendar Days, if extended.</p> <p>The Contractor fails to send 100% of notices of an Adverse Benefit Determination for termination, suspension or reduction of previously authorized services within ten Calendar Days of the effective date of the decision, or within the timeframes specified in 42 C.F.R. §§ 431.214 or 431.213, if applicable.</p> <p>The Contractor fails to send 100% of notices of resolution of Dental</p>	<ul style="list-style-type: none"> <li>Liquidated damages of \$10,000 for each quarter the Contractor is non-compliant.</li> </ul>

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
	Health Plan Enrollee Grievances within three Calendar Days of the resolution of the Grievance.	
Section 1.12.6: "Provider Complaint System"	<p>The Contractor fails to resolve 98% of Provider reconsiderations within 30 Calendar Days of receipt of the request for reconsideration.</p> <p>The Contractor fails to resolve 100% of Provider reconsiderations within 60 Calendar Days of receipt of the request for reconsideration.</p>	<ul style="list-style-type: none"> <li>Liquidated damages of \$10,000 for each quarter the Contractor is non-compliant.</li> </ul>
Section 1.12.6: "Provider Complaint System"	<p>The Contractor fails to resolve 98% of Provider appeals within 30 Calendar Days of receipt of the appeal.</p> <p>The Contractor fails to resolve 100% of Provider appeals within 60 Calendar Days of receipt of the appeal.</p>	<ul style="list-style-type: none"> <li>Liquidated damages of \$10,000 for each quarter the Contractor is non-compliant.</li> </ul>
Section 1.12.6: "Provider Complaint System"	<p>The Contractor fails to send 100% of notices of resolution of Provider reconsiderations within five Calendar Days of resolution of the reconsideration.</p> <p>The Contractor fails to send 100% of notice of resolution of Provider appeals within five Calendar Days of resolution of the appeal.</p>	<ul style="list-style-type: none"> <li>Liquidated damages of \$10,000 for each quarter the Contractor is non-compliant.</li> </ul>
Section 1.15.5.4: "Contractor State Fair Hearing Support"	The Contractor fails to maintain a sufficient level of staff training to competently perform the functions, requirements, roles, and duties involved in State Fair Hearing support.	<ul style="list-style-type: none"> <li>Liquidated damages of \$1,000 per day from the time the training deficiency is identified by the State and until the Contractor resolves the situation to the State's approval.</li> </ul>
Section 1.15.5.4: "Contractor State Fair Hearing Support"	The Contractor fails to provide the state the required summary information within 15 Calendar Days after notification of the request for a State Fair Hearing.	<ul style="list-style-type: none"> <li>1-3 months at less than 95%: \$3,000</li> <li>4-6 months at less than 95%: \$6,000</li> <li>7-9 months at less than 95%: \$9,000</li> </ul>



Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
		<ul style="list-style-type: none"> <li>10-12 months at less than 95%: \$12,000</li> </ul>
Section 1.15.5.4: "Contractor State Fair Hearing Support"	The Contractor fails to provide timely delivery to the Appellant, the state and the Office of Administrative Hearings State Fair Hearing documentation, as required.	<ul style="list-style-type: none"> <li>1-3 months at less than 95%: \$3,000</li> <li>4-6 months at less than 95%: \$6,000</li> <li>7-9 months at less than 95%: \$9,000</li> <li>10-12 months at less than 95%: \$12,000</li> </ul>
Section 1.15.5.4: "Contractor State Fair Hearing Support"	The Contractor fails to summarize the arguments presented by the Appellant and the Contractor in summaries for State Fair Hearings to ensure the dispute and actions by the Appellant and Contractor are clearly identified. The Contractor shall state the legal basis upon which dismissal requests are based and include regulations or statutes in support.	<ul style="list-style-type: none"> <li>1-3 months at less than 95%: \$3,000</li> <li>4-6 months at less than 95%: \$6,000</li> <li>7-9 months at less than 95%: \$9,000</li> <li>10-12 months at less than 95%: \$12,000</li> </ul>
Section 1.15: "Dental Health Plan Enrollee Grievances and Appeals"	The state will monitor performance and set performance targets for each Contractor regarding the percentage of State fair hearing requests that are resolved without a change to the original determination. When performance targets are identified, the State will inform the Contractor as to the required performance and increment of measurement.	<ul style="list-style-type: none"> <li>Starting with the quarter following notification, the Contractor is subject to liquidated damage assessment of \$50,000 for each increment of non-compliance with the performance target.</li> </ul>
Section 1.3.6.2: "Key Staff"	The Contractor fails to fill Key Staff positions.  The Contractor is responsible for maintaining a level of staffing necessary to perform and carry out all of the functions, requirements, roles and duties.	<ul style="list-style-type: none"> <li>Liquidated damages of \$1,000 per Calendar Day for each Key Staff position that remains vacant after 90 days.</li> </ul>
Section 1.18.7: "Disaster"	The Contractor fails to restore operations in a disaster situation.	<ul style="list-style-type: none"> <li>If the Contractor's failure to restore operations requires OHCA to transfer Dental Health Plan</li> </ul>

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
Preparation and Data Recovery”		<p>Enrollees to another Contractor, the Contractor shall pay any difference between the Capitation Rates that would have been paid to the Contractor and the actual rates being paid to the replacement Dental Benefit Manager as a result of the Dental Health Plan Enrollee transfer.</p> <ul style="list-style-type: none"> <li>• Additionally, the Contractor shall pay any costs OHCA incurs to accomplish the transfer of Dental Health Plan Enrollees.</li> </ul>
Section 1.3.10: “Readiness Review”	The Contractor fails to satisfactorily pass the Readiness Review by the deadline imposed by OHCA.	<ul style="list-style-type: none"> <li>• OHCA may delay Enrollment of Eligibles with the Contractor and/or impose other Non-Compliance Remedies, including, but not limited to, Contract termination.</li> <li>• The Contractor shall be responsible for all costs incurred by OHCA as a result of the delay of Enrollment of Eligibles with the Contractor.</li> </ul>
Section 1.3.10: “Readiness Review”	The Contractor fails to submit Readiness Review documentation timely and/or accurately.	<ul style="list-style-type: none"> <li>• Liquidated damages of \$5,000 per Business Day, per Readiness Review deliverable, that has not been submitted correctly, complete, on time and in the OHCA-defined format.</li> </ul>
Section 1.1.15: “Confidentiality; HIPAA and Business Associate Requirements ; Business Associates Requirements”	The Contractor fails to ensure all data containing Personally Identifiable Information (PII), including but not limited to Protected Health Information (PHI), is secured in accordance with all applicable state and federal privacy and security requirements, including but not limited to HIPAA, 42 U.S.C. § 290dd-2; 42 C.F.R. §§ 2.1 – 2.67, and 43A O.S. § 1-109. .	<ul style="list-style-type: none"> <li>• In addition to any remedies available to the OHCA pursuant to the terms of this Contract or available at law, if OHCA deems credit monitoring and/or identity theft safeguards are needed to protect Dental Health Plan Enrollees whose PII/PHI was placed at risk by the Contractor’s failure to comply with Contract terms, the Contractor shall be liable for all costs</li> </ul>

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
		<p>associated with the provision of such monitoring and/or safeguard services.</p>
<p>Section 1.7.4.4: “Timeliness Standards”</p>	<p>The Contractor fails to comply with timeliness requirements for processing Prior Authorizations.</p>	<ul style="list-style-type: none"> <li>• Liquidated damages of \$5,000 for each calendar month the Contractor fails to adjudicate all Prior Authorization requests within 72 hours.</li> <li>• Liquidated damages of \$10,000 for each calendar month the Contractor fails to adjudicate all urgent Prior Authorization requests within 24 hours.</li> <li>• Liquidated damages of \$5,000 for each calendar month the Contractor fails to conduct all retrospective reviews within 14 days.</li> </ul>
<p>Section 1.19: “Financial Standards and Third Party Liability”</p>	<p>The Contractor fails to comply with Oklahoma Insurance Department requirements for minimum net worth and risk-based capital.</p>	<ul style="list-style-type: none"> <li>• Submission of corrective action plan to OHCA.</li> <li>• If the Contractor fails to meet the financial performance standards or otherwise comply with the corrective action plan by the date specified by OHCA, OHCA may freeze Dental Health Plan Enrollee enrollment to the Contractor.</li> </ul>
<p>Section 2.3.2: “Accreditation”</p>	<p>The Contractor fails to be accredited by an Accrediting Entity within 18 months of Contract award.</p>	<ul style="list-style-type: none"> <li>• Achievement of provisional status shall require a corrective action plan within 30 Calendar Days of receipt of notification from Accrediting Entity and may result in termination of this Contract</li> <li>• Liquidated damages of \$100,000 per month for every month the Contractor is non-complaint.</li> </ul>
<p>Miscellaneous Damages</p>	<p>The State is herein provided an administrative procedure to address general Contract compliance issues not defined</p>	<ul style="list-style-type: none"> <li>• If the non-compliance is not corrected by the specified date, the State reserves the right to assess liquidated damages in an amount</li> </ul>

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
	<p>elsewhere in this agreement. The State may identify a condition resulting from the Contractor’s non-compliance with the Contract through monitoring activities. If this occurs, the state will notify the Contractor in writing of the contractual non-compliance. The Contractor shall provide a written response to the notification within five Business Days of receipt of the notice. The State will recommend, when appropriate, a reasonable period of time within which the Contractor shall remedy the non-compliance. This liquidated damage may be independent or combined with any of the liquidated damages listed above.</p>	<p>not to exceed \$500 per Business Day per occurrence after the due date until the non-compliance is corrected.</p>
<p>Section 2.18.11 “Accessibility”</p>	<p>Contractor fails to provide continuous access to information as required.</p>	<ul style="list-style-type: none"> <li>• Liquidated damages of \$5,000 per day</li> </ul>
<p>Section 2.18.11 “Accessibility”</p>	<p>Contractor fails to ensure that all system functions are accessible as required.</p>	<ul style="list-style-type: none"> <li>• Liquidated damages of \$5,000 per day</li> </ul>
<p>Section 2.18.11 “Accessibility”</p>	<p>Contractor fails to provide its URL to OHCA or changes the URL without OHCA’S approval.</p>	<ul style="list-style-type: none"> <li>• Liquidated damages of \$500 per occurrence</li> </ul>
<p>Section 2.18.11 “Accessibility”</p>	<p>Contractor fails to maintain a point of contact to provide assistance interfacing/exchanging data.</p>	<ul style="list-style-type: none"> <li>• Liquidated damages of \$1,000 per day</li> </ul>
<p>Section 2.18.11.1 “System Performance Requirements”</p>	<p>Contractor fails to satisfy any response, retrieval, or display time requirement.</p>	<ul style="list-style-type: none"> <li>• Liquidated damages of \$1,000 per day</li> </ul>
<p>Section 2.18.11.2 “System Performance Notification and Reporting”</p>	<p>Contractor fails to give OHCA the required notification.</p>	<ul style="list-style-type: none"> <li>• Liquidated damages of \$1,000 per occurrence</li> </ul>

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
Section 2.18.11.2 “System Performance Notification and Reporting”	Contractor fails to resolve unscheduled system unavailability as required.	<ul style="list-style-type: none"> <li>Liquidated damages of \$5,000 per day</li> </ul>
Section 1.1.24: “Compliance with Law”	Contractor fails to meet implementation deadlines for mandates and/or laws as directed by the CMS, CDC, or other government entity.	<ul style="list-style-type: none"> <li>Liquidated damages of \$2,500 per Business Day.</li> </ul>

**1.22.7 Offset**

OHCA has the express right to offset any civil monetary penalties, liquidated damages, or other amounts due as a result of non-compliance remedies, together with any amounts due under the Contractor’s indemnification obligations or for breach of this contract, against any payments owed by OHCA to the Contractor under this agreement.

**1.23 Termination**

**1.23.1 Early Termination**

The Contract may be terminated prior to its scheduled expiration date only for the reasons specified in this section.

Upon termination of this Contract, for any reason, the Contractor shall return to OHCA all items belonging to OHCA. This may include, but is not limited, to computers, equipment, badges, and electronic documents or files.

1.23.1.1 Termination for Mutual Consent

OHCA and the Contractor may terminate the Contract by mutual written agreement.

1.23.1.2 Termination for Convenience

The state may terminate the Contract, in whole or in part, for convenience if it is determined that termination is in the state’s best interest. In the event of a termination for convenience, Contractor will be provided at least sixty days’ written notice of termination. Any partial termination of the Contract shall not be construed as a waiver of, and shall not affect, the rights and obligations of any party regarding portions of the Contract that remain in effect.

Upon receipt of notice of such termination, Contractor shall immediately comply with the notice terms and take all necessary steps to minimize the incurrence of costs allocable to the work affected by the notice. If a purchase order or other payment mechanism has been issued and a product or service has been accepted as satisfactory prior to the effective date of termination, the termination does not relieve an obligation to pay for the product or service but there shall not be any liability for further payments ordinarily due under the Contract or for any damages or other amounts caused by or associated with such termination. Such termination shall not be an exclusive remedy but shall be in addition to any other rights and remedies provided for by law. Any amount paid to Contractor in the form of prepaid fees that are unused when the Contract or certain obligations are terminated shall be refunded. Termination of the

Contract under this section, in whole or in part, shall not relieve the Contractor of liability for claims arising under the Contract.

**1.23.1.3 Termination for Default**

In accordance with 42 C.F.R. § 438.708, the OHCA may terminate the Contract, in whole or in part, if at any time the Contractor fails to carry out or otherwise comply with any of the terms of the Contract or meet the applicable requirements of §§ 1932, 1903(m) or 1905(t) of the Act. In addition to and in no way limiting any and all remedies available to it, OHCA may, at its election, assign Dental Health Plan Enrollees to another Dental Benefit Manager or provide benefits through other State Plan authority if the Contractor has breached this Contract and is unable or unwilling to cure such breach within the period of time as specified in writing by OHCA as provided below.

The Contractor shall also be in default, and the provisions in this section shall apply, if it terminates early without the mutual consent of OHCA.

Upon determination by OHCA that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities, the Contractor shall be notified in writing of the failure and of the time period which has been established by OHCA to cure such failure. If the Contractor is unable or unwilling to cure the failure within the specified time period, in accordance with 42 C.F.R. § 438.710, OHCA will provide the Contractor with written notice of its intent to terminate, the reason for termination and the time and place of a pre-termination hearing. After the hearing, OHCA shall provide the Contractor with written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination. For an affirming decision, OHCA shall give Dental Health Plan Enrollees of the Contractor notice of termination and information, consistent with 42 C.F.R. § 438.10, on their options for receiving Medicaid services following the effective date of termination.

In the event of termination for default, in full or in part as provided under this clause, OHCA may procure, upon such terms and in such manner as is deemed appropriate by OHCA, supplies or services similar to those terminated and the Contractor shall be liable for any costs associated for such similar supplies or services and all other damages allowed by law. In addition, the Contractor shall be liable to OHCA for administrative costs incurred to procure such similar supplies or services as are needed to continue operations and for administrative costs incurred to transition Dental Health Plan Enrollees from the Contractor.

In the event of a termination for default, the Contractor shall be paid for any outstanding Capitation Payments due less any assessed damages. If damages exceed Capitation Payments due, collection will be made from the Contractor's performance bond, cash deposit, letter of credit or substitute security, as described in Section 1.1.29: "Performance Bond or Substitutes" of this Model Contract.

The rights and remedies of OHCA provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under the Contract.

**1.23.1.4 Termination for Unavailability of Funds**

In the event funding from federal, State or other sources is not sufficiently appropriated, or is withdrawn, reduced or limited in any way after the effective date of the Contract, OHCA may terminate this Contract immediately, effective on the close of business on the day specified. OHCA shall be the final authority as to the availability of funds.

#### 1.23.1.5 Termination for Lack of Authority

In the event that any necessary federal or State approval or authority to operate the SoonerSelect Dental program is not granted, or the Oklahoma Legislature prohibits OHCA from contracting with an MCO for the provision of health care for Eligibles or Dental Health Plan Enrollees, OHCA may terminate this Contract immediately, effective on the close of business on the day specified.

Should any part of the scope of work under this Contract relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority. The State must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the State paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the Contractor shall return the payment for that work to the State. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the State included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

#### 1.23.1.6 Termination for Financial Instability

In the event that OHCA deems, in its sole discretion, that the Contractor is financially unstable to the point of threatening the ability of OHCA to obtain the services provided for under this Contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors or suffers or permits the appointment of a receiver for its business or its assets, then OHCA may, at its option, immediately terminate this Contract effective on the close of business on the date specified.

In the event OHCA elects to terminate the Contract under this provision, the Contractor shall be notified in writing specifying the date of termination. In the event of the filing of a petition in bankruptcy by or against a principal Subcontractor, the Contractor shall immediately so advise OHCA. The Contractor shall ensure that all tasks related to the subcontract are performed in accordance with the terms of the Contract.

#### 1.23.1.7 Termination for Debarment

Section 1932(d)(1) of the Act prohibits affiliations with individuals debarred by federal agencies. The Contractor may not knowingly have an individual or Affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, who has been debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The prohibited relationships include:

- A director, officer or partner of the Contractor who is (or is affiliated, as defined in the Federal Acquisition Regulation, with a person/entity that is) debarred, suspended or excluded from participation in federal health care programs;
- A Subcontractor of the Contractor who is (or is affiliated, as defined in the Federal Acquisition Regulation, with a person/entity that is) debarred, suspended or excluded from participation in federal health care programs;

- A person with beneficial ownership of five percent or more of the Contractor's equity who is (or is affiliated, as defined in the Federal Acquisition Regulation, with a person/entity that is) debarred, suspended or excluded from participation in federal health care programs;
- A Participating Provider or persons with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under its Contract with the State who is (or is affiliated, as defined in the Federal Acquisition Regulation, with a person/entity that is) debarred, suspended or excluded from participation in federal health care programs;
- An individual or entity that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Act;
- Any individual or entity excluded for cause from participation in any state Medicaid program or the Medicare program; or
- Any individual or entity listed on the State or federal excluded Provider lists.

The Contractor shall not have a relationship with an individual that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Act.

OHCA must notify CMS of any prohibited relationship and terminate a Contract with an entity that is found to be out of compliance with 42 C.F.R. § 438.610 if directed by the CMS, and OHCA cannot renew or otherwise extend the existing Contract for such an organization unless the CMS determines that compelling reasons exist for doing so.

### **1.23.2 Transition Period Obligations**

A Transition Period shall begin upon any of the following triggering events:

- Notice issued by OHCA of intent to terminate the Contract;
- Notice issued by the Contractor or OHCA of intent not to extend the Contract for a subsequent extension period; or
- If the Contract has no remaining extension periods, 180 days before the Contract termination date.

The Contractor shall remain financially responsible for and continue to serve or arrange for the provision of services to Dental Health Plan Enrollees for up to 45 Calendar Days from the Contract termination or expiration date or until the Dental Health Plan Enrollees can be transferred, whichever is longer. The Transition Period ends upon the transition of Dental Health Plan Enrollees to another Dental Benefit Manager or OHCA-designated service delivery system. Upon completion of the Transition Period, the Contractor shall comply with all obligations outlined in Section 1.23.3: "Post-Transition Contract Obligations" of this Model Contract.

The Contractor shall submit a written Transition Plan to OHCA for approval. The Transition Plan shall document the Contractor's plan to ensure the orderly transition of Dental Health Plan Enrollees and to meet all Transition Period and Post-Transition obligations. The Contractor shall make revisions to the Transition Plan at the request of OHCA. The Contractor shall execute, adhere to and provide the services set forth in the OHCA-approved Transition Plan. All changes to the Transition Plan are subject to OHCA approval.



The Contractor shall cooperate in good faith with OHCA and its employees, agents and independent contractors and comply with all duties and/or obligations under the Contract. During the Transition Period, the Contractor shall:

- Appoint a liaison to serve as the single point of contact for all Transition Period activities.
- Maintain sufficient staffing levels to meet all Contract obligations.
- Transfer all applicable clinical information on file, including but not limited to approved and outstanding Prior Authorization requests and a list of Dental Health Plan Enrollees to OHCA and/or the successor Dental Benefit Manager in the timeframe and manner required by OHCA.
- Coordinate the continuation of care for Dental Health Plan Enrollees who are undergoing treatment for an acute condition.
- Notify all Dental Health Plan Enrollees and Participating Providers about the Contract termination or expiration and the process by which Dental Health Plan Enrollees will continue to receive medical care. The notice shall be sent according to a timeline established by OHCA. The Contractor shall be responsible for all expenses associated with Dental Health Plan Enrollee and Participating Provider notification. These notices are subject to OHCA approval.
- Take whatever other actions are necessary to ensure the efficient and orderly transition of Dental Health Plan Enrollees from coverage under this Contract to coverage under any new arrangement developed by OHCA.

### **1.23.3 Post-Transition Contract Obligations**

Termination or expiration of the Contract does not discharge the obligations of the Contractor with respect to services or items furnished prior to Contract termination or expiration. The Contractor shall work in good faith with OHCA to carry out all Post-Transition obligations. Upon any termination or expiration of the Contract, the Contractor shall:

- Appoint a liaison to serve as the single point of contact for all Post-Transition activities.
- Provide OHCA, or its designee, all records related to the Contractor's activities undertaken pursuant to the Contract, in the format and within the timeframes set forth by OHCA. Such records shall be provided at no expense to OHCA or its designee.
- Participate in the External Quality Review, as required in accordance with 42 C.F.R. Part 438, Subpart E, for the final year of the Contract.
- Submit all performance data and reports with a due date following the termination or expiration of the Contract which cover a reporting period prior to termination or expiration. This includes, at minimum, CAHPS and HEDIS data.
- Remain responsible for resolving Grievances and Appeals related to dates of service prior to the Contract termination or expiration.
- Remain responsible for State Fair Hearings related to dates of service prior to the Contract termination or expiration. This includes providing records and representation at State Fair Hearings. In the event the State Fair Hearing officer reverses the Contractor's decision to deny authorization of services and the Dental Health Plan Enrollee received the disputed services while the State Fair Hearing was pending, the Contractor must pay for those services.
- Remain financially responsible for all claims with dates of services through the day of Contract termination or expiration. The Contractor shall maintain claims processing functions as necessary for a minimum of 12 months in order to adjudicate all claims for services delivered prior to the Contract termination or expiration.

- Submit Encounter Data for all claims incurred prior to the Contract termination or expiration.
- Comply with the requirements of Section 1.1.15.4: “Obligations of Contractor upon Termination” of this Model Contract with respect to PHI received from OHCA, or created, maintained or received by the Contractor on behalf of OHCA.

OHCA retains authority to withhold the Contractor’s Capitation Payments until the Contractor has received OHCA approval of its Transition Plan and completed the activities set forth in its Transition Plan, and any other OHCA required activities, to the satisfaction of OHCA. OHCA retains sole authority for determining whether the Contractor has satisfactorily completed the Contractor’s transition responsibilities.

**IN WITNESS WHEREOF**, the Parties have executed this Agreement as of the date of execution by the State Contracts Officer, below.

CONTRACTOR

By: \_\_\_\_\_

Date: \_\_\_\_\_

Title: \_\_\_\_\_

OKLAHOMA HEALTH CARE AUTHORITY

By: \_\_\_\_\_

Date: \_\_\_\_\_

Title: \_\_\_\_\_

Approved as to Form and Legal Sufficiency:

By: \_\_\_\_\_

Date: \_\_\_\_\_

Title: \_\_\_\_\_

## **1 Appendix 1A: Acronyms**

**ABD** – Aged, Blind and Disabled

**ABP** – Alternative benefit Plan

**ACA** – Affordable Care Act

**ADL** – Activities of Daily Living

**AHRQ** – Agency for Health Care Research and Quality

**AI/AN** - American Indian/Alaskan Native

**CAHPS** – Consumer Assessment of Healthcare Providers and Systems Survey

**CAP** – Corrective Action Plan

**CEO** – Chief Executive Officer

**C.F.R.** – Code of Federal Regulations

**CHIP** – Children’s Health Insurance Program

**CMS** – Centers for Medicare & Medicaid Services

**CDT** – Current Dental Terminology (Dental Procedures Codes)

**CPT** – Current Procedural Terminology

**CWS** – Child Welfare Services

**DBM** – Dental Benefit Manager

**DHS** – Oklahoma Department of Human Services

**DHHS** – The United States Department for Health and Human Services

**DIR** – Direct and Indirect Remuneration

**DSH** - Disproportionate Share Hospital

**EHR** – Electronic Health Records

**EOB** – Explanation of Benefits

**EPSDT** – Early and Periodic Screening, Diagnosis and Treatment

**EQR** – External Quality Review

**EQRO** – External Quality Review Organization

**FC** – Foster Care Children

**FFC** – Former Foster Children

**FFS** – Fee for Service

**FPL** – Federal Poverty Level

**FQHC** – Federally Qualified Health Center

**HAN** – Health Access Network

**HCPCS** – Health Care Common Procedure Coding System

**HEDIS** – Healthcare Effectiveness Data and Information Set

**HIE** – Health Information Exchange

**HIPAA** – Health Insurance Portability and Accountability Act

**HITECH** – Health Information Technology for Economic and Clinical Health Act

**HMO** – Health Maintenance Organization

**IADL** – Instrumental Activities of Daily Living

**IHCP** – Indian Health Care Provider

**IHP** – Indian Health Program

**IHS** – Indian Health Service

**IMCE** – Indian Managed Care Entity

**I/DD** – Intellectual and Developmental Disabilities

**I/T/Us** – Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization

**LOC** – Level of Care

**LEP** – Limited English Proficiency

**MAGI** – Modified Adjusted Gross Income

**MAT** – Medication Assisted Treatment

**MCO** – Managed Care Organization

**MFCU** – Medicaid Fraud Control Unit

**MLR** – Medical Loss Ratio

**MMIS** – Medicaid Management Information System

**NAIC** – National Association of Insurance Commissioners

**NDC** – National Drug Code

**NCCI** – National Correct Coding Initiative

**NCPDP** – National Council for Prescription Drug Programs

**NCQA** – National Committee for Quality Assurance

**NQTL** – Non-Quantitative Treatment Limit

**NEMT** – Non-Emergency Medical Transportation

**NPI** – National Provider Identifier

**OAC** – Oklahoma Administrative Code

**ODMHSAS** – Oklahoma Department of Mental Health and Substance Abuse Services

**ODOC** – Oklahoma Department of Corrections

**OHCA** – Oklahoma Health Care Authority

**OID** – Oklahoma Insurance Department

**OIG** – Office of Inspector General

**OJA** – Office of Juvenile Affairs

**OKSHINE** – Oklahoma State Health Information Network and Exchange

**OMB** – Office of Management and Budget

**OSDE** – Oklahoma State Department of Education

**OSDH** – Oklahoma State Department of Health

**PA** – Prior Authorization

**PASRR** – Preadmission Screening and Resident Review

**PCD** – Primary Care Dentist

**PCP** – Primary Care Provider

**PHI** – Protected Health Information

**PIPs** – Performance Improvement Projects

**POS** – Point of Sale

**QAPI** – Quality Assurance and Performance Improvement

**QHP** – Qualified Health Plan

**QIC** – Quality Improvement Committee

**RFP** – Request for Proposals

**RHC** – Rural Health Clinic

**SDOH** – Social Determinants of Health

**SSA** – Social Security Administration

**SSI** – Supplemental Security Income

**STCs** – Special Terms and Conditions

**TANF** – Temporary Assistance for Needy Families

**TPL** – Third Party Liability

**TSET** – Tobacco Settlement Endowment Trust

**TTY/TDD** – Telecommunications Device for the Deaf

**UCAT** – Uniform Comprehensive Assessment Tool

**UM** – Utilization Management

**URAC** – Utilization Review Accreditation Commission

**URA** – Unit Rebate Amount

## **1 Appendix 1B: Definitions**

### **A.1.1 Interpretation of Definitions**

Listed below are the definitions used in this Model Contract. These terms shall be construed and/or interpreted as follows, unless this Model Contract otherwise expressly requires a different construction and/or interpretation.

Terms used in this Model Contract that are not otherwise explicitly defined shall be understood to have the definition laid out in applicable State and federal rules and regulations, including but not limited to 42 C.F.R. Chapter IV and 45 C.F.R. Parts 160 and 164.

The following terms shall have the same meaning as those terms in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules: Breach, Business Associate, Covered Entity, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information (PHI), Required by Law, Secretary, Security Incident, Subcontractor and Use.

Unsecured Protected Health Information shall have the same meaning as in the Health Information Technology for Economic and Clinical Health (HITECH) Act.

### **A.1.2 Oklahoma SoonerSelect Dental Contract Definitions**

**§1915(c) Waiver** – Allows states to offer home and community based services to limited groups of Eligibles as an alternative to institutional care. OHCA has administrative authority over six §1915(c) Waivers: ADvantage, Medically Fragile, Community Waiver, Homeward Bound Waiver, In-Home Supports for Adults Waiver and In-Home Supports for Children Waiver.

**Abuse** – As defined at 42 C.F.R. § 455.2, Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Eligible and Dental Health Plan Enrollee practices that result in unnecessary cost to the Medicaid program.

**Accrediting Entity** – An entity recognized by CMS under 45 C.F.R. § 156.275. Current CMS-recognized Accrediting Entities include AAAHC, NCQA and URAC. To the extent CMS recognizes additional Accrediting Entities, OHCA will also permit the Contractor to achieve accreditation from such entity to meet the requirements of Section 2.3.2: “Accreditation” of the Model Contract.

**Act/The Act** – Refers to the Social Security Act.

**Activities of Daily Living (ADLs)** - Activities that reflect the Dental Health Plan Enrollee’s ability to perform self-care tasks essential for sustaining health and safety such as: bathing; eating; dressing; grooming; transferring (includes getting in and out of the tub, bed to chair, etc.); mobility; toileting and bowel/bladder control. The services help with proper medical care, self-maintenance skills, personal hygiene, adequate food, shelter and protection.

**Adult Protective Services (APS)** - A program within the Oklahoma Department of Human Services that provides vulnerable adults protection from abuse, neglect or exploitation and offers services.

**Adverse Benefit Determination** - Pursuant to 42 C.F.R. § 438.400(b), means:



- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, health care setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by OHCA;
- The failure of the Contractor to act within the timeframes provided in § 438.408(b)(1) and (b)(2) regarding the standard resolution of Grievances and Appeals;
- For a resident of a Rural Area with only one Dental Benefit Manager, the denial of a SoonerCare Eligible's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network; or
- The denial of a Dental Health Plan Enrollee's request to dispute a financial liability, including Cost Sharing, copayments, premiums, deductibles, coinsurance and other Dental Health Plan Enrollee financial liabilities.

**Affiliate** - Associated business concerns or individuals if, directly or indirectly: (1) either one controls or can control the other; or (2) a third party controls or can control both.

**Agent** – Any person or entity who has been delegated the authority to obligate or act on behalf of another

**Alternative Benefit Plan** – The benefit package delivered to Expansion Adults which is developed by OHCA and approved by the CMS in accordance with the requirements of Subpart C of 42 C.F.R. Part 440.

**American Indian/Alaskan Native (AI/AN)** – Pursuant to 42 C.F.R. § 438.14, any individual defined at 25 U.S.C. 1603(13), 1603(28) or 1679(a) or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual:

- Is a member of a Federally recognized Indian Tribe;
- Resides in an urban center and meets one or more of the four criteria;
  - Is a member of a tribe, band or other organized group of Indians, including those tribes, bands or groups terminated since 1940 and those recognized now or in the future by the State in which they reside or who is a descendant, in the first or second degree, of any such member;
  - Is an Eskimo or Aleut or other Alaska Native;
  - Is considered by the Secretary of the Interior to be an Indian for any purpose; or
  - Is determined to be an Indian under regulations issued by the Secretary;
- Is considered by the Secretary of the Interior to be an Indian for any purpose; or
- Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut or other Alaska Native.

**Appeal** - A review of an Adverse Benefit Determination by the Contractor.

**Applicant** – An individual who seeks SoonerCare coverage

**Authorized Representative** – A competent adult who has the Dental Health Plan Enrollee’s signed, written authorization to act on the Dental Health Plan Enrollee’s behalf during the Grievance, Appeal, and State Fair Hearing process. The written authority to act shall specify any limits of the representation.

**Business Days** - Defined as Monday through Friday and is exclusive of weekends and State of Oklahoma holidays.

**Calendar Days** - Defined as all seven days of the week, including State of Oklahoma holidays.

**Capitation Payment** - A payment OHCA will make periodically to the Contractor on behalf of each Dental Health Plan Enrollee enrolled under the SoonerSelect Dental program Contract and based on the actuarially sound Capitation Rate for the provision of services under the State Plan. OHCA shall make the payment regardless of whether the particular Dental Health Plan Enrollee receives services during the period covered by the payment.

**Capitation Rate** - The per-Dental Health Plan Enrollee, per-month amount, including any adjustments, that is paid by OHCA to the Contractor for each Dental Health Plan Enrollee enrolled in the SoonerSelect Dental program for the provision of services during the payment period.

**Case File** - An electronic record that includes Dental Health Plan Enrollee information regarding the management of health care services including but not limited to: Dental Health Plan Enrollee demographics; comprehensive assessment (if applicable); care plan; reassessments; referrals and authorizations and Dental Health Plan Enrollee case notes.

**Children** – A child under age 19 determined eligible for SoonerCare under 42 C.F.R. § 435.118 or the state’s Medicaid expansion CHIP.

**Choice Counseling** - The provision of information and services designed to assist Eligibles in making enrollment decisions. It includes answering questions and identifying factors to consider when choosing among Dental Benefit Managers and PCD Providers. Choice counseling does not include making recommendations for or against enrollment into a specific Dental Benefit Manager.

**Chronic Condition** - A condition that is expected to last one year or more and requires ongoing medical attention and/or limits Activities of Daily Living.

**Civil Monetary Penalty** – A penalty imposed by OHCA which the Contractor must pay for acting or failing to act in accordance with 42 C.F.R. § 438.700. Amounts may not exceed those specified in 42 C.F.R. § 438.704.

**Clean Claim** - A claim or encounter which can be adjudicated and submitted without obtaining additional information from the Provider of service or 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.

**Clinical Practice Guidelines** – Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. The Contractor shall adopt Clinical Practice Guidelines in accordance with 42 C.F.R. § 438.236, ensuring they are based on valid and reliable clinical evidence or a consensus of Providers in the particular field; consider the needs of Dental Health Plan Enrollees; are adopted in consultation with Participating Providers; and are reviewed and updated periodically as appropriate.

**Cold-call Marketing** - Any unsolicited personal contact by the Contractor with an Eligible for the purpose of Marketing.

**Confidential Information** - Information in any medium (e.g., visual, written, numeric, verbal) that is in some capacity restricted in disclosure or distribution. This includes medical information of individuals or Dental Health Plan Enrollees, information given by OHCA to the Contractor that is indicated to be proprietary, non-public information exchanged between the Contractor and its Subcontractors, or others.

**Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey** - A survey administered to healthcare recipients to report on and evaluate their experiences with a particular health care system.

**Continuity of Care Period** – The 90 day period immediately following a Dental Health Plan Enrollee’s enrollment with the Contractor whereby established Dental Health Plan Enrollee and Provider relationships, current services and existing Prior Authorizations and care plans shall remain in place in accordance with the requirements of Section 1.8: “Transition of Care” of the Model Contract.

**Contract** - As a result of receiving an award from OHCA and successfully meeting all Readiness Review requirements, the agreement between the Contractor and OHCA where the Contractor will provide Medicaid services to SoonerSelect Dental program Health Plan Enrollees, comprising of the Contract and any Contract addenda, appendices, attachments or amendments thereto, and be paid by OHCA as described in the terms of the agreement.

**Contract Dispute** - A circumstance whereby the Contractor and OHCA are unable to arrive at a mutual interpretation of the requirements, limitations or compensation for performance of the Contract.

**Contract Officer** - A designated employee of the Contractor authorized and empowered to represent the Contractor with respect to all matters within such area of authority related to the implementation of the Contract.

**Contractor** – A Dental Benefit Manager with which OHCA has entered into a binding agreement for the purpose of procuring services to SoonerSelect Dental program Dental Health Plan Enrollees as specified in the Contract. The term “Contractor” includes all of such Contractor’s Affiliates, Agents, Subsidiaries, any Person with an Ownership or Control Interest, officers, directors, manager, employees, independent contractors and related parties working for or on behalf of the Contractor and other parties required to be disclosed at Section 1.17.9: “Written Disclosures” of this Model Contract.

**Copayment** - A fixed amount that a Dental Health Plan Enrollee pays for a covered health care service when the Dental Health Plan Enrollee receives the service.

**Cost Sharing** - When the state requires that Dental Health Plan Enrollees bear some of the cost of their care through mechanisms such as Copayments, deductibles and other similar charges.

**Credibility Adjustment** - An adjustment to the MLR for a Partially Credible Contractor to account for a difference between the actual and target MLRs that may be due to random statistical variation.

**Days** - Calendar days unless otherwise specified.

**Deemed Newborn** - Children born to SoonerCare enrolled mothers and determined eligible under 42 C.F.R. § 435.117.

**Dental Benefit Manager (DBM)** - A Dental Benefit Manager (DBM) manages and delivers dental benefits and services to eligible Dental Health Plan Enrollees.

**Dental Health Plan Enrollee** – A SoonerCare Eligible who has been enrolled in a SoonerSelect Dental health plan.

**Dental Health Plan Enrollee Handbook** - A guidebook that explains the SoonerSelect Dental program that the Contactor shall distribute to every Dental Health Plan Enrollee. It shall be designed to help the Dental Health Plan Enrollee understand the DBM, the SoonerSelect Dental program and the rights and responsibilities that come with membership in the program.

**Dental Home** - The provision of comprehensive oral health including acute care and preventive services; delivered in a continuously accessible, coordinated and family-centered way.

**Dental Health Professional Shortage Area** – Designation by the United States Health Resources and Services Administration that indicates health care provider shortages in dental health.

**Direct Ownership Interest** – Pursuant to 42 C.F.R. § 455.101 means possession of equity in the capital, the stock, or the profits of the Disclosing Entity.

**Disclosing Entity** – Pursuant to 42 C.F.R. § 455.101 means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

**Disenrollment** - The removal of a Dental Health Plan Enrollee from participation in the Contractor's Dental Benefit Manager.

**Dual Eligible Individuals** - Individuals eligible for both Medicaid and Medicare.

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** – Screening and diagnostic services to determine physical or mental defects in Eligibles or Dental Health Plan Enrollees under age 21 and health care, treatment, and other measures to correct or ameliorate any existing defects and/or Chronic Conditions discovered.

**Eligible** – An individual who has SoonerCare coverage.

**Emergency Dental Care** - Includes, but is not limited to, the immediate service that must be provided to relieve the member from pain due to an acute infection, swelling, trismus or trauma.

**Emergency Medical Condition** - A medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organs or parts.

**Emergency Services** - Health Care Services that are furnished by a Provider qualified to furnish such services and needed to evaluate, treat, or stabilize an Emergency Medical Condition.

**Encounter Data** - Information relating to the receipt of any item(s) or service(s) by a Dental Health Plan Enrollee under the Contract that is subject to the requirements of 42 C.F.R. §§ 438.242 and 438.818.

**Enrollment** - The process by which an Eligible becomes a Dental Health Plan Enrollee with the Contractor.

**Essential Hospital Services** - Tertiary care hospital services to which it is essential for the Contractor to provide access, including but not limited to neonatal, perinatal, pediatric, trauma and burn services.

**Excluded Benefits** – Medicaid-covered services that are not the responsibility of the Contractor as specified in Section 1.6.2: “Benefits” of the Model Contract.

**Excluded Populations** - Populations that are excluded from participation in the SoonerSelect Dental program as specified in Section 1.4.4: “Excluded Populations” of the Model Contract.

**Expansion Adult** – Refers to an Eligible or Dental Health Plan Enrollee age 19 or older and under age 65, with income at or below 138% FPL determined eligible in accordance with 42 C.F.R. § 435.119.

**Exploitation** - An unjust or improper use of the resources of a vulnerable Dental Health Plan Enrollee for the profit or advantage, pecuniary or otherwise, of a person other than the vulnerable Dental Health Plan Enrollee through the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense.

**External Quality Review (EQR)** - The analysis and evaluation by an EQRO, of aggregated information on quality, timeliness and access to the health care services that the Contractor furnishes to Dental Health Plan Enrollees.

**External Quality Review Organization (EQRO)** - An organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354 and performs External Quality Review and other EQR-related activities as set forth in 42 C.F.R. § 438.358.

**Federally Qualified Health Center (FQHC)** - An organization that qualifies for reimbursement under Section 330 of the Public Health Service Act. FQHCs qualify to receive enhanced reimbursements from Medicare and Medicaid, must serve an underserved population or area, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program and have a governing board of directors.

**Former Foster Children (FFC)** – Individuals under age 26 determined eligible in accordance with 42 C.F.R. § 435.150 who were in foster care under the responsibility of the State or an Indian Tribe within Oklahoma and enrolled in SoonerCare on the date of attaining age 18 or aging out of foster care.

**Foster Care** - Planned, goal-directed service that provides 24-hour-a-day substitute temporary care and supportive services in a home environment for children birth to 18 years of age in OKDHS custody.

**Foster Care and Adoption Association of Oklahoma (FAAO)** – Advocacy organization that supports foster and adoptive parents. This group meets with DHS leadership quarterly, and has a very active Facebook group with over 6,000 members.

**Full Credibility or Fully Credible** - A standard for which the experience of the Contractor is determined to be sufficient for the calculation of an MLR with a minimal chance that the difference between the actual and target MLR is not statistically significant. A Contractor that is assigned Full Credibility (or is Fully Credible) will not receive a Credibility Adjustment to its MLR.

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

**Grievance** - A Dental Health Plan Enrollee expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee or failure to respect the Dental Health Plan Enrollee's rights regardless of whether remedial action is requested. A Grievance includes a Dental Health Plan Enrollee's right to dispute an extension of time proposed by the Contractor to make an authorization decision.

**Grievance and Appeal System** - The processes the Contractor implements to handle Dental Health Plan Enrollee Grievances and Appeals of Adverse Benefit Determinations, as well as the processes to collect and track information about them.

**Health Care Services** - All Medicaid services provided by the Contractor in any setting, including but not limited to medical care, behavioral health care and pharmacy.

**Health Risk Screening** - A screening tool developed by the Contractor, and approved by OHCA, to obtain basic health and demographic information, identify any immediate needs a Health Plan Enrollee may have and assist the Contractor to assign a risk level for the Health Plan Enrollee in order to determine the level of care management needed.

**Healthcare Effectiveness Data and Information Set (HEDIS)** - A tool supplied by the NCQA and used by health plans to measure performance on important dimensions of care and service. This information set contains a number of measures designed to evaluate quality of care in a standardized fashion that allows for comparison between health plans.

**Indian Health Care Provider (IHCP)** - A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

**Indian Health Programs** – As defined in 25 U.S.C. § 1603(12): (a) any health program administered directly by the Indian Health Service; (b) any tribal health program; and (c) any Indian Tribe or tribal organization to which the Secretary provides funding pursuant to 25 U.S.C. § 47.

**Indian Managed Care Entity (IMCE)** - An MCO, PIHP, PAHP, PCCM or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization (each as defined in 25 U.S.C. § 1603), which may be composed of one or more I/T/Us and which also may include the Indian Health Service.

**Indian Tribe** – As defined in 25 U.S.C. §1603.

**Indirect Ownership Interest** – Pursuant to 42 C.F.R. § 455.101 means an ownership interest in an entity that has an ownership Interest in the disclosing Entity.

**Initial Program Implementation** – The 90 day period following OHCA initially enrolling all Eligibles who meet criteria for the SoonerSelect Dental program with a Dental Benefit Manager.

**Intermediate Sanction** – The sanctions described in 42 C.F.R. § 438.702 which OHCA may impose for the Contractor's non-compliance for any of the conditions in 42 C.F.R. § 438.700.

**Juvenile Justice Involved** - All persons in OJA custody or under its supervision for whom OJA is required to provide services by law or court order.

**Key Staff** – The following staff positions dedicated full time to the SoonerSelect Dental program and based in the Contractor’s Oklahoma office: CEO; CFO; Compliance Officer; Information Systems Manager; Dental Director; Dental Health Plan Enrollee Services Director; Provider Services Director; Business Process Manager; Quality Management Director; Data Compliance Manager; Dental Health Plan Enrollee Advocate; Grievances and Appeal Manager; Tribal Government Liaison; Community Dental Health Coordinator; Internal Audit Director; and Program Integrity Lead Investigator.

**Limited English Proficiency (LEP)** – Eligibles and Dental Health Plan Enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be Limited English Proficient (LEP) and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

**Major Subcontractor** - A Major Subcontractor is defined as:

- Major administrative Subcontractors are entities anticipated to be paid \$2,000,000 or more for Dental Health Plan Enrollee- or Provider-facing administrative activities, including but not limited to operation of call centers, claims processing and Dental Health Plan Enrollee/Provider education; or
- Major health service Subcontractors are entities not including Participating Providers that have an executed agreement to deliver or arrange for the delivery of any physical health, behavioral health or pharmacy benefit covered under the Contract in accordance with Section 1.6: “Covered Benefits” of the Model Contract.

**Managed Care Organization (MCO)** - A health plan that has a Contract to participate in the SoonerSelect Program and to deliver benefits and services to Health Plan Enrollees.

**Managing Employee** – Pursuant to 42 C.F.R. § 455.101 means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

**Marketing** - Any communication from the Contractor to an Eligible that can reasonably be interpreted as intended to influence the Eligible to enroll in the Contractor’s SoonerSelect Dental product, or either to not enroll in, or to disenroll from, another Dental Benefit Manager’s SoonerSelect Dental product. Marketing does not include communication to an Eligible from the issuer of a QHP about the QHP.

**Marketing Materials** - Materials that are produced in any medium by or on behalf of the Contractor (including its employees, Participating Providers, agents or Subcontractors) and can reasonably be interpreted as intended to market the Contractor to Eligibles.

**Medical Management Program** - Consists of a series of activities undertaken by Providers and the Contractor to maintain and improve quality and Medically Necessary (or similar) service levels and respond to accreditation and regulatory requirements.

**Medically Necessary** - A standard for evaluating the appropriateness of services. Medical necessity, as established under OAC 317:30-3-1, is established through consideration of the following standards:

- Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the prevention, diagnosis or treatment of symptoms of illness, disease or disability;

- Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records, evidence sufficient to justify the Dental Health Plan Enrollee's need for the service;
- Treatment of the Dental Health Plan Enrollee's condition, disease or injury must be based on reasonable and predictable health outcomes;
- Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the Dental Health Plan Enrollee, family or medical provider;
- Services must be delivered in the most cost-effective manner and most appropriate setting; and
- Services must be appropriate for the Dental Health Plan Enrollee's age and health status and developed for the Dental Health Plan Enrollee to achieve, maintain or promote functional capacity or age-appropriate growth and development

Also aligning with federal standards, "Medically Necessary services" are no more restrictive than the State Medicaid program including Quantitative (QTL) and Non-Quantitative Treatment Limits (NQTL), as indicated in State statutes and regulations, the State Plan, and other State policies and procedures. The Contractor shall cover Medically Necessary services related to the ability for a Dental Health Plan Enrollee to attain, maintain, or regain functional capacity.

**Medically Necessary Dental Services** - Those services deemed necessary to prevent and eliminate orofacial disease, infection, and pain, restore the form and function of the dentition and to correct facial disfiguration and dysfunction.

**Medicare Savings Program** – Provides assistance to Eligibles in paying Medicare premium and cost sharing.

**MLR Reporting Year** - A period of 12 months consistent with the Rating Period.

**National Provider Identifier (NPI)** - A unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use an NPI in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

**No Credibility or Non-Credible** - A standard for which the experience of the Contractor is determined to be insufficient for the calculation of an MLR. A Contractor that is assigned No Credibility (or is Non-Credible) will not be measured against any MLR requirements.

**Non-Claims Costs** - Those expenses for administrative services that are not: Incurred claims (as defined in 42 C.F.R. § 438.8(e)(2)); expenditures on activities that improve health care quality (as defined in 42 C.F.R. § 438.8(e)(3)); licensing and regulatory fees, or federal and State taxes (as defined in 42 C.F.R. § 438.8(f)(2)).

**Non-Compliance Remedy** – An action taken by OHCA in response to the Contractor's failure to comply with a Contract requirement or performance standard. Remedies include, but are not limited to: the requirement for the Contractor to develop a formal corrective plan; Capitation Payment suspension; auto-assignment suspension; Intermediate Sanctions; Contract termination and the remedies under Section 1.22.6: "Other Non-Compliance Remedies" of the Model Contract.



**Non-Participating Provider** - A physician or other Provider who has not contracted with or is not employed by the Contractor to deliver services under the SoonerSelect Dental program.

**Non-Urgent Sick Visit** - Medical care given for an acute onset of symptoms which is not emergent or urgent in nature. Examples of Non-Urgent Sick Visits include cold symptoms, sore throat and nasal congestion. Requires face-to-face medical attention within 72 hours of Dental Health Plan Enrollee notification of a non-urgent condition, as clinically indicated.

**Office of Juvenile Affairs (OJA)** - The OJA provides, with its community partners, prevention, educational and treatment services, as well as secure facilities for juveniles in order to promote public safety and reduce juvenile delinquency.

**Oklahoma Department of Corrections (ODOC)** - The mission of the ODOC is to protect the public, promote a safe working environment for staff, and encourage positive change in offender behavior by providing rehabilitation programs to enable successful reentry.

**Oklahoma Department of Human Services (Oklahoma DHS)** - The Oklahoma DHS is the largest state agency in Oklahoma. Oklahoma DHS provides a wide range of assistance programs to help Oklahomans in need including: food benefits (SNAP); temporary cash assistance (TANF); services for persons with developmental disabilities and persons who are aging; Adult Protective Services; child welfare programs; child support services and child care assistance, licensing and monitoring. DHS also handles applications and eligibility for SoonerCare's aged, blind, and disabled population, and long-term care.

**Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)** - The ODMHSAS is responsible for providing services to Oklahomans who are affected by mental illness and substance abuse. The mission of the ODMHSAS is to promote healthy communities and provide the highest quality care to enhance the well-being of all Oklahomans.

**Oklahoma Health Care Authority (OHCA)** - The single state Agency for Medicaid in Oklahoma and the Agency with direct oversight of the SoonerSelect Dental program.

**Oklahoma State Department of Education (OSDE)** - The OSDE is the state education agency of the State of Oklahoma charged with determining the policies and directing the administration and supervision of the public school system of Oklahoma.

**Oklahoma State Department of Health (OSDH)** - The OSDH, through its system of local health services delivery, is ultimately responsible for protecting and improving the public's health status through strategies that focus on preventing disease. Three major service branches, Community & Family Health Services, Prevention & Preparedness Services and Protective Health Services, provide technical support and guidance to 68 county health departments as well as guidance and consultation to the two independent city-county health departments in Oklahoma City and Tulsa.

**Open Enrollment Period** - The annual period, as defined by OHCA, when Dental Health Plan Enrollees and Eligibles can enroll in a Dental Benefit Manager for the SoonerSelect Dental program.

**Other Disclosing Entity** – Pursuant to 42 C.F.R. § 455.101 means any other Medicaid Disclosing Entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes:

- Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, Rural Health Clinic, or health maintenance organization that participates in Medicare;
- Any Medicare intermediary or carrier; and
- Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

**Outcomes** - Changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services.

**Overpayment** – Any payment made to a Participating Provider by the Contractor to which the Participating Provider is not entitled or any payment to the Contractor by a state to which the Contractor is not entitled to under Title XIX of the Act and under the SoonerSelect Dental program.

**Parent and Caretaker Relative** – An individual determined eligible under 42 C.F.R. § 435.110.

**Partial Credibility or Partially Credible** - A standard for which the experience of the Contractor is determined to be sufficient for the calculation of an MLR but with a non-negligible chance that the difference between the actual and target medical loss ratios is statistically significant. A Contractor that is assigned Partial Credibility (or is Partially Credible) will receive a Credibility Adjustment to its MLR.

**Participating Provider** - A physician or other Provider who has a contract with or is employed by the Contractor to provide services to Dental Health Plan Enrollees under the SoonerSelect Dental program.

**Past Performance Information** – The Bidder’s experience, expertise, and performance in connection with prior contracts, including its performance in the areas of cost, quality, schedule, compliance with plans and specifications, and adherence to the applicable laws and regulations.

**Pediatric** – Children from birth through age 21.

**Performance Improvement Projects (PIPs)** - A concentrated effort on a problem, consistent with 42 C.F.R.. § 438.330, and designed to achieve significant improvement, sustained over time, in health outcomes and Dental Health Plan Enrollee satisfaction and must include the following elements:

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the interventions; and
- Planning and initiation of activities for increasing or sustaining improvement.

**Person-Centered Care** - A health delivery system that provides care that is respectful of and responsive to Dental Health Plan Enrollees’ preferences, needs and values. Person-centered care ensures that a Dental Health Plan Enrollee’s values guide all clinical and quality of life decisions.

**Person with Ownership or Control Interest** – Pursuant to 42 C.F.R. § 455.101 means a person or corporation that:

- Has a Direct Ownership Interest totaling five percent or more in a Disclosing Entity;
- Has an Indirect Ownership Interest equal to five percent or more in a Disclosing Entity;

- Has a combination of Direct and Indirect Ownership Interests equal to five percent or more in a Disclosing Entity;
- Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the Disclosing Entity if that interest equals at least five percent of the value of the property or assets of the Disclosing Entity;
- Is an officer or director of a Disclosing Entity that is organized as a corporation; or
- Is a partner in a Disclosing Entity that is organized as a partnership.

**Post-Stabilization Care Services** - Covered services related to an Emergency Medical Condition that are provided after a Dental Health Plan Enrollee is stabilized to maintain the stabilized condition or under the circumstances described in 42 C.F.R. § 438.114 (e), to improve or resolve the Dental Health Plan Enrollee's condition.

**Post-Transition** - The time period that begins upon conclusion of the Transition Period and ends upon the Contractor's successful completion, as determined at the sole discretion of OHCA, of all post-Contract expiration or termination obligations.

**Pregnancy-Related Services** – In accordance with 42 C.F.R. § 440.210, services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having become pregnant. OHCA considers all services received by a Dental Health Plan Enrollee or Eligible that is pregnant to be a Pregnancy-Related Service.

**Pregnant Women** – A women determined eligible for SoonerCare under 42 C.F.R. § 435.116.

**Presumptive Eligibility** – A period of temporary SoonerCare eligibility provided to individuals determined by a qualified entity, on the basis of Applicant self-attested income information, to meet the eligibility requirements for a MAGI eligibility group.

**Primary Care Dentist (PCD)** - The dental care professional providing comprehensive dental care for a Dental Health Plan Enrollee. The PCD is responsible for coordinating and integrating dental care for the Health Care Enrollee.

**Prior Authorization/Service Authorization** - A requirement that a Dental Health Plan Enrollee obtain the Contractor's approval before a requested medical service is provided or before services by a Non-Participating Provider are received. Prior Authorization is not a guarantee of claims payment; however, failure to obtain Prior Authorization may result in denial of the claim or reduction in payment of the claim. For the purposes of this Contract, the term "Prior Authorization" shall be used instead of "pre-authorization."

**Proposal** – The response submitted by the Contractor during the RFP process detailing its approach to meeting terms of the Contract and serving the SoonerSelect Dental program.

**Protected Health Information** - Information considered to be individually identifiable health information, as described in 45 C.F.R. § 160.103.

**Provider** – Includes both Participating and Non-Participating Providers.

**Provider Agreement** - An agreement between the Contractor and a Participating Provider that describes the conditions under which the Participating Provider agrees to furnish covered services to Dental Health Plan Enrollees.

**Provider Complaint** - A verbal or written expression by a Provider involving dissatisfaction with the Contractor's policies, procedures, communication or other action by the Contractor.

**Provider-Preventable Conditions** - A condition occurring in any inpatient hospital setting, identified by the Secretary under Section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State Plan as described in Section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients. Also includes a condition occurring in any health care setting that is identified in the State Plan, has been found by OHCA, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; has a negative consequence for the Dental Health Plan Enrollee or Eligible; is auditable; and includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; and any surgical or other invasive procedure performed on the wrong patient.

**Quality Assessment and Performance Improvement (QAPI)** - A process designed to address and continuously improve Contractor quality metrics. The QAPI activities will provide the Contractor with data which it shall use, in conjunction with input from Dental Health Plan Enrollees and other stakeholders, to improve the delivery of care and care outcomes. The program shall evaluate all SoonerSelect Dental program population groups, care settings and types of services, including physical health services, behavioral health services and pharmacy benefits. The Contractor's QAPI program shall comply with every aspect of State and federal law, including 42 C.F.R. § 438.330 in its entirety.

**Quality Improvement Committee (QIC)** - A committee within the Contractor's organizational structure that oversees all QAPI functions. The Contractor's Medical Director shall chair the committee.

**Rating Period** – The time period selected by OHCA for which the actuarially sound Capitation Rates are developed and documented in the rate certification submitted to CMS as required by 42 C.F.R. § 438.7(a).

**Readiness Review** - The on-site and desk review process required in accordance with 42 C.F.R. § 438.66. The Contractor is required to meet Readiness Review requirements to the satisfaction of OHCA prior to receiving Dental Health Plan Enrollee enrollment.

**Report Period** – The measurement period used for the performance withhold program described in Appendix 1D: "Performance Withhold Program." The Report Period is a calendar year.

**Reporting Manual** – The OHCA-developed manual outlining the Contractor's performance reporting obligations, including required reporting, data definitions, frequency and formats.

**Rural Area** - A county with a population of less than 50,000 people.

**Rural Health Clinic** - Clinics meeting the conditions to qualify for Rural Health Clinic reimbursement as stipulated in Section 330 of the Public Health Services Act. Rural Health Clinics (RHCs) certified for participation in the Medicare Program are considered eligible for participation in the Medicaid Program. Rural Health Clinics may be provider-based (i.e., clinics that are an integral part of a hospital, skilled nursing facility or home health agency that participates in Medicare) or independent (freestanding), and may include Indian Health Clinics. To participate, a Rural Health Clinic must have a current contract on file with OHCA.

**Secretary** – Refers to the Secretary of the U.S. Department of Health and Human Services.

**Service Gap** - A delay in initiating any service and/or a disruption of a scheduled, ongoing service that was not initiated by a Dental Health Plan Enrollee, including late or missed visits.

**Shall** - A verb used to designate duties that will be a required condition of the Contract. Failure of a Contractor to perform a duty required as a condition of the Contract will be considered breach of Contract.

**Social Determinants of Health** – Conditions in the places where a Dental Health Plan Enrollee lives, learns, works and plays that affect the Dental Health Plan Enrollee’s health and quality-of-life risks and outcomes.

**SoonerCare** – The Oklahoma Medicaid program.

**SoonerCare MCO** – Refers to the vendor(s) with whom OHCA contracts to provide SoonerCare covered medical, pharmacy, and behavioral health benefits.

**SoonerSelect Dental Plan** – Refers to the vendor with whom OHCA contracts to provide SoonerCare covered dental benefits.

**Soon-To-Be-Sooner** – Oklahoma’s separate CHIP program providing coverage to unborn children of families earning up to and including 185 percent of the FPL. This program allows coverage of pregnancy related services under Title XXI.

**Special Health Care Needs** - Individuals who have or are at risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health or related services of a type or amount beyond that generally required.

**Standing Referral** - A referral from a PCD Provider or the Contractor for a Dental Health Plan Enrollee needing access to multiple appointments with the specialist over a set period of time, such as a year, without seeking multiple referrals.

**State** - When not otherwise specified, refers to a government entity or entities within the State of Oklahoma.

**State Holidays** – Includes New Year’s Day, Martin Luther King, Jr. Day, Presidents’ Day, Memorial Day, Independence Day, Labor Day, Veterans Day, Thanksgiving Day and the following day, Christmas Eve and Christmas Day, or any updates thereto based on executive order of the Governor of Oklahoma.

**State Plan** – An agreement between OHCA and CMS describing how Oklahoma administers its Medicaid and CHIP programs.

**State Plan Benefits** – The SoonerCare benefits available to all Dental Health Plan Enrollees, with the exception of Expansion Adults.

**State Fair Hearing** - The process set forth in Subpart E of 42 C.F.R. Part 431.

**Steady State Operations**- The time period beginning 90 days after Initial Program Implementation.

**Subcontractor** - An individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor’s obligations under its Contract with the State. A Participating Provider is not a Subcontractor by virtue of the Provider Agreement with the Contractor.

**Subsidiary or Subsidiaries** – A company that is owned or controlled by another company or entity.

**Telehealth** - Means the practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information by means of a two-way, real-time interactive communication, not to exclude store and forward technologies, between a patient and a health care provider with access to and reviewing the patient's relevant clinical information prior to the telemedicine visit. In accordance with Oklahoma law, including OAC 317:30-3-27 and 59 O.S. § 478, telehealth shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure videoconference, or facsimile transmission.

**Third Party Liability (TPL)** – All or part of the expenditures for a Dental Health Plan Enrollee's medical assistance furnished under the OHCA State Plan that may be the liability of a third party individual, entity or program.

**Transition Period** – The time period which begins upon any of the following triggering events: notice issued by OHCA of its intent to terminate the Contract; notice issued by the Contractor or OHCA to not extend the Contract; or if the Contract has no remaining extension periods, 180 days before the Contract termination date. The Transition Period ends upon the transition of Dental Health Plan Enrollees to another Dental Benefit Manager or OHCA-designated service delivery system.

**Transition Plan** – The plan developed by the Contractor and approved by OHCA documenting how the Contractor will ensure the orderly transition of Dental Health Plan Enrollees and meet the Transition Period and Post-Transition obligations upon Contract expiration or termination.

**Urban Area** – A county with a population of 50,000 people or more.

**Urgent Care** - Medical care provided for a condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse), such that a reasonably prudent layperson could expect that the absence of medical attention within 24 hours could result in:

- Placing the health of the individual in serious jeopardy;
- Serious impairment to bodily function; or
- A serious dysfunction of any body organ or part.

**Urgent Dental Care** - The management of dental conditions that require immediate attention to relieve severe pain and/or risk of infection in order to avoid the likely onset of an emergency medical condition.

**Value-Added Benefit** - Any benefit or service offered by the Contractor that is not a covered benefit. These benefits are subject to change annually as determined by the Contractor and OHCA.

**Validation** - The review of information, data and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accordance with standards for data collection and analysis.

**Waste** - The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program; generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

## 1 Appendix 1C: Performance Withhold Program

### 1.1 Overview

OHCA is committed to the delivery of high quality health care through the development of a data-driven, outcomes-based, continuous quality improvement process that focuses on rigorous measurement against relevant targets and appropriately rewards advancement of quality goals. In furtherance of these objectives, OHCA will withhold a portion of the Contractor's Capitation Payments, as set forth in this Appendix. The Contractor shall be eligible to receive retrospectively some or all of the withheld Capitation Payments based on the Contractor's performance in the areas outlined in Section 1.3 of this Appendix.

### 1.24 Performance Withhold

OHCA will withhold a portion of the Contractor's Capitation Payments according to schedule outlined in the table below:

Contract Rating Period	Withhold Percentage	Reporting Year	Measurement Year	Reporting of Measures Due from MCO
One--SFY 2022 (Oct 1, 2021-Jun 30, 2022)	1.0	2023	CY 2022	June 15, 2023
Two--SFY 2023 (Jul 1, 2022-Jun 30, 2023)	1.5	2024	CY 2023	June 15, 2024
Three--SFY 2024 (Jul 1, 2023-Jun 30, 2024)	2.0	2025	CY 2024	June 15, 2025
Four--SFY 2025 (Jul 1, 2024-Jun 30, 2025)	2.5	2026	CY 2025	June 15, 2026
Five--SFY 2026 (Jul 1, 2025-Jun 30, 2026)	3.0	2027	CY 2026	June 15, 2027

#### 1.24.1 Frequency

Contractor performance will be assessed annually per the timeframes listed in the table above. OHCA will issue one assessment and payment, if applicable, per DBM per State fiscal year (SFY).

#### 1.24.2 Report Period

The measurement period used for the performance withhold measures is by each calendar year (CY), according to the following:

- Measurement Year One: CY 2022
- Measurement Year Two: CY 2023
- Measurement Year Three: CY 2024
- Measurement Year Four: CY 2025

- Measurement Year Five: CY 2026

### 1.24.3 Potential Payout

The potential payout for this determination is equal to the amount withheld during each Contract Rating Period.

OHCA reserves the right to adjust the percent of Capitation Payments withheld in future Contract Rating Periods. Such adjustments shall be made through a formal Contract amendment in accordance with the provisions outlined in Model Contract Section 1.1.9: “Amendments or Modifications.”

### 1.25 Outcome Measures and Payment Structure

During the first Contract Rating Period, the Contractor shall be eligible to receive withheld Capitation Payments based on performance in calendar year 2022 on the two outcome measures and targets outlined in the table below. Withhold payment opportunities have been established based on OHCA priority areas.

Each measure will be compared to the previous year’s performance for the OHCA rate among all Dental Health Plans submitting data. For the first year only, comparisons will be made to calendar year 2019.

Measure	Measurement Set	Amount of Capitation Withhold	OHCA Baseline Rate	Annual Target Criteria
<b>Clinical Quality of Care Measures</b>				
Percentage of members aged 1-20 receiving a preventive dental care visit	CMS EPSDT 416	0.5%	FFY 2019: 49.78%	The target is the percentage of members aged 1-20 receiving one Preventive Dental Care Visit per year will increase from the current baseline of 49.78% and increase by at least 2 percent compared to the previous year.
Percentage of members aged 6-14 receiving dental sealants on permanent molars	CMS EPSDT 416	0.5%	FFY2019: 10.07%	The target is the percentage of members aged 6-14 receiving dental sealants on permanent molars will increase by 5% from the previous year, from the current baseline of 10.07%.

OHCA reserves the right to adjust the measures, number of measures, weighting of measures and performance targets in future Contract Rating Periods. Such adjustments shall be made through a formal Contract amendment in accordance with the provisions outlined in Model Contract Section 1.1.9: “Amendments or Modifications.”



### **1.26 Timing of Quality Withhold Determination**

OHCA will make its best efforts to distribute a report identifying Contractor performance and eligibility for payment of withheld Capitation Payments within six months of the end of each established Report Period, as defined in Section 1.2 “Performance Withhold.” Given that unforeseen circumstances may impact the timing of this determination, OHCA reserves the right to revise the time frame in which this report is issued.

### **1.27 Federal Compliance**

In accordance with 42 C.F.R. § 438.6, the performance withhold program:

- Will not be renewed automatically;
- Will be made available to both public and private SoonerSelect Dental DBMs under the same terms of performance;
- Does not condition Contractor participation in the withhold arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements;
- Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives specified in the State’s managed care quality strategy required under 42 C.F.R. § 438.340; and
- Will measure performance for a fixed period of time during the Rating Period under the Contract in which the incentive arrangement is applied.

### **1.28 Contractor Eligibility**

The Contractor may, in OHCA’s sole discretion, lose eligibility for its compensation under the performance withhold program if:

- OHCA has suspended, in whole or in part, Capitation Payments or enrollment to the Contractor;
- OHCA has assigned, in whole or in part, the membership and responsibilities of the Contractor to another participating SoonerSelect Dental Contractor;
- OHCA has assumed or appointed temporary management with respect to the Contractor;
- The Contract has been terminated;
- The Contractor has, based on the sole determination of OHCA, failed to execute a smooth transition at the end of the Contract term, including failure to comply with the Contractor responsibilities set forth in the Model Contract Section 1.23.3: “Post-Transition Contract Obligations;” or
- OHCA has imposed upon the Contractor a Non-Compliance Remedy during the performance withhold measurement year.

OHCA may, at its discretion, reinstate the Contractor’s eligibility for participation in the SoonerSelect Dental performance withhold program once the Contractor has properly cured all prior instances of non-compliance of its obligations under the Contract and OHCA has satisfactory assurances of acceptable future performance.