

ATTACHMENT II
SCOPE OF SERVICE - CORE PROVISIONS – UPDATE: FEBRUARY 1, 2025
DENTAL HEALTH PROGRAM

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Section I. General Overview

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A. Purpose

1. Under the Statewide Medicaid Prepaid Dental Program, the Agency for Health Care Administration (Agency) contracts with Dental Plans, as defined in **Section XVI.**, Definitions and Acronyms, to provide services to recipients.
2. The provisions in this Contract and the terms of the applicable federal waivers apply to all Dental Plans.
3. The Dental Plan shall comply with all provisions of this Contract and any amendments and shall act in good faith in the performance of these Contract provisions.

B. Features: Hope Florida Initiative

Under the Agency’s mission to improve health care for all Floridians and in tandem with the tenets of the Hope Florida initiative, the Statewide Medicaid Prepaid Dental Program is committed to high quality oral health care for children, seniors, disabled adults, and pregnant women. Preventing and treating cavities and gum disease contributes to better overall health. Proper dental care, especially for children and pregnant women, is critical for growth and development. For seniors and disabled adults, high quality oral health care is critical for nutrition, communication, dampening systemic inflammation, and quality of life. The following commitments are developed in the context of the Hope Florida initiative tenets of Positive Return on Investment, Accountability for Taxpayers’ Dollars, Freedom First, Strong Florida Families, Building Communities, and Pathway to Prosperity. In the 2025-2030 contract period, the Agency seeks to:

- Improve oral health outcomes by implementing a quality continuum.
- Enable personalized oral health care, particularly for people with special needs.
- Strengthen the network of dental providers.
- Integrate medical and dental care.

C. Prioritizing Quality and Value

The new Dental Program Quality Strategy drives continual improvement in overall program quality using a balance of incentives and penalties. By rewarding high quality performance, the Agency communicates state health care priorities, holds accountable the Dental Plans that fail to improve oral health care quality, and invests in Dental Plans with proven effectiveness.

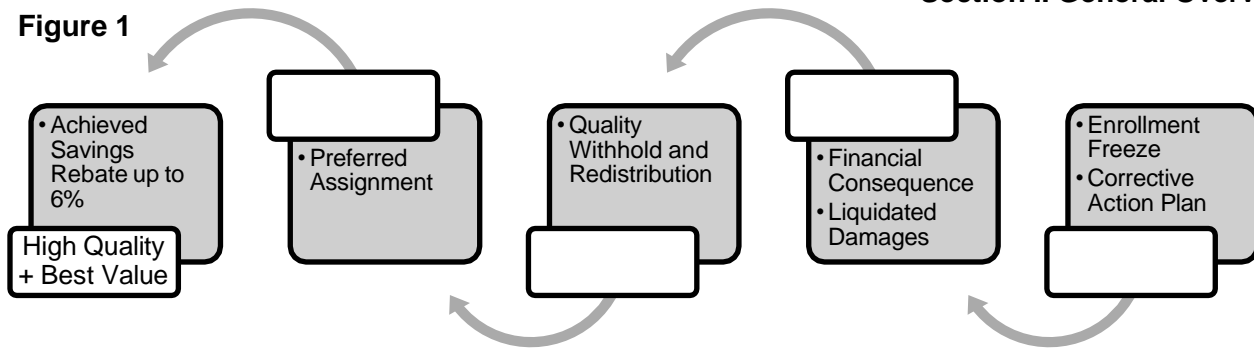
1. Layered Approach to Drive Continued Improvement

By tying performance incentives and penalties to the Agency’s goals, the Agency will drive Dental Plan performance to the height of quality and best value (Figure 1).

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Figure 1



a. Achieved Savings Rebate One Percent Quality Incentive

The Dental Plan operating at top tier performance levels may retain an additional one percent (1%) of revenue through the Achieved Savings Rebate.

- (1) Each year, to be eligible to retain up to an additional one percent (1%) of revenue, the Dental Plan must earn twenty (20) points or more for the Oral Evaluation and have scored at least two (2) points for each reportable performance measure.
- (2) The Agency reserves the right during the Contract term to change the Achieved Savings Rebate One Percent Quality Incentive methodology.

b. Quality Preferred Assignment Incentive

In accordance with Section 409.977(1), F.S., the Agency may adjust enrollment through enhanced auto-assignments to high-performing Dental Plans as a performance incentive.

- (1) In addition to the incentive payments available through the Quality Incentive Withhold Arrangement, the Dental Plan may also be eligible for the Quality Preferred Assignment Incentive.
- (2) Each year, to earn the Quality Preferred Assignment Incentive, the Dental Plan must have earned its full one (1%) to one-and-one-half (1.5%) percent withhold and be the top scoring Dental Plan, based on Total Quality Points as a percentage of the Dental Plan's maximum points as described below, and have scored at least one (1) point for each reportable performance measure rate.
- (3) If the Dental Plan earns the Quality Preferred Assignment incentive, the Dental Plan shall receive enrollee assignments at a factor of 1.5 for a six (6) month period.
- (4) The Agency reserves the right during the Contract term to change the Quality Preferred Assignment Incentive methodology.

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c. Quality Withhold Incentive

The Quality Withhold Incentive creates a financial withhold from the capitation rates paid to the Dental Plan to use as an incentive payment to Dental Plans with high performance on select dental quality measures from the Performance Measures Table, **Table 6**. The Dental Plan may receive a payment higher or lower than their contribution based on performance. The Quality Withhold Incentive will be used in addition to any other capitation rate withhold or other payment mechanism that may be used to adjust capitation funding based on the Dental Plan’s actual utilization of preventive services as part of the actuarial capitation rate development process.

- (1) Each year, the Agency shall withhold 1.5% of the Dental Plan’s capitation rate, with the withhold to be earned based on the Dental Plan’s performance on the following dental quality measures from **Table 6**, Performance Measures:

2.a. - Targets for Quality Continuum						
Quality Measure / Total Quality Points	1 Point	2 Points	3 Points	4 Points	5 Points	6 Points
Oral Evaluation, Dental Services (OEV-CH)	36%	37%	38%	39%	40%	41%
Sealant Receipt on Permanent First Molars (SFM-CH) – At Least One	50%	51%	52%	53%	54%	55%
Topical Fluoride for Children (TFL-CH)	15%	16%	17%	18%	19%	20%
Follow-up after ED Visits for Dental Caries in Children (EDF-CH) – 30 Day	46%	47%	48%	49%	50%	51%

- (2) The Dental Plan shall earn points for each measure based on the Dental Plan’s performance rate relative to specified targets; The Dental Plan agrees to increase each target by one (1) percentage point (additive) in each year of the Contract.
- (3) Earned points for the four (4) measure rates will be added together to determine the Total Quality Points for the Dental Plan. The maximum number of Total Quality Points the Dental Plan may earn is twenty-four (24) (four (4) measures multiplied by six (6) possible points per measure).
- (4) If the Dental Plan’s Total Quality Points equals or exceeds an average of two (2) points per performance measure rate, then the Dental Plan shall earn its full withhold. If the Dental Plan’s Total Quality Points are below an average of two (2) points per performance measure, then the Dental Plan shall not receive its full withhold but may receive a portion of the withhold based on the percentage of Total Quality Points earned to maximum number of points possible.
- (5) Withhold not earned back by the Dental Plan shall be directed to a Quality

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Bonus Pool. If the Dental Plan's Total Quality Points equals or exceeds an average of two (2) points per performance measure rate, such that the Dental

Plan shall earn its full withhold, the Dental Plan may be eligible to earn money directed to the Quality Bonus Pool from other Dental Plans, depending on the Dental Plan's level of performance, the Dental Plan's capitation revenue, and/or the size of the Quality Bonus Pool.

- (6) The Agency reserves the right during the Contract term to change the Quality Withhold Incentive, including the target rates for particular point values.
- (7) The Dental Plan may use designations and rankings related to high performance on performance measures given by and as approved by the Agency.
- (8) **Attachment II, Exhibit II-A**, Quality Withhold Program Illustrative Example Calculation is provided to illustrate the Quality Withhold Incentive. The Dental Plan data in this example are fictitious. Identification with an actual Dental Plan is neither intended nor should be inferred.

d. Financial Consequences and Liquidated Damages

- (1) The Dental Plan agrees that failure to comply with any provisions of this Contract and 42 CFR 438.100 may result in the assessment of sanctions; temporary enrollment limitations, such as temporary enrollment freezes, enrollment algorithm reductions, and/or enrollment caps; and/or termination of this Contract, in whole or in part.
- (2) If the Dental Plan's performance is not consistent with the Agency's expected minimum standards, as specified in this **Sub-Section**, the Agency may sanction the Dental Plan for failure to achieve minimum scores on performance measures after the first year of poor performance. The Agency may impose monetary sanctions, as described in **Section XII.**, Corrective Action Plans, **Sub-Section C.**, Performance Measure Sanctions, and temporary enrollment limitations, such as temporary enrollment freezes, enrollment algorithm reductions, and/or enrollment caps, in accordance with **Section XII.**, Corrective Action Plans, **Sub-Section A.**, Contract Violations and Non-Compliance, for poor performance, as specified in this Contract.

e. Enrollment Freezes and Corrective Action Plans

Section 409.977(1), F.S., directs the Agency not to automatically enroll recipients in a plan that is deficient in performance or quality standards established by the Agency pursuant to s. 409.967, F.S.

- (1) The Dental Plan shall be subject to enrollment limitations when the Dental Plan repeatedly fails to meet substantive requirements in **Section V.**, Service Administration; **Section VII.**, Provider Network and Services; and/or **Section VIII.**, Quality, of this Contract.

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- (2) If a Corrective Action Plan (CAP) is required as determined by the Agency, the Dental Plan's proposed CAP shall be approved or disapproved by the Agency. If the Agency disapproves the CAP, the Dental Plan shall submit a new CAP within ten (10) business days, or an expedited timeframe if required by the Agency, that addresses the concerns identified by the Agency. The Dental Plan shall accept and implement an Agency-defined CAP if required by the Agency.
- (3) The Agency may impose enrollment limitations on the Dental Plan until the Dental Plan implements, to the satisfaction of the Agency, the approved CAP.
- (4) The Agency may impose temporary enrollment limitations, such as temporary enrollment freezes, enrollment algorithm reductions, and/or enrollment caps, in accordance with **Section XII.**, Sanctions and Corrective Action Plans, **Sub-Section A.**, Contract Violations and Non-Compliance, for poor performance, as specified in this Contract.

2. Value-Based Purchasing (VBP) Programs

- a. The Dental Plan shall develop and implement a value-based purchasing (VBP) program to maximize high value care, reduce inappropriate care, and reward best-performing providers. The VBP program must comply with the Agency's value-based insurance design parameters described below in General VBP Agreement Requirements. The Dental Plan shall include VBP agreements between subcontracted provider networks and providers. The Dental Plan shall submit all encounter claims in its VBP agreements in accordance with **Section IX.**, Administration and Management, of the Contract. The Agency reserves the right during the Contract term to modify the mandatory program parameters, performance metrics, data sharing, and reporting requirements.
- b. Value-Based Purchasing (VBP) Program Parameters
 - (1) The goals of the VBP program are to maximize high value care, reduce inappropriate care, and reward best-performing providers.
 - (2) The Dental Plan's VBP Program shall include contractual agreements with providers focused on defined populations.
- c. The Dental Plan shall use the following definitions of patient populations covered in VBP agreements with providers. The Agency reserves the right during this Contract term to change the definitions.
 - (1) Population-Based: Payments applied to a broad population for most of their care. Examples may include, but are not limited to, Accountable Care Organization (ACO) Models, Global Capitation, or Total Cost of Care Shared Savings/Risk.

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- (2) Targeted Population-Based: Payments applied to a specific population of people at highest risk for underutilization of preventive services, overutilization of acute care services, or health disparities, such as certain chronic conditions or diagnoses. Examples may include, but are not limited to, diabetes, serious mental illness and/or substance use disorder, justice-involved enrollees, HIV/AIDS, or enrollees with intellectual disabilities (IDD) on the iBudget Waiver or Waitlist as identified by the Agency.
 - (3) Enhanced Primary Dental Care: Primary dental providers (PDP) receive enhanced payment (e.g., per member per month (PMPM) care management fee or capitation payment) for providing enhanced set of primary dental services to attributed patients. Examples may include, but are not limited to, team-based care models such as Primary Care Medical Home (PCMH) or Primary Care Dental Home (PCDH) models.
 - (4) Targeted Enhanced Primary Dental Care: PDPs receive enhanced payment (e.g., PMPM care management fee or capitation payment) for providing enhanced set of primary dental care services to a specific population of attributed patients at highest risk for underutilization of preventive services, overutilization of acute care services, or health disparities, such as those with a chronic condition or diagnosis.
 - (5) Episode-Based: Payment applied to target population for episode care defined by a time period and/or specific diagnoses or procedures. Examples may include, but are not limited to dental emergency department visits, maternity, mental illness crises, or addiction relapses.
 - (6) Quality: Bonus payments or penalties to providers for quality reporting or performance that aligns with the Agency's performance measures described in **Section VIII.**, Quality of this Attachment.
 - (7) Foundational Payments for Infrastructure & Operations: Payments to providers to support advancement toward value-based payment agreements. Examples may include, but are not limited to, care coordination fees (PMPM or Lump Sum), health information technology investment to improve interoperability of dental records, or investment in payment reform or supplemental payments to address health-related social needs.
- d. The Dental Plan shall use the Learning Action Network (LAN)'s alternative payment framework to categorize its VBP agreements with providers. Agreements in categories LAN 3N or 4N are not considered value-based purchasing agreements and are not measured by the Agency. The Agency reserves the right during this Contract term to change the definitions of risk categories.

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- e. Provider Participation in VBP Agreements with the Dental Plan
 - (1) All providers in a Dental Plan’s provider network, including subcontracted provider networks, shall be eligible for VBP agreements.
 - (2) Dentists who qualify for the Dental Provider Incentive Program (DPIP) shall be given the choice to participate in VBP agreements.
 - (3) If a dentist qualifies for DPIP and chooses to participate in a VBP agreement, then the dentist’s choice must be documented.
 - (4) If the dentist qualifies for the DPIP program and consents to participate in both the DPIP program and a VBP agreement, then payments in the VBP agreement shall be equal to or exceed DPIP payments for the patients included in the DPIP.
 - (5) DPIP agreements between the Dental Plan and its providers shall not be considered a VBP agreement but may be used to augment a VBP agreement.

- f. General VBP Agreement Requirements
 - (1) The Dental Plan must include the following minimum value-based insurance design parameters in all VBP agreements between the Dental Plan and its providers:
 - (a) A detailed methodology used to attribute enrollees to providers. It is recommended that the Dental Plan use the enrollees’ PDP assignments described in **Section V.**, Service Administration, **Sub-Section E.**, Coverage Provisions, of this Attachment.
 - (b) A detailed methodology used to calculate the VBP target budget. The Dental Plan is encouraged to use a percent of risk-adjusted revenue for the target budget but should also consider the providers’ own historical costs to assess adequacy of the target budget. When calculating target budgets, the Dental Plan is encouraged to use the enrollees’ area deprivation index or other social vulnerability index rankings to adjust provider risk.
 - (c) A detailed methodology of regularly sharing data, at a minimum quarterly, with providers that enables proactive care management to achieve performance targets. Shared data shall be in the forms of clinical (e.g., health care utilization, health outcomes, quality performance), financial (e.g., actual expenditures, bonus payments, withholds, shared savings, shared losses), provider’s progress relative to achieving agreement targets (e.g., performance and budget), and others relevant to the VBP agreement. The Dental Plan shall offer

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technical assistance to VBP-participating providers for accessing and interpreting data.

- (d) A list of quality measures used for calculating shared savings or losses, including at least one (1) Child Core Set measure from **Table 6**, Performance Measures, found in **Section VIII.**, Quality, **Sub-Section B.**, Performance Measures, **Item 2.**, Required Performance Measures. The VBP agreement shall be clear on the performance period start and end dates. For providers who have no history of VBP contracting, the VBP agreement may include a ramp-up period prior to the first performance period to allow providers to put in place administrative systems and protocols needed under the VBP agreement.
- (2) The VBP agreement shall be clear on the payment and reconciliation terms with providers, including remittance timeframes (e.g., monthly, quarterly, or annually) and the process for appealing the payments.
- (3) The VBP agreement shall require providers to participate in the Florida Health Information Exchange (HIE) Encounter Notification Service (ENS). The Dental Plan shall achieve and maintain ENS participation in one hundred percent (100%) of VBP arrangements. The Dental Plan shall offer technical assistance to VBP-participating providers for accessing and interpreting data, including but not limited to acute care encounters for dental-related conditions.
- (4) The Agency has the right to review any VBP agreement for compliance with minimum requirements.
- (5) The Dental Plan shall expend a minimum percentage of payments to providers through VBP agreements in accordance with the Incremental Increase in Expenditures in Value-Based Purchasing Agreements with Providers Table, **Table 1**, below. The percentage of payments in various LAN risk levels are calculated by dividing the measured claim-based expenditures in VBP agreements by the total claim-based expenditures for all enrollees as reported in the ASR. If capitation is paid to providers in lieu of fee-for-service claim reimbursement, then the capitation payment amounts shall be included in the numerator and the denominator. If the Dental Plan falls below these minimum percentages, the Agency shall assess liquidated damages pursuant to **Section XIII.**, Liquidated Damages.

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TABLE 1		
INCREMENTAL INCREASE IN EXPENDITURES IN VALUE-BASED PURCHASING AGREEMENTS WITH PROVIDERS*		
Contract Period	VBP LAN 2A+	VBP LAN 3A+
Year 1	Reporting	Reporting
Year 2	10%	5%
Year 3	15%	10%
Year 4	20%	15%
Year 5	30%	20%
Year 6	40%	25%

*The percentages are minimum targets. The plus sign indicates the inclusion of greater risk levels. For example, “2A+” includes LAN risk levels 2A, 2B, 2C, 3A, 3B, 4A, 4B, 4C.

- (6) VBP Reporting Requirements. The Dental Plan shall report quarterly to the Agency on its VBP program in accordance with **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*.

D. Prioritizing Provider Recruitment, Retention, and Training

1. Investments in Dental Provider Training

In addition to the provisions of **Section VII.**, Provider Network and Services, **Sub-Section D.**, Provider Services, **Item 3.**, Provider Education and Training, the Dental Plan shall comply with the following provisions.

- a. The Dental Plan shall analyze provider complaint reasons quarterly to determine the greatest areas of need for provider communication, provider training, and/or plan operational changes. The Dental Plan shall submit, as directed by the Agency, a summary of the findings of its quarterly analysis that addresses any identified needs for provider communication, provider training, and/or plan operational changes, and describes the actions planned or implemented by the Dental Plan to address such areas and the results of those actions.
- b. The Dental Plan shall meet at least annually with dental professional organizations to maintain a proactive and cooperative approach to resolving and preventing issues.

The first summary report of these meetings shall be submitted to the Agency by August 1, 2025, and annually thereafter. In the annual report to the Agency, the Dental Plan must list and describe the changes it has made in response to these meetings that lead to improved quality of oral health care and improved provider experience. Failure to provide this report shall subject the Dental Plan to **Section XIII.**, Liquidated Damages.

- c. The Dental Plan shall ensure sufficient in-person and on-demand training availability to meet the educational needs of its providers.

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- d. The Dental Plan shall provide ongoing training to providers addressing the following topics at a minimum:
- (1) Minimum service coverage guidelines;
 - (2) Service authorization requirements;
 - (3) Billing procedures;
 - (4) Claims processing, including claim denial reason codes and billing solutions;
 - (5) Payment timeframes;
 - (6) Dispute resolution process and timeframes;
 - (7) Complaint submission instructions; and
 - (8) Agency contract requirements.

2. Reducing Administrative Barriers to Participation of Dental Providers

a. Gold Card Program for High-Quality Providers

- (1) The Dental Plan shall implement and maintain a Gold Card program that reduces or eliminates service authorization requirements, including prior authorization and retrospective review, for high performing providers that meet quality performance criteria established by the Dental Plan.
 - (a) The Dental Plan may limit the services that qualify for inclusion in the Gold Card program.
 - (b) The Dental Plan shall review provider eligibility on at least a quarterly basis. The Dental Plan may use data for determining eligibility for a period of time not to exceed one year prior to eligibility determinations.
 - (c) The Dental Plan may include other practice-related benefits for achieving Gold Card status, such as continuing education opportunities, access to state-of-the-art dental equipment and technology, assistance with support staff, collaborative learning environments for professional growth, loan repayment assistance, assistance with marketing, and VBP agreement performance bonuses.

The Agency reserves the right to prescribe the services that must be included in the Dental Plan's Gold Card program in order to facilitate progress towards the Agency's goals.

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In addition to the provisions of **Section VII.**, Provider Network and Services, **Sub-Section B.**, Network Management, **Item 2.**, Annual Network Development Plan, the Dental Plan shall also provide in its Annual Network Development Plan an analysis of the Dental Plan's Gold Card program, including but not limited to:

- (a) The thresholds to achieve Gold Card status.
 - (b) The benefits conferred when achieving Gold Card status.
 - (c) The number of dental providers achieving, maintaining, or losing Gold Card status during the Contract year, and reasons for loss of Gold Card status; and
 - (d) The number of enrollees receiving services from Gold Card providers throughout the Contract year.
 - (e) A statistical analysis of the quality performance scores of enrollees who received services from Gold Card providers compared to quality performance scores of enrollees who received services from non-Gold Card providers.
 - (f) A summary of provider reactions and exact quotations from providers about the Dental Plan's Gold Card Program.
- (3) In addition to the provisions in **Section VII.**, Provider Network and Services, **Sub-Section C.**, Provider Credentialing and Contracting, **Item 5.**, Provider Agreement Requirements, **Sub-Item c.**, the Dental Plan shall assure that all provider agreements shall provide a detailed description of the Dental Plan's service authorization program for Gold Card providers, including provider eligibility criteria and services that are included in the program, including;
- (a) The process for informing providers about the program;
 - (b) Provider eligibility criteria;
 - (c) Services that are included in the program;
 - (d) The process for notifying and educating approved providers about the program;
 - (e) The Dental Plan's oversight of approved high-quality providers; and
 - (f) Criteria for inclusion of additional providers into the program.
- b. Dental Provider Network Requirements
- (1) Dental Provider Incentive Program (DPIP)

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In addition to the provisions of **Section I.**, General Overview, **Sub-Section**

C., Prioritizing Quality and Value, **Item 2.**, Value-Based Purchasing (VBP) Programs, **Sub-Item e.**, Provider Participation in VBP Agreements with the Dental Plan and **Section IX.**, Administration and Management, **Sub-Section C.**, Subcontracts, **Item 1.**, General Provisions, **Sub-item k.**, Dental Provider Incentive Program (DPIP), the Dental Plan shall also comply with the following provisions:

- (a) The Dental Plan shall implement an incentive program wherein payment rates for the following eligible dental providers, who meet certain qualifying criteria, as established by the Agency, are equivalent to 140% of the Florida Medicaid fee-for-service rate. This incentive program shall be referred to as the Dental Provider Incentive Program (DPIP): General and Pediatric Dentists for the services listed below in the Dental Provider Incentive Program (DPIP) Table, **Table 2**, below, provided to enrollees under the age of twenty-one (21) years.
- (b) Payment to a qualified DPIP provider for included services must be equivalent to 140% of the Florida Medicaid fee-for-service rate. The Dental Plan shall use the following list of preventive and diagnostic dental procedure codes for enhanced payments under the DPIP:

TABLE 2	
DENTAL PROVIDER INCENTIVE PROGRAM (DPIP)	
Codes for DPIP-Enhanced Payments	
CPT CODE	DESCRIPTION
D1330	Oral Hygiene Instruction
D1120	Prophylaxis - Child
D1208	Topical application of fluoride – excluding varnish
D1351	Sealant – Per tooth
D1206	Topical application of fluoride varnish
D1999	Unspecified preventive procedure, by report
D0120	Periodic oral evaluation – established patient
D0150	Comprehensive oral evaluation – new or established patient
D1354	Interim caries arresting medication application. Silver Diamine Fluoride
D0145	Oral evaluation for a patient under three years of age and counseling with a primary caregiver

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- (c) The Agency reserves the right to modify the preventive and diagnostic dental procedure codes eligible for enhanced payments under the DPIP.
- (d) All General and Pediatric Dentists in a Dental Plan's provider network shall be eligible for the DPIP, except as follows:
 - (i) Providers that do not have a contractual arrangement with the Dental Plan
 - (ii) Services provided in a Federally Qualified Health Center (FQHC).
 - (iii) Services provided in a Rural Health Clinic (RHC).
 - (iv) Services provided in a County Health Department (CHD).
 - (v) Services provided in a Faculty Plans of Florida Dental School Faculty Physician Group.
- (e) The Dental Plan shall be required to implement the Agency's DPIP model and qualifying criteria. The Agency reserves the right, in its sole discretion, to modify the DPIP qualifying criteria.
- (f) The Dental Plan shall notify eligible providers of the DPIP qualifying criteria at least 60 days prior to October 1 of each year. The Dental Plan shall ensure that the provider contracts for dental providers who meet the qualifying criteria are amended and executed with any updated qualification and payment information prior to October 1 of each Contract year.
- (g) The DPIP qualifying criteria shall remain in place, at a minimum, for one full contract year beginning October 1 through September 30.
- (h) The Dental Plan shall maintain and continuously update the Provider Network Verification files with the appropriate indicators, as defined by the Agency, to identify those providers that qualify for the DPIP.
- (i) Non-compliance with this section, including failure to make appropriate payment to an eligible provider that meets the qualifying criteria, may be subject to liquidated damages and sanctions, as determined by the Agency.
- (j) The Dental Plan shall submit a report bi-annually to provide DPIP payment data to the Agency in accordance with **Section XV.**, Accountability.
- (k) The Dental Plan shall submit a report annually to provide the Agency with provider-level performance measure data on the DPIP Qualifying Criteria in accordance with **Section XV.**, Accountability.

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- (l) The Dental Plan agrees to evaluate whether the dental provider was paid equal to or greater than the DPIIP fee schedule amount using the following guiding principles in its rate calculation methodology:

Step 1: The Dental Plan shall calculate the dental provider's total compensation for included services provided to eligible enrollees for the time period (e.g., October 1, 2023 – September 30, 2024), including all of the following: fee-for-service payments, capitation payments, case management fees, incentive payments, shared savings payments (upside), and shared risk payments (upside or downside).

Step 2: The Dental Plan shall calculate the dental provider's compensation if they were paid at the DPIIP fee schedule rate for included services that were provided to an eligible enrollee, including:

- For services that the dental provider was paid under a fee-for-service arrangement, reprice all FFS claims at the DPIIP fee schedule amount.
- For services that the dental provider was paid under a sub-capitated arrangement, reprice all encounter claims at the DPIIP fee schedule amount.

Step 3: The Dental Plan shall compare the results of Steps 1 and 2. The dental provider is deemed to be paid equal to or greater than the DPIIP rate if the sum of all payments under Step 1 is equal to or greater than the sum of all payments under Step 2.

- (2) Value Based Purchasing (VBP) Program

The Dental Plan shall develop and implement a value-based purchasing program to reduce costs associated with preventable care and improved dental outcomes. See **Section I.**, General Overview, **Sub-Section C.**, Prioritizing Quality and Value, **Item 2.**, Value-Based Purchasing (VBP) Programs for provisions related to the VBP program.

- (3) Improving Provider Recruitment and Retention

One (1) of the Dental Plan's three (3) Agency-approved statewide performance improvement projects (PIPs) shall be an administrative PIP focusing on improving provider recruitment, retention, and experience. For additional provisions relating to PIPs, see **Section VIII.**, Quality, **Sub-Section C.**, Performance Improvement Projects.

E. Prioritizing Florida's Vulnerable Citizens

The Agency strives to improve dental care for special populations, including Medicaid enrollees on the iBudget Waiver or Waitlist as identified by the Agency, pregnant enrollees, enrollees with chronic disease such as diabetes, cancer, or HIV, and enrollees who are

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ages sixty-five (65) years and older. Observing the Agency’s mission of “Better Health Care for All Floridians,” the Agency is implementing several enhancements for the 2025 – 2030 Contract term to improve the Statewide Medicaid Prepaid Dental Program and ensure seamless delivery for special populations of enrollees in need of more intensive dental care.

1. Expanded Benefits

a. Leveraging the power of the managed care delivery system, the Agency negotiated additional, innovative services to Medicaid enrollees on the iBudget Waiver or Waitlist as identified by the Agency, pregnant enrollees, enrollees with chronic disease such as diabetes, cancer, or HIV, and enrollees who are ages sixty-five (65) years and older. See **Section V.**, Service Administration, **Sub-Section C.**, Expanded Benefits.

2. Supplemental Assessment for Enrollees on the iBudget Waiver or Waitlist

In addition to the provisions of **Section V.**, Service Administration, **Sub-Section E.**, Coverage Provisions, the Dental Plan shall conduct a Supplemental Assessment for enrollees on the iBudget Waiver or Waitlist as identified by the Agency.

- a. The Dental Plan shall complete an Agency-provided Supplemental Assessment tool for each enrollee on the iBudget Waiver or Waitlist across multiple domains, including: current health conditions; historical providers; caregiver or other supports available; medications; behavioral health conditions; preferences for treatment; designated healthcare decision maker (if applicable); and the need for increased appointment time and support.
- b. The enrollee and their Waiver Support Coordinator or Waitlist Coordinator, as identified by the Agency, shall be included in the process of completing the Supplemental Assessment regardless of perceived ability of the enrollee.
- c. The Supplemental Assessment shall form part of the enrollee’s dental care plan. The Dental Plan shall assist the enrollee and their caregiver to locate a suitable dental provider.
- d. The Supplemental Assessment shall be shared with dental providers prior to acclimation visits. The Dental Plan shall coordinate initial phone calls between the Dental Plan, the dental provider, and the enrollees and their supports as appropriate, prior to acclimation visits to ensure the dental office can meet the enrollee’s specific needs.

3. Care Coordination/Case Management Contact Requirements for Special Populations

In addition to the provisions of **Section V.**, Service Administration, **Sub-Section F.**, Care Coordination/Case Management, the Dental Plan shall comply with the following provisions regarding care coordination/case management contact requirements for special populations.

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- a. The Dental Plan shall complete initial contact within thirty (30) days of the enrollee's transition into the Dental Plan with enrollees in a special population, including Medicaid enrollees on the iBudget Waiver or Waitlist as identified by the Agency, pregnant enrollees, enrollees with chronic diseases such as diabetes, cancer, or HIV, and enrollees who are ages sixty-five (65) years and older.
- b. The Dental Plan shall assign a care coordinator to an enrollee who is enrolled on the iBudget Waiver or Waitlist. The Dental Plan's care coordinator shall assume a lead role in identifying services that can meet the enrollee's need even when there are multiple agencies (e.g. the Agency for Persons with Disabilities (APD), Waiver Support Coordination, iBudget Waiver providers) involved in the enrollee's care.
- c. The Dental Plan shall contact special populations at least once per quarter to review, at a minimum, previous and upcoming dental treatment appointments, assist with locating a dental provider (as needed), and updating enrollee contact information, including current support systems and designated representatives.
- d. The Dental Plan shall report to the Agency on contacts made with enrollees in a special population, including Medicaid enrollees on the iBudget Waiver or Waitlist as identified by the Agency, pregnant enrollees, enrollees with chronic diseases such as diabetes, cancer, or HIV, and enrollees who are ages sixty-five (65) years and older, as specified in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*, and in the manner and format determined by the Agency.
- e. The Dental Plan shall document coordination and communication efforts in the Dental Plan enrollee records.

4. Enhanced Provider Network Requirements

In addition to the provisions in **Section VII.**, Provider Network and Services, **Sub-Section A.**, Network Adequacy Standards, **Item 2.**, Network Capacity and Geographic Access Standards, the Dental Plan shall be responsible for meeting enhanced network adequacy standards established by the Agency.

- a. The Dental Plan must assure the availability of enhanced access to the following dental providers and specialists:
 - (1) Rural access to general dentists and pediatric dentists within 65 minutes or 45 miles;
 - (2) Rural access to orthodontists and oral surgeons within 90 minutes or 75 miles;
 - (3) Urban access to endodontists, orthodontists, and oral surgeons within 60 minutes or 50 miles;
 - (4) Access to two (2) per county of ambulatory surgical centers; and
 - (5) Access to two (2) per county of hospital outpatient settings.

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- b. The Dental Plan must cover all medically necessary non-emergency dental services delivered in hospitals and ambulatory surgical centers, including medical services provided secondary to dental care (e.g., anesthesiology).
- c. The Dental Plan must cover medically necessary anesthesiology services when delivered in a dental office setting by a provider practicing within the scope of their license.
- d. The Dental Plan shall ensure that its provider network has availability of PDP General Dentist and Pediatric Dentist practices in each county with after hours availability on the weekend or extended hours for non-emergency dental services.
- e. Access to Specialty-Qualified Providers

The Dental Plan shall provide access on at least a referral basis to periodontist and prosthodontist providers in accordance with **Section VII.**, Provider Network and Services, **Sub-Section A.**, Network Adequacy Standards, **Item 1.**, General Provisions. The Dental Plan may assure access to specialists on at least a referral basis. The Dental Plan shall determine when exceptional referrals to non-participating specialty-qualified providers are needed to address any unique dental needs of an enrollee. The Dental Plan and provider shall agree to financial arrangements for the provision of such services prior to the provision of services. The Dental Plan shall develop and maintain policies and procedures for such referrals.

5. Sedation Dentistry

- a. In addition to the provisions of **Section VII.**, Provider Network and Services, **Sub-Section B.**, Network Management, **Item 2.**, Annual Network Development Plan, the Dental Plan shall assure various levels of sedation dentistry (moderate sedation, general anesthesia, or pediatric moderate sedation) are available to enrollees:

The Dental Plan's annual network development plan shall include a description or explanation of the current status of the network by each covered service at all levels, including Providers having a sedation permit (moderate sedation, general anesthesia, or pediatric moderate sedation).

- b. In addition to the provisions of **Section VII.**, Provider Network and Services, **Sub-Section A.**, Network Adequacy Standards, **Item 4.**, Specialists and Other Providers, the Dental Plan shall enter into sufficient provider agreements to ensure the availability of providers offering moderate sedation, general anesthesia, and pediatric moderate sedation, as medically necessary.

6. Community Partnerships

Community partnerships provide other services and supports for enrollees' health-related social needs. For purposes of this procurement, the Dental Plan shall focus on

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developing and maintaining community partnerships to enhance the array of dental services provided to enrollees in Special Populations, including Medicaid enrollees on the iBudget Waiver or Waitlist as identified by the Agency, pregnant enrollees, enrollees with chronic diseases such as diabetes, cancer, or HIV, and enrollees who are ages

sixty-five (65) years and older. In addition, the Dental Plan shall leverage community partnerships to contribute to the growth and maintenance of an increased dental provider workforce. The Dental Plan shall partner with community-based organizations (CBOs) to enhance the availability of dental student loans and scholarships, as well as other innovative approaches toward increasing dental provider recruitment and retention. In addition to the following provisions, see **Section V.**, Service Administration, **Sub-Section G.**, Community Partnerships to Improve Outcomes (CPIO).

- a. The Dental Plan shall engage in community partnerships with private, public, or non-profit community-based organizations (partner CBOs) that provide specialized oral health-related services aimed at improving access to preventive dental care, increase the Dental Plan's provider network, and ensure that special populations in their community and provider network receive adequate care.
- b. The Dental Plan shall partner with CBOs that provide distinct supports and services in the promotion of oral health within their communities. The Dental Plan shall partner with at least one CBO that provides services or supports to enrollees within each Medicaid region in which the Dental Plan operates.
- c. Each partner CBO must have principal address in and operate in Florida. Each CBO must also meet at least two (2) of the following criteria:
 - (1) Provides services or supports to improve access to dental services, improve utilization of preventive care, improve provider participation in Medicaid, improve dental care for special populations, including Medicaid enrollees on the iBudget Waiver or Waitlist as identified by the Agency, pregnant enrollees, enrollees with chronic diseases such as diabetes, cancer, or HIV, and enrollees who are ages sixty-five (65) years and older, and promote oral health education and literacy.
 - (2) Provides support for general dentistry students and dental hygiene student training, certification, and education.
 - (3) Uses a closed-loop software system to receive enrollee referrals from providers and verify with the Dental Plan that services or supports are provided to enrollees.
- d. Prior to the execution of the Contract, the Dental Plan shall disclose to the Agency:
 - (1) All partnerships previously established with current partner CBOs.
 - (2) All financial investments provided to each partner CBO.

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- (3) All in-kind support provided to each partner CBO.
- (4) The identification, role(s), and responsibilities of each partner CBO representative who serves on a committee or advisory board for the Dental Plan.

7. Quality Measures

Two (2) of the Dental Plan's three (3) Agency-approved statewide performance improvement projects (PIPs) shall focus on quality measure targeted to Florida's vulnerable populations.

- a. One (1) of the PIPs shall focus on increasing the rate of enrollees with oral evaluations, including children and adults.
- b. One (1) of the PIPs shall focus on reducing potentially preventable dental-related emergency department (ED) visits for dental caries in children and for non-traumatic dental conditions in adults in collaboration with the Managed Medical Assistance (MMA) plans.

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Section II. Eligibility and Enrollment

Section II. Eligibility and Enrollment

A. General Provisions

1. The State has sole authority for determining eligibility for Medicaid. The Department of Children and Families (DCF) acts as the Agency's agent by enrolling recipients in the Medicaid program.
2. The Agency shall have the sole authority for determining whether Medicaid recipients are required to enroll in or may not enroll in a Dental Plan or are subject to annual open enrollment. The Agency or its enrollment broker shall be responsible for enrollment, including enrollment into the Dental Plan, disenrollment, and outreach and education activities. The Agency shall use an established algorithm to assign mandatory potential enrollees who do not select a Dental Plan during their choice period.
3. The Dental Plan shall accept Medicaid recipients without restriction in accordance with 42 CFR 438.3(d)(1) and s. 1903(m)(2)(A) of the Social Security Act. The Dental Plan shall not discriminate on the basis of religion, sex, race, color, age or national origin, health status, pre-existing condition or need for health care services and shall not use any policy or practice that has the effect of such discrimination in accordance with 42 CFR 438.3(d)(4) and 438.3(q)(4).
4. The Dental Plan shall coordinate with the Agency and its agent(s) as necessary for all enrollment and disenrollment functions.
5. The Dental Plan or its subcontractors, providers, or vendors shall not provide or assist in the completion of enrollment or disenrollment requests or restrict the enrollee's right to disenroll voluntarily in any way. (42 CFR 438.56(b)(1), (2), and (3)).

B. Eligibility

In accordance with s. 409.973(5)(b), Florida Statutes (F.S.), all Medicaid recipients shall receive Medicaid covered dental services through the Dental Plan, unless otherwise exempted in this **Sub-Section**. The Agency shall determine eligibility for enrollment under this Contract. The Agency shall provide the Dental Plan with a list of recipient aid categories that are eligible to enroll in the Statewide Medicaid Prepaid Dental Program.

1. Excluded Populations

The following categories describe Medicaid recipients who are residing in one of the following institutional settings and who are not eligible to enroll in the Statewide Medicaid Prepaid Dental Program:

- a. A State Mental Health Hospital (if under the age of 65 years), or
- b. A residential treatment facility;
- c. Individuals eligible for emergency services only due to immigration status (aliens);
- d. Presumptively eligible pregnant women;

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- e. Program for All-Inclusive Care for the Elderly (PACE);
- f. Individuals eligible through the family planning waiver; and
- g. Partial Dual Eligibles.

C. Enrollment

1. General Provisions

- a. The Dental Plan shall coordinate with the Agency and its agent(s) for all enrollment functions.
- b. The Dental Plan shall provide services to Medicaid recipients who meet eligibility requirements and reside in the State of Florida.
- c. The Agency or its agents shall notify the Dental Plan of an enrollee's selection or assignment to the Dental Plan by file transfer or other Agency prescribed method. Enrollment in the Dental Plan shall be effective at 12:01 a.m. on the effective date of enrollment provided on the Enrollment File.
- d. The Agency shall enroll newborns in the Dental Plan of the mother, unless the mother chooses another Dental Plan. The Dental Plan shall be responsible for newborns of pregnant enrollees from the date of their birth.

2. Verification of Enrollment

- a. The Dental Plan shall review its X12-834 enrollment files to ensure that all enrollees are eligible to receive services from the Dental Plan.
- b. The Dental Plan shall notify the Agency within seven (7) business days of receipt of the enrollment file of any discrepancies in enrollment, including enrollees not residing in the same region in which they were enrolled and enrollees not eligible for the Dental Plan. (42 CFR 438.608(a)(3))

3. Temporarily Stopping, Limiting, or Adjusting Enrollment

- a. The Dental Plan shall ask the Agency to halt or reduce enrollment temporarily if continued enrollment would exceed the Dental Plan's capacity to provide required services under this Contract.
- b. The Agency shall limit Dental Plan enrollments when such an action is considered to be in the Agency or enrollees' best interest in accordance with the provisions of this Contract.
- c. The Agency may adjust enrollment through enhanced auto-assignments to high-performing Dental Plans, as a performance incentive, as described in **Attachment II, Section VIII.**, Quality.

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D. Disenrollment

1. General Provisions

- a. The Dental Plan shall ensure that it does not restrict the enrollee's right to disenroll voluntarily in any way.
- b. The Dental Plan or its subcontractors, providers, or vendors shall not provide or assist in the completion of a disenrollment request, except as specified by the Agency. (42 CFR 438.56(b)(1))
- c. The Agency shall notify enrollees of their right to request disenrollment. The Agency shall process all disenrollments from the Dental Plan. The Agency or its agent shall make final determinations about granting disenrollment requests and shall notify the Dental Plan by file transfer and the enrollee by surface mail of any disenrollment decision and the enrollee's right to request a Medicaid Fair Hearing if he or she is dissatisfied with an Agency determination.
- d. The Agency shall make disenrollment requests effective no later than the first day of the second month following the month in which the enrollee requests disenrollment or the Dental Plan refers the request for involuntary disenrollment to the Agency.

If the Agency fails to make a disenrollment determination within the specified timeframes, the disenrollment shall be considered approved for the same effective date that would have been established had the Agency made a determination in the specified timeframe. (42 CFR 438.56(e)(1) - (2); 42 CFR 438.56(d)(3)(ii); 42 CFR 438.3(q); 42 CFR 438.56(c))

2. Voluntary Disenrollment

In addition to the reasons cited in Rule 59G-8.600, F.A.C., the following reasons constitute cause for disenrollment from the Dental Plan:

- a. The enrollee is an American Indian or Alaskan Native as defined in 42 CFR 438.14(a).
- b. The Agency has posed intermediate sanctions on the Dental Plan (42 CFR 438.3(q)(5); 42 CFR 438.56(c)(2)(iv)).

3. Involuntary Disenrollment

- a. With proper written documentation, the Dental Plan shall submit involuntary disenrollment requests to the Agency or its enrollment broker in a manner prescribed by the Agency and in accordance with 42 CFR 438.56(b)(1)-(3).
- b. The following are acceptable reasons for which the Dental Plan shall submit an involuntary disenrollment request:

- (1) Fraudulent use of the enrollee identification (ID) card; or

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Section II. Eligibility and Enrollment

- (2) Falsification of prescriptions by an enrollee.
- c. The Dental Plan shall not request disenrollment of an enrollee due to:
 - (1) Health diagnosis.
 - (2) Adverse changes in an enrollee's health status.
 - (3) Utilization of medical services.
 - (4) Diminished mental capacity.
 - (5) Pre-existing medical condition.
 - (6) Attempt to exercise rights under the Dental Plan's grievance and appeal system.
 - (7) Referral by a provider of an enrollee to a non-participating provider.
 - (8) The enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Dental Plan's ability to furnish services to the enrollee or other enrollees).

(42 CFR 438.3(q)(5); 42 CFR 438.56(c)(1); 42 CFR 438.56(c)(2)(i) - (iii))
- d. The Dental Plan shall ensure that involuntary disenrollment documents are maintained in the Dental Plan enrollee record.
- e. When the Dental Plan submits a request to the Agency for an involuntary disenrollment of an enrollee, the Dental Plan shall notify the enrollee in writing of the request for disenrollment, the reason for the request, and an explanation that the Dental Plan is requesting that the enrollee be disenrolled in the next Contract month, or earlier if necessary, pending an Agency decision. Until the enrollee is disenrolled, the Dental Plan shall be responsible for the provision of services to that enrollee.
- f. The Agency shall review all disenrollment requests on a case-by-case basis, and it is at the sole discretion of the Agency to approve or deny such requests. Any request not approved is final and not subject to Dental Plan dispute or appeal. The Dental Plan shall notify the enrollee in writing of the decision.

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Section III. Marketing

Section III. Marketing

A. General Provisions

1. The Dental Plan shall ensure compliance with all State and federal marketing requirements and SMMC Marketing Guidelines, including monitoring and overseeing the activities of its subcontractors and all persons acting for, or on behalf of, the Dental Plan. (42 CFR 438.104; ss. 409.912, 641.3901, 641.3903, 641.386, 626.112, 626.342, 626.451, 626.471, 626.511, 626.611, 626.9541, and 626.9521, F.S.)
2. The Dental Plan shall not market nor distribute any marketing materials without first obtaining Agency approval. (42 CFR 438.104(b)(1)(i))
3. The Dental Plan shall ensure that marketing, including marketing plans and materials, is accurate and does not mislead, confuse, or defraud recipients or the Agency. (42 CFR 438.104(b)(2)) The Dental Plan shall not distribute marketing materials that are materially inaccurate, misleading, or otherwise make material misrepresentations.
4. The Dental Plan may participate in social networking (e.g., Facebook, X (formerly Twitter), Scan Code, YouTube, LinkedIn, Instagram, or QR Code) in accordance with the requirements of this Contract and federal and State law. Websites and social/electronic media posts that contain marketing content must be submitted to the Agency for review and approval.
5. The Dental Plan shall not engage in unfair methods of competition, or unfair or deceptive acts or practices as defined in s. 641.3903, F.S., and s. 626.9541, F.S.
6. In compliance with s. 409.912, F.S., marketing to enrollees or potential enrollees in State offices or any location where eligibility is determined is prohibited. The Dental Plan shall not use any other State office or any location where eligibility is determined in the retention of enrollees or recruitment of potential enrollees, including DCF community partner sites.
7. Dental Plans must provide an opt-out process for enrollees and potential enrollees who previously voluntarily agreed to receive mail or other electronic communications to longer receive such communications.

B. Prohibited Statements and Claims

1. The Dental Plan shall not, whether orally or in writing:
 - a. Claim that a Medicaid recipient must enroll in the Dental Plan in order to obtain or to not lose Medicaid benefits or any other health or welfare benefits. (42 CFR 438.104(b)(2)(i))
 - b. Claim that the Dental Plan is recommended or endorsed by CMS, the federal or State government, or similar entity. (42 CFR 438.104(b)(2)(ii))
 - c. Claim that the State or the county recommends that a Medicaid recipient enroll with the Dental Plan.

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- d. Claim that marketing agents are employees of the federal, State, or county government, or of anyone other than the Dental Plan or the organization by whom they are reimbursed.
2. The Dental Plan may not compare itself to another Dental Plan, verbally or in writing, unless the Dental Plan can support the comparison and such comparisons are factually based and not misleading.

C. Prohibited Activities

1. The Dental Plan shall not enlist the assistance of any government employee, government officer, elected official, or the State's enrollment broker in recruitment of potential enrollees or the retention of enrollees.
2. The Dental Plan shall not provide any gift, commission, or any form of compensation to the enrollment broker, including its full-time, part-time, or temporary employees and subcontractors.
3. The Dental Plan shall not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities or market through unsolicited contacts. (42 CFR 438.104(b)(1)(v))
4. If the Dental Plan receives permission to call or otherwise contact an enrollee or potential enrollee, the Dental Plan shall treat the permission as event-specific and shall not interpret the permission as an open-ended permission to contact the enrollee or potential enrollee after the Dental Plan has answered the enrollee or potential enrollee's inquiry or questions.
5. The Dental Plan shall not rent or purchase email lists to distribute information about its Medicaid Dental Plan to enrollees or potential enrollees.
6. The marketing agent shall not make unsolicited offers of business cards to attendees of marketing events.
7. The Dental Plan shall not treat social media interactions (e.g., like, comment, follow a Dental Plan, or participation in a virtual event) on social/electronic media as an agreement to receive Dental Plan communications outside the social media forum, unless there is a request for follow-up from the Dental Plan. The Dental Plan shall not address subjects beyond the question or statement initiated by the individual.
8. The Dental Plan marketing agents shall not visit a resident of a long-term care facility (e.g., nursing homes, assisted living facilities, board and care homes), or an individual receiving services from any other facility or organization that provides residential services, temporary supervision, and/or health care assistance unless requested by the individual or individual's guardian.

D. Marketing of Multiple Lines of Business

1. The Dental Plan shall not influence enrollment in conjunction with the sale or offering of any private insurance. (42 CFR 438.104(b)(1)(iv))

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2. The Dental Plan shall ensure that marketing materials requested by enrollees or potential enrollees describing other health-related lines of business contain instructions that describe how enrollees and potential enrollees may opt out of receiving such communications. The Dental Plan shall not send such communications to enrollees or potential enrollees who have asked to opt out of receiving future marketing communications about other lines of business.
3. If the Dental Plan advertises multiple lines of business within the same marketing material or at the same event, it shall keep the Dental Plan's other lines of business clearly and understandably distinct from the Medicaid Dental Plan.
4. The Dental Plan shall not include enrollment applications for other health-related lines of business in Medicaid Dental Plan marketing materials.

E. Marketing Agents

1. The Dental Plan shall only use licensed and appointed insurance agents to conduct face-to-face and telephonic marketing in the State of Florida, to market to enrollees and potential enrollees. The Dental Plan shall ensure all such marketing agents or representatives comply with s. 626.112, F.S.
2. The Dental Plan shall report new marketing agents to the Agency, as specified in **Section XV.**, *Accountability*, and the *Managed Care Plan Report Guide*, and in the manner and format determined by the Agency.
3. The Dental Plan shall ensure that all marketing agents (including employed agents) are trained annually on State and federal requirements and on details specific to the Dental Plan. The Dental Plan shall ensure that its training programs are made available to the Agency upon request.
4. The Dental Plan shall report to the Agency any marketing agent who violates any requirements of this Contract, within fifteen (15) days of knowledge of such violation. The Dental Plan shall submit reports to the Agency as specified in **Section XV.**, *Accountability*, and the *Managed Care Plan Report Guide*, and in the manner and format determined by the Agency.
5. The Dental Plan shall report the termination of any marketing agents to the Agency, as specified in **Section XV.**, *Accountability*, and the *Managed Care Plan Report Guide*, and in the manner and format determined by the Agency.
6. The Dental Plan shall ensure that all marketing agents at marketing events display a Dental Plan nametag that includes the Dental Plan's name, logo, and agent's name at marketing events. The Dental Plan shall have business cards available to attendees of events.

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F. Telephonic Activities and Scripts

1. The Dental Plan may:
 - a. Call enrollees or potential enrollees who have expressly given permission for the Dental Plan to contact them.
 - b. Return phone calls or messages from enrollees or potential enrollees, as these are not unsolicited.
2. The Dental Plan shall:
 - a. Transfer calls to a marketing agent only at the proactive request of the enrollee or potential enrollee.
 - b. Clearly inform the enrollee or potential enrollee of any change in the nature of a call from informational to marketing. This shall be done with the full and active concurrence of the enrollee or potential enrollee with a yes/no question.
3. The Dental Plan shall not:
 - a. Include information about other lines of business in scripts.
 - b. Conduct unsolicited calls about other business as a means of generating leads for the Dental Plan.
 - c. Conduct calls based on referrals. If an enrollee would like to refer a friend or relative to the Dental Plan, the Dental Plan shall provide contact information such as a business card that the enrollee shall give to the friend or family member. In all cases, a referred individual needs to contact the Dental Plan directly.
 - d. Conduct calls to former enrollees or to enrollees who are in the process of voluntarily disenrolling, for the purpose of marketing the Dental Plan or other products.
 - e. Conduct calls to enrollees or potential enrollees to confirm receipt of marketing material.
 - f. Using language in scripts that implies the Dental Plan is endorsed by the Agency, calling on behalf of the Agency, or that the Agency asked the Dental Plan to call the recipient.
4. Any marketing script must be prior approved by the Agency. The Dental Plan shall submit all marketing scripts verbatim (bullets or talking points are unacceptable).

G. Standards for Marketing Materials

The Dental Plan shall submit Medicaid marketing material or changes in marketing materials to the Agency for review and approval prior to use.

1. The following components constitute marketing material:
 - a. Enrollment information;

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- b. Benefit information;
 - c. Plan-specific information (beyond allowable plan name, logo, tagline, phone number, or website);
 - d. Verbiage intended to draw a potential enrollee’s attention or retain an enrollee in the Dental Plan;
 - e. Calls to action; and
 - f. Testimonials and endorsements.
2. The following types of marketing materials are subject to review by the Agency:
- a. Branding materials;
 - b. Scripts, including marketing scripts (presentations), telephonic scripts, and broadcast scripts (television, radio, and social media); and
 - c. Written materials.
3. The Dental Plan shall submit marketing material to the Agency by the fifth (5th) of each month before the proposed use of the marketing material or revised material, or as prescribed by the Agency.
4. The Dental Plan shall submit all materials in publication-ready form, including a sample of each version if the Dental Plan intends to use several versions. Each material must be submitted separately to the Agency for review.
5. The Dental Plan shall conduct a quality check and ensure that all materials are consistent with this Contract and State and federal requirements prior to submitting materials for review to the Agency. The Agency shall not review materials for typographical or grammatical errors unless such errors render the material inaccurate or misleading.
6. The Dental Plan shall ensure that all marketing materials comply with the standards for written materials specified in **Section IV.**, Enrollee Services, **Sub-Section A.**, General Provisions. The Dental Plan shall submit readability scores with its marketing material and denote any redacted wording and ensure that all materials submitted for approval are at or near the fourth (4th) grade comprehension level. The Dental Plan shall exclude the following from the readability score: addresses, phone numbers, PDP, department names, required disclaimers, medical terminology, medical conditions, proper names, legal terms, and words that cannot be easily substituted.
7. The Dental Plan shall include the following statements and disclaimers verbatim in any marketing materials that include information on benefits:
- a. “[insert Dental Plan’s legal or marketing name] is a Dental Plan with a Florida Medicaid Contract.”

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- b. “The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the Dental Plan.”
 - c. “[Limitations, copayments, and/or restrictions] may apply.”
 - d. “[Benefits, formulary, pharmacy network, premium and/or co-payments/co- insurance] shall change.”
- 8.** The Dental Plan shall include a written statement on all marketing materials promoting drawings, prizes, or any promise of a free gift that there is no obligation to enroll in the Dental Plan. For example, “Eligible for a free drawing and prizes with no obligation.” Or “Free drawing without obligation.”
- 9.** The Dental Plan shall ensure that advertisements and invitations to marketing and enrollee educational events include the following two statements on marketing materials:
- a. “A Dental Plan representative will be present with information.”
 - b. “For accommodation of persons with special needs at marketing or enrollee educational events call <insert phone and TTY number>.”
- 10.** The Dental Plan shall include a Teletypewriter Telephone (TTY) number in conjunction with the Dental Plan’s toll-free customer service number. This requirement does not apply to outdoor advertising, banner/banner-like ads, radio ads, or marketing and telephonic scripts.
- 11.** The Dental Plan shall include the Enrollment Broker number and TTY/TDD number in any marketing materials that contain enrollment information.
- 12.** The Dental Plan shall ensure all written marketing materials comply with non-discrimination requirements specified in **Section IX.**, Administration and Management, **Sub-Section B.**, Organizational Governance and Staffing, **Item 6.**, Non-discrimination Compliance Requirements. The Dental Plan shall include a statement on all marketing materials regarding their non-discrimination policies in accordance with the Nondiscrimination Final Rule, Section 1557 of the Affordable Care Act.
- 13.** The Dental Plan shall make all written marketing materials available in multiple languages, as prescribed by the Agency. Upon request, the Dental Plan shall notify enrollees or potential enrollees that information is available in alternative formats and how to access those formats. (42 CFR 438.10(d)(3))

H. Use of Superlatives in Marketing Materials

- 1. The Dental Plan may use statements in its logos and in its product taglines (e.g., “Your health is our major concern,” “Quality care is our pledge to you,”). The Dental Plan shall not use superlatives in logos/product taglines (e.g., “XYZ plan means the first in quality care” or “XYZ plan means the best in managed care”).

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2. The Dental Plan shall not use absolute superlatives (e.g., “the best,” “highest ranked,” “rated number 1”), unless they are substantiated with supporting data provided to the Agency as a part of the marketing review process.
3. The Dental Plan may use designations and rankings related to high performance on performance measures given by and as approved by the Agency.

I. Nominal Gifts

1. The Dental Plan may distribute nominal gifts as long as the gifts are provided regardless of enrollment. The Dental Plan shall obtain Agency approval before distributing any nominal gifts.
2. The Dental Plan shall adhere to the following requirements for nominal gift submissions.
 - a. Ensure nominal gifts do not include more than the Dental Plan name, logo, product tagline, telephone contact number and/or website.
 - b. Include a cost verification sheet for each nominal gift submitted.
 - c. Submit all nominal gifts and indicate all Dental Plan information that will be included on the nominal gift.
3. The Dental Plan shall ensure the following for nominal gifts offered by the Dental Plan:
 - a. If a nominal gift is one large gift that is available for all in attendance, the total retail cost must be fifteen dollars (**\$15**) or less per person when it is divided by the estimated attendance. For planning purposes, anticipated attendance shall be used, but must be based on venue size, response rate, or advertisement circulation.
 - b. Nominal gifts shall not be in the form of cash, gift card/certificates, vouchers, or other monetary rebates.
4. The Dental Plan shall ensure that any nominal gifts provided by the Dental Plan:
 - a. Are offered to individual regardless of enrollment and without discrimination;
 - b. Are not items that are considered a health or dental benefit (i.e. a free checkup);
 - c. Do not consist of lowering or waiving co-payment;
 - d. Are not used or included with the enrollee handbook;
 - e. Do not inappropriately influence the enrollee’s selection of a provider, practitioner, or supplier of any item or service;
 - f. Are not tied directly or indirectly to the provision of any other covered item service.

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5. The Dental Plan shall track nominal gifts given to enrollees. The Dental Plan is not required to track nominal gifts distributed during pre-enrollment marketing activities on a per person basis; however, the Dental Plan shall not structure pre-enrollment activities with the intent to give potential enrollees or enrollees gifts in excess of a maximum value of seventy-five dollars (**\$75**) per person, per State fiscal year (SFY).
6. The Dental Plan shall not provide meals (or have meals subsidized) at marketing events.

J. Regional Distribution of Marketing Materials

1. If the Dental Plan markets, it shall distribute marketing materials to the entire region served by the Dental Plan. (42 CFR 438.104(b)(1)(ii))
2. The Dental Plan shall not advertise outside of its contracted region(s) unless such advertising is unavoidable. For situations in which this cannot be avoided (e.g., advertising in print or broadcast media with a statewide audience or with an audience that includes some individuals outside of the region), the Dental Plan shall clearly disclose all counties in the applicable region(s) in which the Dental Plan is contracted.
3. If the Dental Plan is a joint enterprise, it shall market the Dental Plan under a single name throughout the region.

K. References to Studies

1. The Dental Plan shall only compare itself to another Dental Plan by referencing an independent study. If the Dental Plan references a study in any marketing material, it must provide all of the following information, either in the text or as a footnote, on the marketing material:
 - a. Reference information (e.g., publication, date, page number);
 - b. Information about the Dental Plan's relationship with the entity that conducted the study including funding source;
 - c. The study sample size and number of Dental Plans surveyed (unless the study that is referenced is a CMS or Agency study);
 - d. The name of the organization sponsoring the study; and
 - e. Statement that the study/survey or statistical data is not endorsed by the Agency.
2. The Dental Plan shall not compare itself to another Dental Plan by name unless it has written permission from all Dental Plans being compared and include this documentation with the Dental Plan's marketing submission.
3. The Dental Plan shall only use Plan-specific quality indicators which compare the Dental Plan's previous performance to the Dental Plan's current performance in marketing materials and must include the substantiating data with the Dental Plan's marketing submission.

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L. Product Endorsements/Testimonials

1. The Dental Plan shall ensure that all product endorsements and testimonials adhere to the following:
 - a. The speaker must identify the Dental Plan by name; and
 - b. If an individual is paid to portray a real or fictitious situation, the ad must clearly state it is a “Paid endorsement.”
2. An enrollee may offer endorsement of the Dental Plan, provided the enrollee is a current enrollee and voluntarily chooses to endorse the Dental Plan.
3. Any endorsement or testimonial by an individual shall not use any quotes by dentists or other dental providers.
4. The endorsement or testimonial shall not use negative testimonials about other Dental Plans.
5. The Dental Plan shall not pay or compensate enrollees or potential enrollees in any way to endorse or promote the Dental Plan.
6. Re-publication of an individual user’s content or comment(s) that promote a Dental Plan from social/electronic media sites is considered a product endorsement/testimonial and must adhere to the requirements of this Section.
7. Materials containing testimonials and/or endorsements are subject to Agency approval prior to distribution or reproduction on social/electronic media sites. These materials must meet all applicable requirements of **Section III.**, Marketing.

M. Marketing Events

1. The Dental Plan shall obtain Agency approval prior to conducting any marketing events.
2. At a marketing event, the Dental Plan shall not:
 - a. Conduct health or dental screenings or other like activities that could give the impression of “biased selection.”
 - b. Require enrollees or potential enrollees to provide any contact information as a prerequisite for attending the event. The Dental Plan shall clearly indicate on any sign-in sheets that completion of any contact information is optional.
3. The Dental Plan may use personal contact information to notify enrollees or potential enrollees of raffle or drawing winnings.
4. The Dental Plan shall notify the Agency of any change of plan attendance in advance of the scheduled event, including event cancellation and instances where the event is not

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cancelled but the Dental Plan has decided not to attend. The Dental Plan shall report any changes to an event via a variable report, as specified in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*.

5. If a marketing event is cancelled or the Dental Plan has decided not to attend less than forty-eight (48) hours before its originally scheduled date and time, the Dental Plan shall:
 - a. Ensure a Dental Plan licensed and appointed marketing agent is present at the site of the event, at the time that the event was scheduled to occur, to inform enrollees and potential enrollees of the cancellation or decision not to attend and distribute information about the Dental Plan.
 - b. Ensure a Dental Plan licensed and appointed marketing agent remains onsite at least fifteen (15) minutes after the scheduled start of the event. If the event was cancelled due to inclement weather, a Dental Plan marketing agent is not required to be present at the site.
6. If a marketing event is cancelled or the Dental Plan decides not to attend more than forty-eight (48) hours before the originally scheduled date and time, the Dental Plan shall notify enrollees and potential enrollees of the cancellation or decision by the Dental Plan not to attend through the same means the Dental Plan used to advertise the event. A Dental Plan licensed and appointed marketing agent is not required to be present at the site.
7. All marketing events shall be reported to the Agency, as specified in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*.

N. Individual Marketing Appointments

1. All individual marketing appointments with enrollees or potential enrollees are considered marketing events.
2. The Dental Plan shall only discuss those products that have been agreed upon by the enrollee or potential enrollee for that appointment (“scope of appointment”). If other products need to be discussed at the request of the potential enrollee, the Dental Plan shall document a second scope of appointment for the new product type and then the marketing appointment shall be continued.
3. Each scope of appointment for an individual marketing event must be documented either in writing, in the form of a signed, dated agreement by the enrollee or potential enrollee, or a recorded oral agreement. The Dental Plan is allowed and encouraged to use a variety of technological means to fulfill the requirement to document each scope of appointment requirement, including conference calls, fax machines, designated recording line, prepaid envelopes, and email, etc.
4. An enrollee or potential enrollee may set a scope of appointment at a marketing event for a future individual marketing appointment.

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5. The Dental Plan shall submit all business reply cards for documenting enrollee or potential enrollee scope of appointment or agreement to be contacted to the Agency. The Dental Plan shall include a statement on the business reply card informing the enrollee potential enrollee that a marketing agent shall call as a result of the enrollee or potential enrollee returning a business reply card.
6. If the Dental Plan has a pre-scheduled appointment that becomes a “no-show,” the Dental Plan may leave information at the no-show enrollee or potential enrollee’s residence.
7. The Dental Plan shall not:
 - a. Market non-health care related products (such as annuities or life insurance).
 - b. Ask an enrollee or potential enrollee for referrals.
8. The Dental Plan shall report all individual marketing appointments to the Agency, as specified in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*.

O. Marketing in the Health Care Setting

1. The Dental Plan shall not conduct marketing activities in health care settings, except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing facility cafeterias, community or recreational rooms, and conference rooms. If a pharmacy counter area is located within a retail store, common areas may include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.
2. The Dental Plan shall not conduct marketing in areas where patients primarily intend to receive dental services or health care services or are waiting to receive dental health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas (where patients interact with their clinical team and receive treatment), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications). The prohibition against conducting marketing activities in health care settings extends to activities planned in health care settings outside of normal business hours.

P. Provider-Based Activities

1. If the Dental Plan chooses to utilize its provider network to distribute marketing materials, the Dental Plan shall ensure through its provider agreements that providers shall remain neutral.
2. The Dental Plan may permit providers to make available and/or distribute Dental Plan marketing materials as long as the provider does so for all Dental Plans with which the provider participates.
3. The Dental Plan may permit providers to display posters or other materials in common areas, such as the provider’s waiting room.

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4. The Dental Plan shall not permit providers to:
- a. Offer marketing/appointment forms.
 - b. Make phone calls or direct, urge, or attempt to persuade potential enrollees to enroll or enrollees to remain enrolled in the Dental Plan based on financial or any other interests of the provider.
 - c. Mail marketing materials on behalf of the Dental Plan.
 - d. Offer anything of value to retain enrollees or persuade potential enrollees to select them as their provider or to enroll in a particular Dental Plan.
 - e. Accept compensation directly or indirectly from the Dental Plan for marketing activities.

5. Provider Affiliation Information

- a. Providers may announce new or continuing affiliations with the Dental Plan through general advertising (e.g., radio, television, websites).
 - b. Providers may make new affiliation announcements within the first thirty (30) days of the new provider agreement.
 - c. Providers may make one (1) announcement to patients of a new affiliation that names only the Dental Plan when such announcement is conveyed through direct mail, email, or phone.
 - d. Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all Dental Plans with which the provider has agreements.
6. Materials that indicate the provider has an affiliation with certain Dental Plans and that only list Dental Plan names, logos, product taglines, telephone contact numbers, and/or websites do not require Agency approval.

Q. Public Events

- 1. The Dental Plan may conduct, participate in, or sponsor public events. Such events must be held in a public venue. At such events, the Dental Plan may distribute public event materials. Public event materials do not require Agency review or approval.
- 2. The Dental Plan may conduct the following permissible activities at public events:
 - a. Distribute approved public event material with the Dental Plan name, logo, product tagline, telephone contact number and/or website;
 - b. Distribute approved nominal gifts at public events, as described in **Section III.**,

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Marketing, **Sub-Section I.**, Nominal Gifts;

- c. Provide free screenings without any association with the Dental Plan name, logo, product tagline, telephone contact number, and/or website in any notices, signage, advertisements, or displays advertising such; and
- d. Display banners, posters, or other displays with the Dental Plan name, logo, product tagline, telephone contact number, and/or website.

The Dental Plan must comply with costs and limitations associated with nominal gifts in **Section III.**, Marketing, **Sub-Section I.**, Nominal Gifts.

- 3. The Dental Plan shall not do the following with regard to public events:
 - a. Hold a public event at the home of an individual;
 - b. Conduct one-on-one appointments;
 - c. Conduct marketing, including the distribution of marketing material;
 - d. Discuss Dental Plan-specific benefits; and
 - e. Distribute Dental Plan-specific materials.
- 4. The Dental Plan shall report participation in public events to the Agency, as specified in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*.

R. Enrollee Educational Events

- 1. Enrollee educational events may be hosted by the Dental Plan or an outside entity and must be held in a public venue. The Dental Plan shall ensure that events are not held at the home of an individual or as a one-on-one appointment. The Dental Plan shall not allow potential enrollees to participate in an educational event.
- 2. The Dental Plan may conduct the following permissible activities at enrollee educational events:
 - a. Distribute public event material with the Dental Plan name, logo, product tagline, telephone contact number, and/or website;
 - b. Distribute approved nominal gifts at educational events, as described in **Section III.**, Marketing, **Sub-Section I.**, Nominal Gifts of this Contract;
 - c. Provide free screenings without any association with the Dental Plan name, logo, product tagline, telephone contact number, and/or website in any notices, signage, advertisements, or displays advertising such;
 - d. Display banners, posters or other displays with the Dental Plan name, logo, product tagline, telephone contact number, and/or website;

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- e. Distribute or display business cards, scope of appointment forms and sign-up sheets;
 - f. Set up individual marketing appointments; and
 - g. Provide meals at enrollee educational events. Dental Plans must comply with cost and limitations associated with nominal gifts in **Section III.**, Marketing, **Sub-Section I.**, Nominal Gifts.
- 3.** The Dental Plan shall submit enrollee material for educational events to the Agency for review and approval prior to use. All enrollee educational events shall be reported to the Agency, as specified in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*.
- 4.** The Dental Plan shall not do the following with regard to enrollee educational events:
- a. Conduct marketing activities;
 - b. Distribute marketing materials;
 - c. Advertise event to anyone other than enrollees; nor
 - d. Conduct a marketing event immediately following an enrollee educational event in the same general location.

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Section IV. Enrollee Services

Section IV. Enrollee Services

A. General Provisions

1. The Dental Plan shall establish and maintain an enrollee services function with the capability to answer enrollee inquiries and ensure that enrollees are notified of their rights and responsibilities, as described in 42 CFR 438.100, and incorporated in the model enrollee handbook.
2. The Dental Plan shall have the capability to answer enrollee inquiries through written materials, telephone, electronic transmission, and face-to-face communication.
3. The Dental Plan shall provide written notice of changes affecting enrollees to those enrollees at least thirty (30) days before the effective date of change, unless otherwise specified in this Contract.
4. The Dental Plan shall develop and maintain processes, compliant with applicable federal and State laws (including but not limited to 42 CFR Part 435, and Chapters 709, 744, and 765 of the F.S.), which shall ensure that the Dental Plan possesses accurate and current information indicating who has legal authority to make health care decisions on behalf of an enrollee.
5. The Dental Plan shall send notices to the enrollee's guardian or legally authorized representative as applicable.
6. In accordance with Title VI of the Civil Rights Act of 1964, the Dental Plan shall provide language assistance services, including the provision of foreign language interpreter and translation services, and auxiliary aids and services to enrollees to achieve effective communication. (42 CFR 438.10(d)(3))

B. Enrollee Material

1. General Provisions

The Dental Plan shall submit enrollee material or changes in enrollee material related to this Contract to the Agency for review and approval prior to use.

- a. The Dental Plan shall submit enrollee material to the Agency at least seventy-five (75) days before the proposed use of the enrollee material or revised material.
- b. The Dental Plan shall conduct a quality check and ensure that all materials are consistent with this Contract and State and federal requirements prior to submitting materials for review to the Agency. Generally, the Agency shall not review materials for typographical or grammatical errors, unless such errors render the material inaccurate or misleading.

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2. Requirements for Written Material

- a. The Dental Plan shall provide enrollee information in accordance with 42 CFR 438.10(c)(1), 42 CFR 438.10(c)(7), 42 CFR 438.10(d)(6)(ii)-(iv), 42 CFR 438.10(f)(3), and 42 CFR 438.3(i), which addresses information requirements related to written and oral information provided to enrollees.
- b. The Dental Plan shall provide all enrollee communications, including written materials, spoken scripts, and websites in an easily understood language and format. Enrollee communications shall be at or near the fourth (4th) grade comprehension level. (42 CFR 438.10(d)(6)(i)) Readability tests to determine whether the written materials meet this requirement are:
 - (1) Fry Readability Index;
 - (2) PROSE The Readability Analyst (software developed by Education Activities, Inc.);
 - (3) Gunning FOG Index;
 - (4) McLaughlin SMOG Index;
 - (5) The Flesch-Kincaid Index; and/or
 - (6) Other readability tests approved by the Agency.
- c. The Dental Plan shall make all written material available in multiple languages, as prescribed by the Agency. The Dental Plan shall notify all enrollees and, upon request, potential enrollees that information is available in alternative formats and how to access those formats. (42 CFR 438.10(d)(3))
- d. If the Dental Plan meets the five percent (5%) threshold for language translation, the Dental Plan shall place the following alternate language disclaimer on all enrollee materials:

“This information is available for free in other languages. Please contact our customer service number at [insert enrollee help line and TTY/TTD numbers and hours of operation].”

The Dental Plan shall include the alternate language disclaimer in both English and all non-English languages that meet the five percent (5%) threshold. The Dental Plan shall place the non-English disclaimer(s) below the English version and in the same font size as the English version. Information on language use shall be found at <https://www.census.gov/topics/population/language-use.html#tab2>.
- e. The Dental Plan shall include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided. Information on the top fifteen (15) non-English languages is located at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf>.

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3. Requirements for Mailing Materials to Enrollees

- a. The Dental Plan shall provide materials to enrollees by mail or consistent with the enrollee’s preferred method of contact.
- b. The Dental Plan shall display one of the following four (4) statements verbatim on the front of the envelope or, if no envelope is being sent, the mailing itself:
 - (1) Advertising pieces – “This is an advertisement.”
 - (2) Dental Plan information – “Important Dental Plan information”
 - (3) Health and wellness information – “Health and wellness or prevention information”
 - (4) Non-dental or non-Dental Plan information – “Non-dental or non-Dental Plan related information”

The Agency does not require resubmission of envelopes based only on the envelope size.

- c. The Dental Plan shall ensure that its Dental Plan name or logo is included in every mailing to enrollees.
- d. The Dental Plan shall include a request for address correction in mailing envelopes for enrollee materials.
- e. The Dental Plan shall not send emails unless the enrollee has agreed to receive those emails and shall provide an opt-out process for enrollees no longer to receive email communications.

4. Enrollee Procedures and Materials

- a. The Dental Plan shall notify, in writing, within five (5) days following the receipt of the X12-834 enrollment file from the Agency or its designee, each enrollee who is to be newly enrolled or reinstated with the Dental Plan.
- b. The Dental Plan shall furnish enrollee materials to the new enrollee:
 - (1) An enrollment notice.
 - (2) An enrollee identification (ID) card.
 - (3) A current enrollee handbook.
 - (4) A current provider directory.
 - (5) Name, telephone number and address of the enrollee’s PDP assignment.

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- c. The Dental Plan shall furnish a reinstatement notice to a reinstated enrollee.

5. Required Enrollment Notice

The Dental Plan shall include in its enrollment notice:

- a. The effective date of enrollment.
- b. The enrollees' right to change their Dental Plan selections, subject to Medicaid limitations. The notifications shall distinguish between enrollees subject to open enrollment and those who are not and shall include information about change procedures for cause, or general plan change procedures through the Agency's enrollment broker website (www.flmedicaidmanagedcare.com) and toll-free enrollment broker telephone number as appropriate.
- c. A notice that enrollees who lose eligibility and are disenrolled shall be automatically reinstated in the Dental Plan if eligibility is regained within the temporary loss period of one hundred eighty (180) days (42 CFR 438.56(g)).

A request to update the enrollee's name, address (home and mailing), county of residence and telephone number, and include information on how to update this information with the Dental Plan and through DCF and/or the Social Security Administration.

- d. A postage-paid, pre-addressed return envelope.

6. Reinstatement Notice

The Dental Plan shall include in its reinstatement notice:

- a. The effective date of the reinstatement.
- b. Instructions on how the enrollee can contact the Dental Plan if a new enrollee card, new enrollee handbook, and/or a new provider directory are needed.
- c. A request to update the enrollee's name, address (home and mailing), county of residence and telephone number, and include information on how to update this information with the Dental Plan and through DCF and/or the Social Security Administration.
- d. A postage-paid, pre-addressed return envelope.

7. Enrollee ID Card Requirements

- a. The Dental Plan shall include on its enrollee ID card:
 - (1) The enrollee's name and Medicaid ID number;

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- (2) The Dental Plan's name, address, and enrollee help line number; and
 - (3) A telephone number that a non-participating provider may call for billing information.
- b. The Dental Plan shall provide replacement ID cards at the enrollee's request.

8. Enrollee Handbook Requirements

- a. The Dental Plan shall furnish each new enrollee an enrollee handbook using the model enrollee handbook template provided by the Agency. The model enrollee handbook shall comply with the provisions of 42 CFR 438.3(j), 42 CFR 438.102(b)(2), 42 CFR 438.10(c)(4)(ii), 42 CFR 438.10(g), 42 CFR 438.62(b)(3), 42 CFR 489.102(a), and 45 CFR 147.200(a).
- b. The Dental Plan shall provide the enrollee handbook through one of the following methods:
 - (1) Mailing a printed copy of the information to the enrollee's address;
 - (2) Providing the information by email, as permitted by this Contract;
 - (3) Advising the enrollee in paper or electronic form that the information is available on the Dental Plan's website and providing the applicable internet address; or
 - (4) Providing the information by any other method that can reasonably be expected to result in the enrollee receiving that information.

Prior to utilizing methods (2), (3), or (4) above, the Dental Plan shall submit a written description to the Agency Contract Manager of the process ensuring enrollees have access to a printed copy upon request.

9. Printed Provider Directory

- a. The Dental Plan shall include in its printed provider directory the following information:
 - (1) Provider(s) names and group affiliations;
 - (2) Street address(es);
 - (3) Telephone number;
 - (4) Website URLs, if the provider has a website;
 - (5) Specialty credentials and other certifications, as applicable;
 - (6) Whether the provider will accept new enrollees;
 - (7) The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competency training;
 - (8) Office hours;

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- (9) Specific performance indicators;
 - (10) In accordance with s. 1932(b)(3) of the Social Security Act, a statement that some providers may choose not to perform certain services based on religious or moral beliefs;
 - (11) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment. (42 CFR 438.10(h)(1)(viii));
 - (12) Whether the provider provides services via teledentistry;
 - (13) Special needs population indicator(s), as defined by the Agency.
- b. The Dental Plan shall arrange the provider directory by county as follows:
- (1) Providers listed by name in alphabetical order, showing the provider's specialty; and
 - (2) Providers listed by specialty, in alphabetical order by name.
- c. The Dental Plan shall provide a copy of the printed provider directory through one of the following methods:
- (1) Mailing a printed copy to the enrollee's address;
 - (2) Providing the information by email, as permitted by this Contract;
 - (3) Advising the enrollee in paper or electronic form that the information is available on the internet and including the applicable internet address; or
 - (4) Providing the information by any other method that can reasonably be expected to result in the enrollee receiving that information.
- d. The Dental Plan shall update the printable version of the provider directory at least monthly and include the date of revision. (42 CFR 438.10(h)(3))
- e. When distributing printed provider directories, the Dental Plan shall include information stating that the most current listing of providers is available by calling the Dental Plan at its toll-free telephone number and at the Dental Plan's website. The letter shall include the telephone number and the internet address that links directly to the online provider database.

10. Online Enrollee Materials

- a. The Dental Plan shall make available electronically at the Dental Plan's website without requiring enrollee login, the enrollee handbook(s), the printed provider directory, and a searchable provider database.
- (1) The Dental Plan shall provide enrollee information electronically and meet the

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criteria as outlined in 42 CFR 438.10(c)(6)(i)-(v).

- (2) The Dental Plan may provide a link to applications (smartphone applications, or “apps”) for enrollee use that will take enrollees directly to existing Agency-approved materials (such as the Dental Plan’s enrollee handbook and provider directory) on the Dental Plan’s website.
 - (3) The online provider directory shall be made available in a machine-readable file and format in compliance with 42 CFR 438.10(h)(4).
- b. The Dental Plan shall maintain an accurate and complete online provider database containing all the information required in the printed provider directory and as required by s. 409.967(2)(c)1, F.S. The online provider database must be searchable by:
- (1) Name;
 - (2) Provider type;
 - (3) Distance from the enrollee’s address;
 - (4) County;
 - (5) Zip code;
 - (6) Whether the provider is accepting new patients;
 - (7) Whether the provider offers afterhours and weekend appointments; and
 - (8) Whether provider offers services for special populations as described in **Section E.**, Prioritizing Florida’s Vulnerable Citizens, of this Attachment.
- c. The Dental Plan shall update the online provider database at least weekly to match the most recent provider network file submitted to the Agency.

11. Procedures for Provider Network Changes

- a. The Dental Plan shall have procedures to inform potential enrollees and enrollees, upon request, of any changes to service delivery and/or the provider network including the following:
 - (1) Up-to-date information about any restrictions on access to providers, including providers who are not taking new patients; and
 - (2) Any restrictions on counseling and referral services based on moral or religious grounds within ninety (90) days after adopting the policy with respect to any service. (42 CFR 438.102(b)(1)(i)(B); 42 CFR 438.10(g)(4))
- b. The Dental Plan shall have procedures to inform enrollees of adverse changes to its provider network.

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C. Enrollee Services

1. General Provisions

- a. The Dental Plan shall establish and maintain an enrollee services function with the capability to answer enrollee inquiries and ensure that enrollees are notified of their rights and responsibilities.
- b. The Dental Plan shall ensure language translation quality in all enrollee materials.

2. Translation and Interpretation Services

- a. The Dental Plan is required to provide interpretation services at all points of contact to any potential enrollee or enrollee who speaks any non-English language regardless of whether the enrollee speaks a language that meets the threshold of a prevalent non-English language. This includes written translation, oral interpretation, and the use of auxiliary aids such as TTY/TDY and American Sign Language. (42 CFR 438.10(d)(4); and 42 CFR 438.406(a))
- b. The Dental Plan is required to notify its enrollees of the availability of interpretation services and to inform them of how to access such services. Interpretation services are required for all Dental Plan information provided to enrollees, including notices of adverse action. There shall be no charge to the enrollee for translation services. (42 CFR 438.10(d)(5)(i)-(iii), 42 CFR 438.10(d)(4))
- c. Upon request, the Dental Plan shall provide, free of charge, interpreters for potential enrollees or enrollees whose primary language is not English. (42 CFR 438.10(d)(4))

3. Toll-Free Enrollee Help Line

- a. The Dental Plan shall operate a toll-free help line equipped with caller identification, automatic call distribution equipment capable of handling the expected volume of calls, a telecommunication device for the deaf (TTY/TDD), and access to the interpreter services for non-English speaking beneficiaries. The Dental Plan shall operate its enrollee help line as part of an inbound call center or similar functional arrangement where agents or operators staff telephones to field incoming calls.
- b. The Dental Plan shall staff the enrollee help line twenty-four hours per day, seven days a week (24/7) to handle care-related inquiries, including emergency services from enrollees and caregivers.
- c. The enrollee help line agents/operators shall be trained to respond to enrollee questions in all areas, including information on accessing dental related services excluded from coverage under the Dental Plan Contract. (See **Section V.**, Service Administration, **Section D.**, Excluded Services.)
- d. The Dental Plan shall develop and implement an operational manual relevant to the call center. This manual shall provide information to agents/operators on how to conduct various call center tasks and provide procedures for processing enrollee inquiries, including procedures such as call scripts, call-handling procedures, first call

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resolution, and escalation protocols.

- e. If the Dental Plan utilizes an automated phone tree system, the Dental Plan's phone tree must include the option for enrollees to bypass options in the automated phone tree system and speak with an enrollee help line representative.
- f. The Dental Plan may use a voice mail option in an automated phone tree system for callers to leave messages between the hours of 7:00 p.m. and 8:00 a.m., in the enrollee's time zone, Monday through Friday and at all hours on weekends and holidays. This phone tree must provide callers with clear instructions on what to do in case of an emergency and an option to speak to a Dental Plan representative.
- g. If the Dental Plan utilizes a voice mailbox option, the Dental Plan shall ensure that the voice mailbox has adequate capacity to receive all messages. A Dental Plan representative shall respond to all messages on the next business day.
- h. The Dental Plan shall have administrative procedures that include requirements for staffing, operations, technologies, and performance measurement. The administrative procedures shall address:
 - (1) Personnel management such as staff development and training, scheduling, and skill-based routing;
 - (2) Operational management of all call center activities such as call center shrinkage and schedule adherence, workload, and call load forecasting;
 - (3) Software and technologies, such as automatic call distribution (ACD), telephone phone tree/IVR technology and call recording systems; and
 - (4) Call center quality control metrics and measurement for the performance of agents/operators.
- i. The Dental Plan shall maintain enrollee call center metrics at the following levels on a monthly basis at the following levels, measured on a monthly basis, for call center performance:
 - (1) The Dental Plan shall ensure that at least ninety percent (90%) of calls are answered within thirty (30) seconds.
 - (2) The Dental Plan shall ensure that the rate of first-call resolution shall be at least eighty percent (80%).
 - (3) The Dental Plan shall ensure that the average hold time shall not exceed sixty (60) seconds.
 - (4) The Dental Plan shall ensure that the quality assurance monitoring score shall be ninety-five percent (95%) or greater.
 - (5) The Dental Plan shall ensure that the average speed of answer shall not exceed thirty (30) seconds.

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- (6) The Dental Plan shall ensure that the call abandonment rate shall not exceed three percent (3%).
- (7) The Dental Plan shall ensure that the call blockage rate, as reported from the telecom provider, is no more than one-half percent (0.5%).
- (8) The Dental Plan shall ensure that the call blockage rate, as reported by the ACD reporting software, is no more than zero percent (0.00%).

If the Dental Plan fails to comply with the requirements of this provision, the Dental Care Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

- j. The Dental Plan shall ensure that hold time messages do not include non-health related items (e.g., life insurance, disability). The Dental Plan shall submit hold time messages that promote the Dental Plan or include benefit information to the Agency for prior approval.

4. Cultural Competency Plan

As required by 42 CFR 438.206(c)(2), the Dental Plan shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.

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A. Required Benefits

1. General Provisions

- a. The Agency shall be responsible for promulgating coverage requirements applicable to Dental Plans through Florida Medicaid Coverage Policies, services listed in the associated Florida Medicaid fee schedules, and the Florida Medicaid State Plan, as well as plan communications specific to changes in federal and State law, rules, or regulations, and the federal CMS waivers applicable to this Contract.
- b. The Dental Plan shall ensure the provision of services defined and specified in this Contract and the applicable federal waivers in sufficient amount, duration, and scope to be reasonably expected to achieve the purpose for which the services are furnished and shall ensure the provision of the covered services defined and specified in this Contract. (42 CFR 438.210(a)(3)(i))
- c. Nothing in this Contract waives the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) requirements of 42 U.S.C. s. 1396d(r)(5). As such, in accordance with s. 1396d(r) and all binding federal precedents interpreting it, the Dental Plan shall, for Medicaid eligible children under the age of twenty-one (21) years, pay for any “other necessary health care, diagnostic services, treatment, and other measures described in Sub-Section (a) of this Section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.” (42 U.S.C. 1396d(r)(5)) The Dental Plan shall not place any time caps (e.g., hourly limits, daily limits, or annual limits) or expenditure caps on services for children under the age of twenty-one (21) years. The Dental Plan shall develop a special services process to authorize services exceeding the coverage described in each service-specific coverage policy, if medically necessary.
- d. The Dental Plan shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the enrollee’s diagnosis, type of illness or condition. (42 CFR 438.910(b)(2) and (c)) The Dental Plan may place appropriate limits on a service on the basis of medical necessity, as defined by the Agency, consistent with the terms of this Contract and as required by 42 CFR 438.210(a)(4)(i)-(ii) and 438.210(a)(1), provided the services furnished can be reasonably expected to achieve their purpose.
- e. The Dental Plan shall provide the services identified in this **Attachment** in accordance with the Florida Medicaid State Plan, the applicable federal waivers, as well as the Florida Medicaid promulgated rules in Chapter 59G-4, F.A.C., that include the Florida Medicaid Coverage Policies, and services listed in the associated Florida Medicaid fee schedules, except where the provisions of this Contract or the applicable federal waivers alter the requirements set forth in the Coverage Policies and Medicaid fee schedules.

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- (1) In no instance may the Dental Plan impose coverage and service limitations or exclusions more stringent than those specified in the aforementioned documents. (42 CFR 438.210(a)(5)(i))
- (2) The Dental Plan may exceed specific coverage criteria included in the above and specific coverage exclusions specified in the aforementioned documents.
- f. The Dental Plan is responsible for ensuring that all coverage and service requirements specified in the Florida Medicaid Services Coverage & Limitations Handbooks, Florida Medicaid Coverage Policies are incorporated into the Dental Plan’s provider agreements. This includes professional licensure and certification standards for all service providers. Exceptions exist where different standards are specified elsewhere in this Contract.
- g. The Agency shall be responsible for accepting complaints directly from Medicaid recipients and providers, conducting Medicaid Fair Hearings for Medicaid enrollees, conducting State reviews for Title XXI MediKids enrollees and Title XXI CMS Health Plan enrollees, as well as reviewing complaints, grievances, and plan appeals reported by Dental Plans to ensure appropriate resolution and monitor for contractual compliance, the Dental Plan performance, and trends that shall reflect policy changes or operational changes needed.
- h. This Contract shall prevail in any instance when compliance with provisions in the Medicaid State Plan, the applicable federal waivers, as well as the Florida Medicaid promulgated rules in Chapter 59G, F.A.C. conflict with the terms of this Contract.

B. Required Dental Benefits

1. Specific Dental Services to be Provided

- a. The Dental Plan shall provide covered dental services in accordance with **Section V.**, Service Administration, the approved federal waiver for the Statewide Medicaid Statewide Medicaid Prepaid Dental Program, and the following Medicaid dental rules and services listed on the associated fee schedules and billing codes listings in the Florida Medicaid Dental Rules, and Billing Codes Table, **Table 3**, below:

TABLE 3	
FLORIDA MEDICAID DENTAL RULES AND BILLING CODES	
Rule No.	Policy Name
59G-4.002	<u>Dental General Fee Schedule</u> <u>Practitioner Fee Schedule*</u> <u>Prescribed Drugs (Not Reviewed by the Pharmaceutical and Therapeutics Committee) Fee Schedule*</u> <u>Prescribed Drug Fee Schedule*</u> <u>Federally Qualified Health Center Billing Codes*</u> <u>County Health Department Billing Codes*</u>
59G-4.020	<u>Ambulatory Surgical Center Services*</u>
59G-4.022	<u>Anesthesia Services*</u>
59G-4.055	<u>County Health Department Clinic Services*</u>

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59G-4.060	<u>Dental Services Coverage Policy</u>
59G-4-100	<u>Federally Qualified Health Care Services*</u>
59G-4.207	<u>Oral and Maxillofacial Surgery Services Coverage Policy</u>
59G-4.160	<u>Outpatient Hospital Services*</u>
59G-4.250	<u>Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook*</u>

**For applicable services rendered by a dentist, registered dental hygienist, or orthodontist in accordance with the referenced policy(ies) as applicable.*

Ambulatory Surgical Center Service

The Dental Plan shall be responsible for the coverage of dental services provided in an ambulatory surgical center.

Anesthesia Services

The Dental Plan shall be responsible for the coverage of anesthesiology services when provided in conjunction with covered dental services.

Outpatient Hospital Services

The Dental Plan shall be responsible for the coverage of non-emergency dental services provided in an outpatient hospital setting.

b. Post-stabilization Dental Care Services

- (1) In addition to the requirements outlined in s. 641.513, F.S., the Dental Plan shall ensure the enrollee has a follow-up appointment scheduled within seven (7) days after discharge.
- (2) Whether the enrollee receives treatment related to an emergency dental condition through the fee-for-service delivery system or through a Managed Medical Assistance Plan, the Dental Plan shall be responsible for coordinating medically necessary dental services following the delivery of post-stabilization care services in a hospital.

C. Expanded Benefits

1. General Provisions

- a. The Dental Plan may offer expanded benefits as approved by the Agency.
- b. The Dental Plan shall offer the approved expanded benefits to eligible enrollees in the Dental Plan, subject to any Agency-agreed service limitations set forth in this Contract.
- c. The Dental Plan shall inform new enrollees about its expanded benefits program and shall proactively engage in outreach and communication on a quarterly basis about the availability of such benefits to its enrollees.

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- d. The Dental Plan shall promote expanded benefits and communicate routine reminders through multiple channels to both enrollees and providers to ensure equal utilization across the target populations identified in **Attachment II, Section I.E.**, item 1. Expanded Benefits.
- e. The Dental Plan shall administer the expanded benefits of Medicaid covered services in accordance with any applicable service standards pursuant to this Contract, the applicable federal waivers, and any Florida Medicaid Coverage and Limitations Handbooks, and Medicaid Coverage Policies.

2. Types of Expanded Benefits

The Dental Plan shall offer the following expanded benefits:

- a. Services in excess of the amount, duration, and scope of those listed in this Contract for its respective enrollees.
- b. Other services and benefits not listed in **Section V.**, Service Administration, **Sub-Section B.**, Required Dental Benefits, upon approval of the Agency.

3. Changes to Expanded Benefits Offered

- a. The Dental Plan's expanded benefits may be changed on a Contract year basis in a manner and format approved by the Agency, if determined by the Agency to be beneficial to enrollees.
- b. The Dental Plan may increase its expanded benefits upon approval by the Agency.
- c. The Dental Plan may exchange an expanded benefit for another, if determined to be actuarially equivalent by the Agency, upon approval by the Agency.

D. Excluded Services

1. General Provisions

- a. The Dental Plan is not obligated to provide any services not specified in this Contract, except as federally required under EPSDT provisions.
- b. Enrollees who require services not covered by this Contract may receive the services through other appropriate Medicaid and non-Medicaid programs. In such cases, the Dental Plan's responsibility shall include coordination and referrals in compliance with 42 CFR 438.208(b)(2)(iii)-(iv).
- c. The following services are not provided by the Dental Plan but are available to Dental Plan enrollees through the fee-for-service delivery system or through a MMA Plan, as applicable:
 - (1) Facility fees associated with the provision of dental services rendered in an inpatient hospital setting;

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- (2) Emergency dental services provided in a facility setting;
- (3) Outpatient prescription drugs prescribed by the dental provider for treatment of a dental condition;
- (4) Preventive dental services when rendered by a non-dental provider; and
- (5) Transportation to and from dental appointments.

2. Moral or Religious Objections

- a. The Dental Plan shall provide or arrange for the provision of all covered services. If, during the course of this Contract period, pursuant to 42 CFR 438.102, the Dental Plan elects not to provide or reimburse for counseling or referral to a covered service because of an objection on moral or religious grounds, the Dental Plan shall notify:
 - (1) The Agency within one hundred twenty (120) days before implementing the policy with respect to any covered service; (42 CFR 438.102(b)(1)(i)(A)(2)) and
 - (2) Enrollees within sixty (60) days before implementing the policy with respect to any covered service.
- b. In accordance with 42 CFR 438.10, if the Dental Plan chooses not to cover or furnish counseling or referral service information to enrollees due to moral or religious objections, the Agency will be responsible for providing information on how and where to obtain the service. (42 CFR 438.102(b)(1)(i)(A)(1))

E. Coverage Provisions

1. Service-Specific Requirements

- a. The Dental Plan shall offer the enrollee a choice of PDPs. Each enrollee shall have a single or group PDP.
- b. The Dental Plan shall permit enrollees to request to change PDPs at any time. If the enrollee request is not received by the Dental Plan's established monthly cut-off date for system processing, the PDP change shall be effective the first day of the next month.
- c. The Dental Plan shall assign all enrollees that are reinstated after a temporary loss of eligibility to the PDP to which they were assigned prior to loss of eligibility, unless the enrollee specifically requests another PDP, or the PDP is at capacity or no longer participates in the Dental Plan.

2. Enrollee Screening and Education

- a. The Dental Plan shall conduct an oral health risk assessment to identify enrollees who have not received well-child dental screenings in accordance with the Agency-approved periodicity schedule.

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- b. The Dental Plan shall develop and implement an education and outreach program to increase the number of eligible enrollees receiving annual dental visits and preventive dental visits. This program shall include, at a minimum, the following:
 - (1) A tracking system to identify enrollees for whom a visit is due or overdue;
 - (2) Systematic reminder notices sent to enrollees before a visit is due. The notice shall include an offer to assist with scheduling.
 - (3) A process for following up with enrollees who do not get timely visits. This shall include contacting twice, if necessary, any enrollee more than two (2) months behind in the Agency-approved periodicity screening schedule to urge those enrollees, or their legal representatives, to make an appointment with the enrollee's PDP for a screening visit and offering to assist with scheduling and transportation. The Dental Plan shall document all outreach education attempts. For this Sub-Section, "contact" is defined as mailing a notice to or calling an enrollee at the most recent address or telephone number available; and
 - (4) Provision of enrollee education and outreach in community settings.
- c. The Dental Plan shall develop and implement an education outreach program to encourage preventive dental visits and a dental home.
- d. The Dental Plan shall take immediate action to address any identified urgent dental needs.
- e. The Dental Plan may have a program for recognizing dental homes. If the Dental Plan has a dental home program, it shall submit its procedures for such program to the Agency, which shall include recognition standards developed by the Dental Plan for the program.
- f. In addition to the above Enrollee Screening and Education provisions, see **Section I.**, General Overview, **Sub-Section E.**, Prioritizing Florida's Vulnerable Citizens, **Item 2.**, Supplemental Assessment for Enrollees on the iBudget Waiver or Waitlist.

3. New Enrollee Procedures

- a. The Dental Plan shall contact each new enrollee, at least twice, if necessary, within ninety (90) days of the enrollee's enrollment to conduct an initial oral health risk assessment of the enrollee's needs, and to offer to schedule the enrollee's initial appointment with the PDP, which should occur within one hundred eighty (180) days of enrollment. This appointment is to obtain an oral health evaluation and cleaning, as appropriate. For this Sub-Section, "contact" is defined as mailing a notice to or telephoning an enrollee at the most recent address or telephone number available. Contact shall also include emailing as permitted by **Section IV.**, Enrollee Services, **Sub-Section B.**, Enrollee Material, **Item 3.**, Requirements for Mailing Materials to Enrollees.

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- b. Within thirty (30) days of enrollment, the Dental Plan shall ask the enrollee to authorize release of the provider's enrollee records to the new PDP or other appropriate provider and shall assist by requesting those records from the enrollee's previous provider(s).
- c. The Dental Plan shall comply with the following standards, measured on a quarterly basis, for completion of oral health risk assessments within the specified timeframes and shall submit a quarterly report to the Agency of the completion rates for oral health risk assessments on the target populations identified below:
 - (1) The Dental Plan shall ensure that oral health risk assessments are completed on at least fifty percent (50%) of enrollees under the age of twenty-one (21) years (as identified by the Agency through enrollment files provided to the Dental Plan) within sixty (60) days of enrollment into the Dental Plan.
 - (2) The Dental Plan shall ensure that oral health risk assessments are completed on at least seventy percent (70%) of all pregnant enrollees (as identified by the Agency through enrollment files provided to the Dental Plan) within sixty (60) days of enrollment into the Dental Plan.
 - (3) The Dental Plan shall ensure that oral health risk assessments are completed on at least fifty percent (50%) of enrollees diagnosed with developmental disability (as identified by the Agency through enrollment files provided to the Dental Plan) within sixty (60) days of enrollment into the Dental Plan.
- d. If the Dental Plan fails to comply with the requirements of this section, the Dental Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

4. Teledentistry

- a. The Dental Plan shall pay for teledentistry services to the same extent as in-person encounters with dental providers and shall be no more restrictive in the coverage requirements than Rule 59G-1.057, F.A.C., Teledentistry.
- b. At the choice of the enrollee, the Dental Plan may assure access to participating dentistry specialists by providing teledentistry consultations. The enrollee must be present for the teledentistry consultation at an agreed upon location, which must be located within sixty (60) minutes' travel time or forty-five (45) miles from the enrollee's residence, or at the PDP's office.
- c. When teledentistry services are provided, the Managed Care Plan shall ensure that the provider's enrollee record includes documentation, as described in **Section VIII.**, Quality, **Sub-Section E.**, Enrollee Record Requirements, **Item 1.**, General Provisions.
- d. If the Dental Plan fails to comply with the requirements of this section, the Dental Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

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F. Care Coordination/Case Management

1. General Provisions

- a. The Dental Plan shall be responsible for care coordination/case management of oral health benefits for enrollees as specified in this Contract and the applicable **Exhibit(s)**. (42 CFR 438.208(b)(2)(ii))
- b. The Dental Plan shall have protocols in place to identify enrollees who require care coordination/case management services and maintain written procedures for identifying, assessing, and implementing interventions for enrollees.
- c. The Dental Plan shall ensure case managers meet the appropriate experience and educational requirements.

2. Care Coordination/Case Management Program Description

The Dental Plan shall submit a Care Coordination/Case Management Program Description to the Agency by June 1 of each Contract year. The Care Coordination/Case Management Program Description shall address:

- a. How the Dental Plan shall implement and monitor the care coordination/case management program and standards outlined in this Contract.
- b. A description of the methodology for assigning and monitoring case management caseloads.
- c. Minimum qualifications and training requirements for the case manager and case manager supervisor.
- d. A description of the Dental Plan's procedures for resolving conflict or disagreement in the care planning process, including guidelines for all participants.
- e. A description of how the activities performed by the Dental Plan's care coordination, utilization management (UM), and quality management/improvement departments interface in the development of the enrollee's plan of care, including how services that are managed and authorized through sub-contracted entities are incorporated into the workflow and support a person-centered care planning approach. Interface shall include electronic and written reports and verbal communication required for coordination of care planning activities.
- f. An evaluation of the Dental Plan's care coordination/case management program from the previous year, highlighting lessons learned and strategies for improvement.
- g. All required elements of the care coordination/case management program and responsibilities of the case manager and case manager supervisor as outlined in this Contract.

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3. Care Coordination/Case Management Contact Requirements for Special Populations

See **Section I.**, General Overview, **Sub-Section E.**, Prioritizing Florida’s Vulnerable Citizens, **Item 3.**, Care Coordination/Case Management Contact Requirements for Special Populations.

4. Additional Care Coordination/Case Management Requirements

- a. The Dental Plan shall maintain written care coordination and continuity of care procedures that include the following minimum functions:
- (1) Appropriate referral and scheduling assistance for enrollees needing specialty dental care;
 - (2) A mechanism for access to specialists, without the need for a referral, for enrollees identified as having special health care needs, as appropriate for their conditions and identified needs;
 - (3) Coordination with the enrollee’s MMA Plan or the Medicaid FFS delivery system, as applicable, for oral health issues exceeding the coverage of this Contract;
 - (4) Coordination with the enrollee’s MMA Plan or the Medicaid FFS delivery system, as applicable, for transportation to and from covered oral health services;
 - (5) Coordination with the enrollee’s MMA Plan or the Medicaid FFS delivery system, as applicable, for pharmacy services and facility benefits related to the delivery of covered oral health services;
 - (6) Coordination with the enrollee’s MMA Plan or the Medicaid FFS delivery system, as applicable, through a closed-loop verification system. The verification system will provide functionality for the Dental Plan and the MMA Plan to share the enrollee’s health information safely and securely.
 - (7) Coordination with the enrollee’s iBudget Waiver Support Coordinator, as applicable, for additional support service needs (e.g., behavior assistance, occupational therapy);
 - (8) Documentation of referral services in the enrollee records, including results;
 - (9) Coordination of care that is proportional to the clinical and psychosocial needs for enrollees that are identified as high risk through application of the Dental Plan’s case management risk stratification protocol; and
 - (10) Documentation in Dental Plan and provider dental records of appropriate follow-up to enrollee emergency encounters, when indicated.

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- b. The Dental Plan shall maintain written procedures for identifying, assessing, and implementing interventions for special population enrollees, including Medicaid enrollees on the iBudget Waiver or Waitlist as identified by the Agency, pregnant enrollees, enrollees with chronic diseases such as diabetes, cancer, or HIV, enrollee who are ages sixty-five (65) years and older, or those with high service utilization, intensive health care needs, or who consistently access services at the highest level of care. This shall include, at a minimum, the following:
- (1) Identifying eligible enrollees and stratifying enrollees by severity and risk level including developing an algorithm to identify and stratify eligible enrollees, including identifying enrollees with co-morbid medical conditions and addressing the co-morbid medical conditions;
 - (2) Developing different types of interventions and specifying minimum touch frequency for each severity and/or risk level;
 - (3) Determining maximum caseloads for each case manager and support staff and managing and monitoring caseloads;
 - (4) Specifying experience and educational requirements for case managers and case management support staff;
 - (5) Providing training and continuing education for case management staff including but not limited to person-centered care practices for working with enrollees on the iBudget Waiver or Waitlist as identified by the Agency;
 - (6) Identifying and documenting accurate and current information indicating who has legal authority to make health care decisions, pursuant to applicable federal and State laws (including but not limited to 42 CFR Part 435, and Chapters 709, 744, and 765 of the F.S.), on behalf of an enrollee;
 - (7) Using evidence-based guidelines to enhance enrollee engagement;
 - (8) Ensure the development of treatment plans that address all of the following:
 - (a) Incorporate the health risk issues identified during the oral assessment;
 - (b) Incorporate the treatment preferences of the enrollee;
 - (c) Contain goals that are outcomes based and measurable;
 - (d) Include the interventions and services to be provided to obtain goals;
 - (e) Include community service linkage, improving support services, and lifestyle management as appropriate based on the enrollee's identified issues.

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- (f) Assessing enrollees for literacy levels and other hearing, vision, or cognitive functions that may impact an enrollee's ability to participate in his/her care and implementing interventions to address the limitations; and
- (g) Assessing enrollees for community, environmental, or other supportive services needs and referring enrollees to get needed assistance.
- (9) Ensure that treatment plans are updated at least every six (6) months when there are significant changes in enrollee's condition; and
- (10) Interfacing with the enrollee's PDP and/or dentistry specialists.

5. Care Coordination/Case Management Contact

- a. The Dental Plan shall maintain contact with enrollees receiving care coordination/case management as specified in this section and as frequently as the enrollee's health condition requires.
- b. The Dental Plan shall complete initial contact with an enrollee in a Specialty Population within thirty (30) days of the enrollee's transition into the Dental Plan.

6. Transition of Care

- a. The Dental Plan shall develop and maintain transition of care procedures that address all transitional care coordination/case management requirements and submit these procedures for review and approval to the Agency. (42 CFR 438.62(b)(1)-(2)) Transition of care procedures shall include the following minimum functions:
 - (1) Appropriate support to case managers, and to enrollees and caregivers as needed, for referral and scheduling assistance for enrollees needing specialty health care, transportation, or other service supports; (42 CFR 438.208(b)(1))
 - (2) Determination of the need for non-covered services and referral of the enrollee for assessment and referral to the appropriate service setting with assistance, as needed, by the Agency. (42 CFR 438.208(b)(6); 42 CFR 438.224; 45 CFR 160; 45 CFR 164) Transfer of Dental Plan enrollee records in compliance with HIPAA privacy and security rules;
 - (3) Documentation of referral services in Dental Plan enrollee records, including follow up resulting from the referral;
 - (4) Monitoring of enrollees with co-morbidities and complex medical conditions and coordination of services for high utilizers to identify gaps in services and evaluate progress of case management.
- b. The Dental Plan shall be responsible for coordination of care for new enrollees transitioning into the Dental Plan.

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- c. The Dental Plan shall be responsible for coordination of care for enrollees transitioning to another Dental Plan or delivery system and ensure information for active services is shared with the new Dental Plan or delivery system within thirty (30) days following an enrollee's enrollment date into the new Dental Plan.
- d. In addition to the provisions of **Section V.**, Service Administration, **Sub-Section F.**, Care Coordination/Case Management, **Item 2.**, Care Coordination/Case Management Program Description, the Dental Plan's transition of care procedures shall include the following minimum functions:
 - (1) Collaborating with the enrollee's MMA Plan or the Medicaid FFS delivery system, as applicable, to assure the provision of post-stabilization dental care services;
 - (2) Facilitating communication with community service providers; and
 - (3) Coordination of care after emergency department visits. (42 CFR 438.208(b)(2)(i))
- e. The Dental Plan shall enroll and participate in the Florida Health Information Exchange ENS, as directed by the Agency, in order to access emergency department encounter notifications for all of its enrollees.
- f. The Dental Plan shall contact each enrollee with an emergency department visit (based on notification through the ENS) within seven (7) days of discharge and implement the strategies identified in this contract to ensure appropriate follow-up care is obtained by the enrollee.

7. Healthy Behaviors Program

- a. Pursuant to s. 409.973(3), F.S., the Dental Plan shall establish and maintain programs to encourage and reward healthy behaviors.
- b. The Dental Plan shall receive written approval of its healthy behavior programs from the Agency before implementing the programs. The Dental Plan's program shall include a detailed description of the program, including the goals of the program, how targeted enrollees shall be identified, the interventions the Dental Plan intends to use, rewards for or incentives to participate, research to support the effectiveness of the program, and evidence that the program is medically approved or directed, as applicable. Programs administered by the Dental Plan shall comply with all applicable laws, including fraud and abuse laws that fall within the purview of the United States Department of Health and Human Services (DHHS) Office of Inspector General (OIG). The Dental Plan is encouraged to seek an advisory opinion from OIG once the specifics of its Healthy Behaviors programs are determined.
- c. Healthy behaviors may be adjusted during the readiness process and/or during the Contract period, at the discretion of the Agency. The Dental Plan also agrees that the Agency will have the right to request additional healthy behaviors if the Dental Plan does not meet the minimum requirements as identified in this Sub-Section.

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- d. The Dental Plan shall, through its healthy behavior programs, deploy a number of interventions as part of the overall therapeutic process.
- e. At a minimum, the Dental Plan must establish one or more healthy behavior programs for each of the following groups of members:
 - (1) Children under twenty-one (21) years of age;
 - (2) Pregnant women; and
 - (3) Adults ages twenty-one (21) years and older.
- f. The Dental Plan must establish at least one (1) healthy behavior program with an online interactive education component. This program must include oral health-related education and include a mechanism by which the Dental Plan can confirm that the member has watched or read the material(s) (e.g., through the user clicking on each slide and/or taking a test after viewing a video).
- g. The Dental Plan shall make all programs, including incentives and rewards, available to all enrollees and shall not use incentives or rewards to direct individuals to select a particular provider.
- h. The Dental Plan shall inform new enrollees about the healthy behaviors program and actively engage in outreach and communication about the health benefits of its healthy behavior programs, including incentives and rewards.
- i. The Dental Plan shall promote healthy behavior programs and communicate routine reminders through multiple channels to enrollees to encourage participation and program completion.
- j. The Dental Plan shall consider partnering with other agencies such as State and local public health entities, provider organizations, local community groups, or other entities to educate enrollees about the program or to help administer it.
- k. The Dental Plan shall annually inform PDP providers of the availability of healthy behavior programs and incentives to support enrollee engagement.
- l. The Dental Plan shall not include the provision of gambling, alcohol, tobacco, or drugs (except for over-the-counter drugs) in any of its incentives or rewards and shall state on the incentive or reward that it may not be used for such purposes.
- m. The Dental Plan's healthy behavior program shall include a detailed description of the rewards and incentives offered to enrollees. Incentives alone do not constitute an effective program. Incentives or rewards may have some health- or child development-related function (e.g., clothing, food, books, safety devices, infant care items, subscriptions to publications that include health-related subjects, membership in clubs advocating educational advancement and healthy lifestyles, etc.). Incentive or reward

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- dollar values shall be in proportion to the importance of the healthy behavior being encouraged or rewarded (e.g., a tee-shirt for attending one (1) health education class, but a gift card for completion of a series of classes).
- n. Both incentives and rewards offered to enrollees shall be reasonable, simple, and provided on a timely basis. Incentives or rewards may include any of the following:
- (1) Flexible spending accounts that shall be used for health and wellness items;
 - (2) Vouchers for health and wellness related items; and
 - (3) Points or credits that are redeemable for goods or services.
- o. Incentives and rewards shall be limited to a value of twenty dollars (**\$20**). The exceptions to this monetary limit are as follows:
- (1) Programs that require the enrollee to complete a series of activities (e.g.; completion of a series of health education classes). In these instances, the incentive or reward shall be limited to a value of fifty dollars (**\$50**).
 - (2) Items that are offered as incentives to engage in a healthy behavior program or rewards for completion of an action or a series of activities may have a special exception to the dollar value, with Agency approval.
 - (3) Participation in multiple healthy behavior programs. In these instances, the incentive or reward shall be limited to a value of no more than fifty dollars (**\$50**) for each healthy behavior program.
- p. The Dental Plan shall not include in the dollar limits on incentives or rewards any money spent on childcare provided during the delivery of services, or the healthy behavior program or associated interventions.
- q. Healthy Behavior incentives/rewards are non-transferable from one Dental Plan to another.
- r. The Dental Plan shall report on its healthy behavior programs in accordance with **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*. This shall include submitting data related to each healthy behavior program, caseloads (new and ongoing) for each healthy behavior program, and the amount and type of rewards/incentives provided for each healthy behavior program.
- s. The Dental Plan shall evaluate each healthy behavior program annually in order to assess enrollee engagement (i.e., the number of enrollees participating), program completion rates, and health benefit outcomes/effectiveness and to submit the results of its annual evaluation to the Agency, in a format prescribed by the Agency, by October 1 of each Contract year. The Dental Plan shall publish the results of the annual evaluation on its website by October 1 of each Contract year.

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If the Dental Plan fails to comply with the requirements of this provision, the Dental Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

G. Community Partnerships to Improve Outcomes (CPIO)

See **Section I.**, General Overview, **Sub-Section E.**, Prioritizing Florida's Vulnerable Citizens, **Item 6.**, Community Partnerships, for provisions related to coordination with community-based organizations.

1. Children's Wellness Programs

The Dental Plan shall provide regular general dental wellness programs targeted specifically toward enrollees under the age of twenty-one (21) years or the Dental Plan shall make a good faith effort to involve enrollees in existing community oral health programs.

2. Public Health Partnerships

The Dental Plan shall engage in public health partnerships that promote access to preventive and screening services for children as established in **Attachment I**, Scope of Services, of this Contract.

H. Authorization of Services

1. General Provisions

- a. The Dental Plan shall establish and maintain a UM system to monitor utilization of services, including an automated service authorization system for denials, service limitations, and reductions of authorization. The Dental Plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required service because of the enrollee's diagnosis, type of illness, or condition (42 CFR 438.210(a)(3)(ii)).
- b. The Dental Plan shall ensure that applicable evidence-based guidelines are utilized with consideration given to characteristics of the local delivery systems available for specific enrollees as well as enrollee-specific factors, such as enrollee's age, co-morbidities, complications, progress in treatment, psychosocial situation, and home environment.
- c. The Dental Plan shall provide that compensation to individuals or entities (including subcontractors) that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee, in accordance with 42 CFR 438.210(e).
- d. The Dental Plan shall develop a process for authorization of any medically necessary service to enrollees under the age of twenty-one (21) years, in accordance with s. 1905(a) of the Social Security Act, when:

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- (1) The service is not listed in the service-specific Florida Medicaid Coverage Policy or the associated Florida Medicaid fee schedule, or is not a covered dental-related service of the Dental Plan; or
 - (2) The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific Handbook or Coverage Policy, or the corresponding fee schedule.
- e. The Dental Plan shall provide approval or denial of authorization in accordance with **Section VI.**, Grievance and Appeal System, **Sub-Section H.**, Expedited Resolution of Plan Appeals, **Item 3.**, for out-of-network use of non-emergency services through the assignment of a prior authorization number, which refers to and documents the approval. The Dental Plan shall provide written follow-up documentation of the approval to the non-participating provider within one (1) business day after the approval.
- f. Dental Plans may utilize a national standardized set of criteria or other evidence-based guidelines approved by the Agency to approve services. Such criteria and guidelines shall not solely be used to deny, reduce, suspend, or terminate a good or service, but may be used as evidence of generally accepted medical practices that support the basis of a medical necessity determination.

2. Utilization Management Program Description

The UM program shall comply with 42 CFR Parts 438 and 456 (as applicable), reflected in a written Utilization Management Program Description, and include, but not be limited to:

- a. Procedures to ensure consistent application of the review criteria for authorization decisions.
- b. Procedures for identifying patterns of over-utilization and under-utilization of services and for addressing potential problems identified as a result of these analyses;
- c. Procedures for reporting fraud and abuse information identified through the UM program to the Agency's MPI as described in **Section IX.**, Administration and Management, and referenced in 42 CFR 455.1(a)(1);
- d. Procedures for enrollees to obtain a second medical opinion at no expense to the enrollee and for the Dental Plan to authorize claims for such services in accordance with 42 CFR 438.236(c) and s. 641.51, F.S.; and
- e. Protocols for prior authorization and denial of services;
- f. The process used to evaluate initial and continuing authorization;

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- g. A detailed description of the Dental Plan's service authorization program for providers, including provider eligibility criteria and services that are included in the program;
- h. Objective evidence-based criteria to support authorization decisions;
- i. Mechanisms to ensure consistent application of review criteria for authorization decisions, including consultation with the requesting provider when appropriate (42 CFR 438.210(b)(1), (2)(i)-(ii), and (3));
- j. Practitioner profiling;
- k. Protocols for retrospective review with procedures for the dental provider or facility to provide electronic records or on-site reviews at the dental practice or facility at no cost to the provider, or to submit hardcopy records to the Dental Plan for a reimbursement rate to be specified in the provider agreement; and
- l. For enrollees with special health care needs determined through an assessment by appropriate qualified individuals (42 CFR 438.208(c)(2)) to need a course of treatment or regular care monitoring, a mechanism in place to allow enrollees to directly access a dentistry specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

3. Service Authorization System

- a. The Dental Plan shall have automated authorization systems, as required in s. 409.967(2)(c)3., F.S. and shall not require paper authorization in addition as a condition for providing treatment.
- b. The Dental Plan's service authorization systems shall provide written notice of all denials, service limitations, and reductions of authorization to providers and enrollees. (42 CFR 438.210(c).)
- c. The Dental Plan's service authorization systems shall provide the authorization number and effective dates for authorization to providers and non-participating providers.
- d. The Dental Plan shall not require service authorization for preventive dental services, tooth re-implantation, stainless steel crowns, and extractions (simple and surgical) for enrollees under the age of twenty-one (21) years when the service is provided by a participating provider. The Dental Plan may require service authorization for preventive dental services rendered by a non-participating provider.
- e. The Dental Plan shall not delay service authorization if written documentation is not available in a timely manner. However, the Dental Plan is not required to approve claims for which it has received no written documentation.
- f. The Dental Plan shall provide the Agency with prior authorization denial data, upon request by the Agency and in a format specified by the Agency,

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- g. See **Section I.**, General Overview, **Sub-Section D.**, Prioritizing Provider Recruitment, Retention, and Training, **Item 2.**, Reducing Administrative Barriers to Participation of Dental Providers, **Sub-Item a.**, Gold Card Program for High-Quality Providers, for enhanced provisions on the Dental Plan's Gold Card requirements.

4. Practice Guidelines/Evidence-based Criteria

- a. The Dental Plan shall adopt practice guidelines that meet the following requirements (42 CFR 438.236(c):
 - (1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field; (42 CFR 438.263)
 - (2) Consider the needs of the enrollees; (42 CFR 438.236(b)(2))
 - (3) Are adopted in consultation with providers; (42 CFR 438.236(b)(3)) and
 - (4) Are reviewed and updated periodically, as appropriate. (42 CFR 438.236(b)(4))
- b. The Dental Plan shall disseminate any revised practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees. (42 CFR 438.236(c))
- c. The Dental Plan shall ensure consistency with regard to all decisions relating to UM, enrollee education, covered services, and other areas to which the practice guidelines apply. (42 CFR 438.236(d))
- d. If the Dental Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Dental Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C.

5. Clinical Decision-Making

- a. The Dental Plan shall ensure that all decisions to deny a service authorization request, or limit a service in amount, duration or scope that is less than requested, must be:
 - (1) Made by a licensed dentist, or other professional as approved by the Agency, who has the appropriate clinical expertise in treating the enrollee's condition or disease (42 CFR 438.210(b)(3)); and
 - (2) Determined using the acceptable standards of care, state and federal laws, the Agency's medical necessity definition, and clinical judgment of a licensed dentist, or other professional as approved by the Agency.
- b. Inter-Rater Reliability
 - (1) The Dental Plan shall conduct inter-rater reliability audits on all clinical

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professionals who review service authorization requests under this Contract. The Dental Plan shall audit for consistency in decisions, which account for state and federal Medicaid requirements (e.g., EPSDT). At a minimum, the Dental Plan shall monitor one percent (1%) of service authorization decisions per reviewer per quarter.

- (2) Each clinical reviewer must maintain an eighty-five percent (85%) accuracy rate.
- (3) The Dental Plan shall submit a quarterly report of the results of the inter-rater reliability audit to the Agency as specified in **Section XV.**, Accountability, and the *Statewide Medicaid Managed Care Plan Report Guide*.

6. Service Authorization Standards for Decisions

- a. The Dental Plan shall notify the provider and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 CFR 438.210(c); 42 CFR 438.404)
- b. The Dental Plan shall comply with the following standards, measured on a monthly basis, for notifying providers and enrollees in a timely manner for:
 - (1) Standard Authorization Decisions
 - (a) The Dental Plan shall provide standard authorization decisions within no more than seven (7) days following receipt of the request for service. (42 CFR 438.210(d)(1))
 - (b) The Dental Plan may extend the timeframe for standard authorization decisions up to four (4) additional days, if the enrollee or the provider requests extension, or the Dental Plan justifies the need for additional information and how the extension is in the enrollee's interest.
 - (2) Expedited Authorization Decisions
 - (a) The Dental Plan shall provide expedited authorization decisions no later than two (2) days after receipt of the request for service. (42 CFR 438.210(d)(2))
 - (b) The Dental Plan may extend the timeframe for expedited authorization decisions by up to one (1) additional day if the enrollee or the provider requests an extension or if the Dental Plan justifies the need for additional information and how the extension is in the enrollee's interest.
- c. The Dental Plan shall submit a monthly report of the timeliness standards specified above to the Agency as specified in **Section XV.**, Accountability, and the *Statewide Medicaid Managed Care Plan Report Guide*.

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- d. If the Dental Plan extends the timeframe for a service authorization decision, in which case it shall:
 - (1) Notify the enrollee of the reason for extending the timeframe and advising of the right to file a grievance if the enrollee disagrees with the extension of time;
 - (2) Issue and carry out its determination as expeditiously as possible but no later than the date the extension expires; and
 - (3) Send notice of the extension to the enrollee within five (5) business days of determining the need for an extension.

- e. The Dental Plan shall submit a monthly report to the Agency on the outcome of service authorization decisions as specified in **Section XV.**, Accountability, and the *Statewide Medicaid Managed Care Plan Report Guide*. At a minimum, the standards that shall be measured include:
 - (1) Number of service authorization requests received.
 - (2) Number and percentage of service authorization requests partially approved (this includes requests for continued authorization that were reduced).
 - (3) Number and percentage of service authorization requests denied (in whole).
 - (4) Number and percentage of requests referred to a dentist.
 - (5) Number and percentage of requests that required a peer-to-peer review.
 - (6) Number and percentage of requests that required an extension in order to request/receive additional information.

7. Changes to Utilization Management Components

- a. The Dental Plan shall obtain written approval from the Agency for its service authorization protocols and any changes.

- b. The Dental Plan shall provide no less than sixty (60) days' written notice to the Agency before making any changes to the administration and/or management procedures and/or authorization, denial, or review procedures, including any delegations, as described in this Section.

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Section VI. Grievance and Appeal System

Section VI. Grievance and Appeal System

A. General Provisions

1. The Dental Plan shall establish and maintain a grievance and appeal system for reviewing and resolving enrollee complaints, grievances, and appeals. Components must include a complaint process, a grievance process, a single plan appeal process, access to an applicable review outside of the Dental Plan, and access to a Medicaid Fair Hearing. (s. 641.511, F.S.; 42 CFR 431, Subpart E; 42 CFR 438, Subpart F; and Rule 59G-1.100, F.A.C.)
2. The Dental Plan shall ensure that all decisions on grievances and appeals are made by health care professionals in accordance with 42 CFR 438.406(b).
3. The Dental Plan shall refer all enrollees who are dissatisfied with the Dental Plan or its activities to the Dental Plan's grievance and appeal system. In accordance with **Section IV.**, Enrollee Services, the Dental Plan shall assist the enrollee in completing forms and following the procedures for filing a grievance or plan appeal or requesting a Medicaid Fair Hearing.
4. Upon request, the Dental Plan shall provide the enrollee and his or her authorized representative the Dental Plan enrollee record, including all dental records and any other documents and records considered or relied upon by the Dental Plan regarding a plan appeal, Medicaid fair hearing for Medicaid enrollees or State review for Title XXI MediKids enrollees and Title XXI CMS Health Plan enrollees, including the opportunity before and during the plan appeal or hearing process for the enrollee or an authorized representative to examine the record. The Dental Plan shall provide such records free of charge, within seven (7) calendar days of request. (42 CFR 438.406(b)(5))
5. The Dental Plan shall maintain a complete and accurate record of all complaints, grievances, and plan appeals. The Dental Plan shall maintain and make complaint, grievance, and plan appeal records available upon request of the Agency and CMS. (42 CFR 438.416(c))
 - a. The Dental Plan shall address, log, track, and trend all complaints, regardless of the degree of seriousness or whether the enrollee or provider expressly requests filing the concern.
 - b. The record of each grievance and appeal must contain, at a minimum, the information specified in 42 CFR 438.416(b)(1)-(6) and additional information as specified in the *Managed Care Plan Report Guide*.
6. The Dental Plan shall report on complaints, grievances, and plan appeals to the Agency as specified in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*, and in the manner and format determined by the Agency. (42 CFR 438.416(a))

B. Use of Independent Review Organization

1. The Dental Plan may elect to have all its unresolved grievances and plan appeals subject to external review processes by an independent review organization.

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2. The Dental Plan shall notify the Agency in writing if it elects to have all its plan appeals subject to such external review.

C. Process for Complaints

1. The Dental Plan shall resolve complaints by close of business on the business day following receipt .
2. If a complaint is not resolved within one (1) business day following receipt, the Dental Plan shall enter the complaint as a grievance by close of business the following day.

D. Process for Grievances

1. An enrollee may file a grievance with the Dental Plan, orally or in writing at any time. (42 CFR 438.402(c)(2)(i); 42 CFR 438.402(c)(3)(i))
2. The Dental Plan's process for handling enrollee grievances must include acknowledgement in writing within five (5) business days of receipt of each grievance. (42 CFR 438.406(b)(1); 42 CFR 438.406(a))
3. The Dental Plan shall review the grievance and provide written notice of results to the enrollee, as expeditiously as the enrollee's health condition requires, no later than thirty (30) calendar days from the date the Dental Plan receives the grievance. (42 CFR 438.408(a) and (b)(1))
4. The Dental Plan shall extend the timeframe for a grievance resolution up to fourteen (14) calendar days if the enrollee asks for an extension, or the Dental Plan documents that additional information is needed and the delay is in the enrollee's interest (42 CFR 438.408(c)(1)(i)-(ii); 438.408(b)(1)).
 - a. If the timeframe is extended other than at the enrollee's request, the Dental Plan shall provide the following notices to the enrollee:
 - (1) Oral notice of the reason for the delay by close of business on the day of the determination; and
 - (2) Written notice of the reason for the delay and the enrollee's right to file a grievance if he or she disagrees with the Dental Plan's decision to extend the timeline within two (2) calendar days of the determination.
 - (3) Written notice of extended grievance resolution must be provided to the provider within forty-four (44) calendar days of receipt.
 - b. If notified by the Agency of an enrollee's request for a for cause plan change pursuant to Rule 59G-8.600, F.A.C., the Dental Plan shall complete the grievance process within a timeframe prescribed by the Agency in accordance with 42 CFR 438.56(e). If the Dental Plan fails to provide the Agency with the outcome of the grievance process

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within the Agency-prescribed timeframes, the enrollee's request for a For Cause plan change is considered approved.

E. Notice of Adverse Benefit Determination

1. The Dental Plan shall give the enrollee written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or currently authorized under the fee-for-service delivery system or from the enrollee's immediate former Dental Plan at the time of the enrollee's transition into the Dental Plan. The Dental Plan shall provide the enrollee with a written notice of adverse benefit determination for any service authorization decisions, using the template provided by the Agency (42 CFR 438.10(c)(4)(ii); 42 CFR 438.404(b); 42 CFR 438.402(b)-(c)).
2. The Dental Plan shall include an identifying number on each notice of adverse benefit determination in a manner prescribed by the Agency.
3. The Dental Plan shall mail the notice of adverse benefit determination as follows:
 - a. For termination, suspension or reduction of previously authorized Medicaid covered services no later than ten (10) days before the adverse benefit determination is to take effect. (42 CFR 438.404(c)(1); 42 CFR 431.211) Certain exceptions apply under 42 CFR 431.213 and 214;
 - b. By the date of the action when any of the following occur:
 - (1) The enrollee has died;
 - (2) The enrollee submits a signed, dated, written statement requesting service termination that includes information that requires service termination or reduction and indicates that he or she understands that the service termination or reduction will result;
 - (3) The enrollee has been admitted to an institution where he or she is ineligible under the Dental Plan for further services;
 - (4) The enrollee's whereabouts is determined unknown based on returned mail with no forwarding address;
 - (5) The enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth; or
 - (6) The enrollee's dentist or specialty dental provider prescribes a change in the level of dental care.
 - c. For denial of payment, at the time of any adverse benefit determination affecting the clean claim; (42 CFR 438.404(c)(2))
 - d. For service authorization decisions not reached within required timeframes, on the date the timeframes expire. Such failures constitute a denial and are, therefore, an adverse benefit determination.

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4. The Dental Plan may delegate completion and issuance of the notice of adverse benefit determination to a utilization management subcontractor, with approval of the Agency, when the Dental Plan:
 - a. Conducts a comprehensive, quarterly audit of a sample of each delegated subcontractor's notice of adverse benefit determination letters (and associated service authorization decisions). The audit sample shall include ten (10) notices of adverse benefit determination, which shall be expanded to thirty (30) notices if issues are found in the initial sample; and
 - b. Conducts a quarterly review of the delegated subcontractor's adherence to the timeliness standards as established in **Section VII.**, Provider Network and Services, **Sub-Section A.**, Network Adequacy Standards, **Item 6.**, Demonstration of Network Adequacy, **Sub-Item b.**
5. The Dental Plan shall report to the Agency on its service authorization subcontractor monitoring within forty-five (45) days after completion of the reporting quarter, in a manner and format as specified by the Agency in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*.

F. Standard Resolution of Plan Appeals

1. The Dental Plan shall adhere to the following timeframes for processing plan appeals:
 - a. An enrollee, authorized representative or, if the enrollee is deceased, the legal representative of the estate may file a plan appeal orally or in writing within sixty (60) calendar days from the date on the notice of adverse benefit determination. (42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii))
 - b. An enrollee, authorized representative, or, if the enrollee is deceased, the legal representative of the estate shall follow an oral appeal with a signed, dated, written appeal within ten (10) calendar days of the oral filing, unless the enrollee requests an expedited resolution. However, oral inquiries seeking to appeal an adverse benefit determination are treated as appeals and shall be confirmed in writing by the Dental Plan unless the enrollee or his or her authorized representative requests expedited resolution. (42 CFR 438.402(c)(3)(ii); 42 CFR 438.406(b)(3))
 - c. The date of oral filing shall constitute the date of receipt.
 - d. The Dental Plan shall acknowledge each plan appeal in writing within five (5) business days of receipt of each plan appeal unless the enrollee requests an expedited resolution. (42 CFR 438.406(b)(1); 42 CFR 438.406(a))
 - e. The Dental Plan shall ensure that enrollees who are disenrolled and wish to file an appeal have the opportunity to do so. All enrollees shall be afforded the right to file an appeal on disenrollment except for the following reasons:
 - (1) Moving out of the region;
 - (2) Loss of Medicaid eligibility;
 - (3) Determination that an enrollee is in an excluded population, as defined in this

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Contract; or

- (4) Enrollee death.
- f. The Dental Plan shall continue and pay for the enrollee's benefits during the plan appeal if all of the following occur:
 - (1) The enrollee or the enrollee's authorized representative files the request for a plan appeal timely in accordance with 42 CFR 438.402(c)(2)(ii).
 - (2) The plan appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
 - (3) The services were ordered by an authorized provider;
 - (4) The period covered by the original authorization has not expired at the time the plan appeal was filed; and
 - (5) The enrollee timely files for continuation of benefits, including those services previously authorized under the fee-for-service delivery system or by the enrollee's immediate former Dental Plan.
- g. If, at the enrollee's request, the Dental Plan continues or reinstates the benefits while the plan appeal is pending, the benefits must continue until one (1) of the following occurs:
 - (1) The enrollee withdraws the plan appeal; or
 - (2) The enrollee fails to request a fair hearing and continuation of benefits within ten (10) calendar days after the Dental Plan sends the notice of plan appeal resolution that is not wholly in the enrollee's favor.
- h. The Dental Plan shall provide the enrollee with a reasonable opportunity to present evidence and testimony and make allegations of fact or law in person as well as in writing. (42 CFR 438.406(b)(4))
- i. The Dental Plan shall pay for disputed services received by the enrollee while the appeal was pending. The Dental Plan may require the enrollee to pay for the cost of those benefits if the Medicaid Fair Hearing upholds the Dental Plan's appeal resolution.
- j. If the final resolution of the plan appeal is adverse to the enrollee, the Dental Plan may recover the cost of services furnished to the enrollee while the plan appeal was pending to the extent they were furnished solely because of the requirements for continuation of benefits.
- k. For resolution, a plan appeal shall be heard, and notice of plan appeal resolution shall be sent to the enrollee no later than thirty (30) calendar days from the date the Dental Plan receives the plan appeal.

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- l. If the Dental Plan fails to adhere to the notice and timing requirements for resolution of the plan appeal, the Dental Plan shall give notice on the date that the timeframes expire. In such cases, the enrollee is deemed to have completed the Dental Plan's appeals process, and the enrollee may initiate a Medicaid fair hearing. (42 CFR 438.408; 42 CFR 402(c)(1)(i)(A))
- m. The Dental Plan shall consider as parties to the plan appeal the enrollee or an authorized representative or, if the enrollee is deceased, the legal representative of the estate. (42 CFR 438.406(b)(6))

G. Extension of Plan Appeal

- 1. The timeframe for a plan appeal may be extended up to fourteen (14) calendar days if the enrollee asks for an extension, or the Dental Plan documents that additional information is needed and the delay is in the enrollee's interest. (42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2))
- 2. If the timeframe is extended other than at the enrollee's request, the Dental Plan must provide oral notice of the reason for the delay to the enrollee by close of business on the day of the determination, and written notice of the reason for the delay to the enrollee within two (2) calendar days of the determination. (42 CFR 438.408(c)(2)(i)-(iii); 42 CFR 438.408(b)(2))
- 3. Written notice of extended appeal resolution must be provided to the provider within forty-four (44) calendar days of receipt.

H. Expedited Resolution of Plan Appeals

- 1. The Dental Plan shall have an expedited review process for plan appeals for use when taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain or regain maximum function. (42 CFR 438.410(a))
- 2. The Dental Plan shall resolve each expedited plan appeal and provide written notice to the enrollee, as quickly as the enrollee's health condition requires, within State established timeframes not to exceed forty-eight (48) hours after the Dental Plan receives the plan appeal request, whether the plan appeal was made orally or in writing.
- 3. The Dental Plan shall inform the enrollee of the limited time available to present evidence and allegations of fact or law, in the case of expedited plan appeal resolution, and ensure that the enrollee understands any time limits that shall apply.
- 4. If the Dental Plan denies the request to expedite the plan appeal, it shall immediately transfer the plan appeal to the timeframes for standard resolution and so notify the enrollee. (42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2); 42 CFR 438.410(c))
- 5. If an enrollee asks for an extension, the Dental Plan shall treat the request as a denial to expedite the plan appeal, immediately transfer the plan appeal to the timeframe for standard resolution, and so notify the enrollee. Nothing in this Section relieves the plan of its obligation to resolve the enrollee's appeal as expeditiously as the enrollee's health condition requires, in accordance with 42 CFR 438.408(b)(2).

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6. In the case where the Dental Plan denies a request to expedite the plan appeal, the Dental Plan shall also provide oral notice to the enrollee by close of business on the day of resolution, and written notice to the enrollee within two (2) calendar days of the disposition.

I. Notice of Plan Appeal Resolution

1. The Dental Plan shall provide the enrollee with a written notice using the notice of plan appeal resolution template provided by the Agency (42 CFR 438.10(c)(4)(ii)).
2. The Dental Plan shall include on the notice a unique identifying number, corresponding to the number on the notice of adverse benefit determination that gave rise to the plan appeal.

J. Process for Medicaid Fair Hearings (for Medicaid Enrollees)

1. The Dental Plan shall comply with Rule 59G-1.100, F.A.C., and all terms and conditions set forth in any orders and instructions issued by the Office of Fair Hearing or a hearing officer.
2. A Medicaid enrollee may request a Medicaid Fair Hearing after completing the Dental Plan's appeal process. A Medicaid enrollee has completed the plan appeal process after receiving a notice of plan appeal resolution indicating that the Dental Plan is upholding, in whole or in part, the adverse benefit determination or after the Dental Plan fails to adhere to the notice and timing requirements applicable to plan appeals. (42 CFR 438.402(c)(1); 42 CFR 438.408)
3. A Medicaid enrollee, or his or her authorized representative, who has completed the Dental Plan's appeal process shall file for a Medicaid Fair Hearing in accordance with Rule 59G-1.100, F.A.C.
4. Parties to the Medicaid Fair Hearing include the Dental Plan as well as the Medicaid enrollee, or the enrollee's authorized representative.
5. The Dental Plan shall attend fair hearings as scheduled. The Dental Plan shall attend hearings with the necessary witnesses and evidentiary materials.
6. The Dental Plan shall submit an evidence packet to the Agency and to the enrollee, free of charge, within ten (10) business days from the time the Dental Plan receives notification of the hearing and must be submitted to the Agency in accordance with any prehearing instructions. The evidence packet must include all necessary documents including the statement of matters (or, alternatively, the denial letter) and any medical records or other documents/records considered or relied upon by the Dental Plan, supporting the Dental Plan's adverse benefit determination and plan appeal resolution.
7. Within two (2) business days of notification of the fair hearing request, the Dental Plan shall provide the corresponding Notice of Adverse Benefit Determination and the Notice of Plan Appeal Resolution that relate to the fair hearing request to the Agency. (42 CFR 438.228(b))

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8. The Dental Plan shall designate an email address with the Agency for Health Care Administration Office of Fair Hearings for all fair hearing-related communications from the Office and any party to the fair hearing.
9. The Dental Plan shall continue the enrollee's benefits while the fair hearing is pending if the enrollee timely files for continuation of benefits within ten (10) calendar days after the Dental Plan sends the notice of plan appeal resolution that is not wholly in the enrollee's favor.
10. If, at the enrollee's request, the Dental Plan continues or reinstates the benefits while fair hearing is pending, the benefits must continue until one (1) of the following occurs:
 - a. The enrollee withdraws the fair hearing request;
 - b. The enrollee fails to request a fair hearing and continuation of benefits within ten (10) calendar days after the Dental Plan sends the notice of plan appeal resolution that is not wholly in the enrollee's favor; or
 - c. The fair hearing office issues a hearing decision adverse to the enrollee.
11. If the Dental Plan's action is sustained by the hearing decision, the Dental Plan may recover the cost of services furnished to the enrollee while the plan appeal and fair hearing were pending, to the extent they were furnished solely because of the requirements for continuation of benefits.
12. If the Dental Plan's action is reversed by the hearing decision and services were not furnished while the plan appeal was pending, the Dental Plan shall authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours from the date the Dental Plan receives the notice reversing the determination.
13. Title XXI MediKids and Title XXI CMS Health Plan enrollees shall be entitled to a State Review in lieu of a Medicaid Fair Hearing. (Rule 59G-14.001, F.A.C.)

K. Appellate Responsibilities

1. Should a Medicaid enrollee appeal a Medicaid Fair Hearing final order to the appropriate DCA or Florida Supreme Court, the Dental Plan shall fully participate as a party in the appellate process and shall be responsible for defending both its actions and the Hearing Officer's final order, to the extent that position on appeal is consistent with the rules governing The Florida Bar and Florida law. The Agency shall choose whether or not to participate in the appellate proceeding as a party and/or whether or not to participate in briefing.
2. The Dental Plan shall file all appropriate document(s) with the DCA or Florida Supreme Court to participate in the appeal as a party and defend both its actions and the Hearing Officer's final order to the extent that position on appeal is consistent with the rules governing The Florida Bar and Florida law.

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3. The Dental Plan shall bear all costs associated with completing the record and transmitting it to the DCA or Florida Supreme Court, including transcribing the audio recording of the Medicaid Fair Hearing proceedings. The Dental Plan shall ensure that a copy of the record is provided to all of the following:
 - a. The enrollee, or enrollee's authorized representative;
 - b. The enrollee's attorney, if applicable; and
 - c. The Agency's Appellate Section.
4. The Dental Plan shall contact the Agency's Appellate Section to coordinate the appeal within five (5) business days after receipt of notification that an appeal of a Medicaid Fair Hearing has been filed with the DCA or Florida Supreme Court.
5. The Dental Plan shall provide the Agency's Appellate Section with a copy of its draft brief(s) for review no later than ten (10) business days in advance of the filing deadline(s) set by the DCA or Florida Supreme Court.

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Section VII. Provider Network and Services

Section VII. Provider Network and Services

A. Network Adequacy Standards

1. General Provisions

- a. The Dental Plan shall develop and maintain a provider network that meets the needs of enrollees in accordance with the requirements in **Section VII.**, Provider Network and Services, of this Contract. The Dental Plan shall submit model provider agreement templates to the Agency for review as specified in **Section VII.**, Provider Network and Services.
- b. Pursuant to s. 42 CFR 438.68(b)(1)(i)-(viii), the Dental Plan shall maintain a statewide network of providers in sufficient numbers to meet the network capacity and geographic access standards for each region for services with respect to the applicable Dental Plan.
- c. The Agency shall be responsible for establishing standards and requirements for provider networks, reviewing Dental Plan's provider networks, and monitoring such Dental Plans to ensure provider networks are capable of meeting the needs of their enrollees and are sufficient to serve the number of enrollees in the Dental Plan in accordance with this Contract.
- d. The Dental Plan shall enter into provider agreements with a sufficient number of providers to provide all covered services to enrollees and ensure that each medically necessary covered service is accessible and provided to the enrollee with reasonable promptness (within the meaning of that term as set forth in 42 U.S.C. s. 1396a(a)(8)). (42 CFR 438.3(q)(1) and (3)) The Dental Plan shall take any and all necessary action to ensure that all medically necessary covered services are provided to enrollees with reasonable promptness, including but not limited to the following:
 - (1) Utilizing out-of-network providers (42 CFR 438.206(b)(4)); and
 - (2) Using financial incentives to induce network or out-of-network providers to accept an enrollee as a patient/client and provide all medically necessary covered services with reasonable promptness.
- e. The Dental Plan shall develop and maintain a provider network as required by this Contract and in accordance with 42 CFR 438.68(c).
- f. The Agency reserves the right to change Provider Qualifications and Minimum Network Adequacy Requirements.
- g. The Dental Plan shall perform ongoing monitoring activities, including Agency-prescribed secret shopper activities.
- h. The Dental Plan shall allow each enrollee to choose among participating providers in accordance with 42 CFR 431.51.

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- i. The Dental Plan shall require non-participating providers to coordinate with respect to payment and must ensure that cost to the enrollee is no greater than it would be if the covered services were furnished within the network. (42 CFR 438.206(b)(5))
- j. Dental Plans must maintain sufficient Indian Health Care Providers (IHCPs) in the network to ensure timely access to services available under the Contract for Indian enrollees who are eligible to receive services from such providers, in accordance with the American Recovery and Reinvestment Act of 2009 and 42 CFR 438.14(b), and must permit out-of-network or out-of-state IHCPs to provide covered services and make referrals to network providers for Indian enrollees.

2. Network Capacity and Geographic Access Standards

- a. The Dental Plan shall have sufficient service locations and dental practitioners to provide the covered services as required by this Contract.
- b. The Dental Plan shall have the dental provider capacity to provide covered services to all enrollees, by region, as indicated in this Contract.
- c. The Dental Plan shall provide the services required in this Contract.
- d. The Dental Plan shall provide access in each region for urgent care to a dentist(s) that offers extended office hours (before 8:00 a.m., after 5:00 p.m. in the enrollee's time zone, and on Saturday or Sunday).
- e. Pursuant to 42 CFR 438.68(b)(1)(i)-(viii), the Dental Plan must maintain a region-wide network of dental providers in sufficient numbers to meet the access standards for specific dental services for all Dental Plan enrollees. At a minimum, the Dental Plan shall contract with the providers specified in the Dental Plan Provider Network Standards Table, **Table 4**, below. The Dental Plan shall ensure regional provider ratios and provider-specific geographic access standards for enrollees in urban or rural counties are met and maintained throughout the life of this Contract, as specified in the table. The regional provider ratios shall be based upon one hundred percent (100%) of the Dental Plan's actual monthly enrollment measured at the first of each month, by region.

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TABLE 4 DENTAL PLAN PROVIDER NETWORK STANDARDS TABLE					
	Urban County		Rural County		Regional Provider Ratios
Required Providers	<i>Maximum Time (minutes)</i>	<i>Maximum Distance (miles)</i>	<i>Maximum Time (minutes)</i>	<i>Maximum Distance (miles)</i>	<i>Providers per Enrollee</i>
Primary Dental Providers					
General Dentist	50	35	65	45	1:1,500
Dentistry Specialists					
Pediatric Dentist	50	35	65	45	1:3,000
Endodontist	60	50	90	75	1:5,000
Orthodontist	60	50	90	75	1:38,500
Oral Surgeon	60	50	90	75	1:20,600
Facilities*					
Ambulatory Surgical Center	N/A	N/A	N/A	N/A	2:County**
Hospital Outpatient Setting	N/A	N/A	N/A	N/A	2:County

**Each facility must have an Anesthesiologist on staff or under an agreement for sedation.*

***The Dental Plan shall contract with two additional ASCs in a Region for each county in the Region that does not contain two ASCs. In Region A only, the Dental Plan shall contract with ASCs proximally located in bordering states to reach the Region A minimum of 36 ASCs.*

3. Primary Dental Providers

- a. The Dental Plan shall enter into provider contracts with a sufficient number of PDPs providing dental services to ensure adequate accessibility for enrollees of all ages. The Dental Plan shall ensure that PDPs provide services in accordance with this Contract and the Medicaid Dental Services Coverage Policies.
- b. The Dental Plan shall establish and maintain PDP adequacy in accordance with **Table 4**, Dental Plan Provider Network Standards Table. The Dental Plan may increase the PDP General Dentist ratio by five hundred (500) enrollees for each licensed dental hygienist affiliated with a PDP General Dentist providing dental services. However, this increase is limited to two (2) licensed dental hygienists per dentist.
- c. The Dental Plan shall ensure PDP and General Dentist practices in the Dental Plan's network have after hours availability on the weekend or extended hours for non-emergency dental services in accordance with **Item 8.**, Network Adequacy Measures, of this **Sub-Section**. If the Dental Plan fails to comply with the requirements of this

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provision, the Dental Plan may be subject to liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

4. Specialists and Other Providers

- a. The Dental Plan shall contract with a sufficient number of specialists providing specialty dental services to ensure adequate accessibility for enrollees of all ages. The Dental Plan shall ensure that specialists provide services in accordance with this Contract and the Medicaid Dental Services Coverage Policies.
- b. The Dental Plan shall establish and maintain specialist adequacy in accordance with **Table 4**, Dental Plan Provider Network Standards Table.
- c. The Dental Plan shall ensure PDPs and Pediatric Dentist practices in the Dental Plan's network must offer after hours availability on the weekend or extended hours for non-emergency dental services in accordance with **Item 8.**, Network Adequacy Measures, of this **Sub-Section**. If the Dental Plan fails to comply with the requirements of this provision, the Dental Plan may be subject to liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.
- d. The Dental Plan shall ensure the availability of specialists, including periodontics and prosthodontics on at least a referral basis. The Dental Plan shall determine when exceptional referrals to non-participating specialty-qualified providers are needed to address any unique dental needs of an enrollee. Financial arrangements for the provision of such services shall be agreed to prior to the provision of services. The Dental Plan shall develop and maintain policies and procedures for such referrals.
- e. See **Section I.**, General Overview, **Sub-Section E.**, Prioritizing Florida's Vulnerable Citizens, **Item 5.**, Sedation Dentistry, **Sub-Item a.**, for additional provisions related to sedation dentistry requirements.

5. Public Health Providers

- a. The Dental Plan shall enter into provider agreements, as specified in this **Sub-Section**, with public health providers, including:
 - (1) CHDs qualified pursuant to rule 59G-4.055, F.A.C.; and
 - (2) FQHCs qualified pursuant to rule 59G-4.100, F.A.C.
- b. The Dental Plan shall pay without authorization at the rate negotiated between the Dental Plan and the CHD or the Medicaid FFS rate for all authorized claims for preventive dental services provided by the CHD. The Medicaid FFS rate is the standard Medicaid fee schedule rate or the CHD encounter rate as specified by the County Health Department Clinic Rule and the associated Florida Medicaid fee schedule for applicable rates.

The Dental Plan shall not deny claims for services delivered by CHD providers solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred sixty-five (365) days.

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- c. The Dental Plan shall reimburse FQHCs at rates comparable to those rates paid for similar services in the FQHC's community.
- d. The Dental Plan shall make a good faith effort to execute memoranda of agreement with private schools, charter schools, and school districts participating in the certified match program regarding the coordinated provision of school-based dental services pursuant to ss. 1011.70, 409.9071, F.S., 409.908(22), F.S., and 409.9072, F.S.
- e. The Dental Plan shall reimburse health access settings for dental hygiene services provided in accordance with s. 409.906(6), F.S.
- f. The Dental Plan shall reimburse Indian Health Care Providers (IHCPs) at rates comparable to those rates paid for similar services in the IHCPs community.
- g. The Dental Plan shall report quarterly to the Agency in a format specified by the Agency, the payment rates and the payment amounts made to IHCPs for contractual services provided by these entities. When the amount the IHCP receives from the Dental Plan is less than the amount the IHCP would have received under the fee-for-service reimbursement system, the Agency shall comply with 42 CFR 438.14(c)(3).

6. Demonstration of Network Adequacy

The Dental Plan shall submit a provider network file of all participating providers to the Agency or its agent(s) on a weekly basis and at any time upon request of the Agency with sufficient evidence that the Dental Plan has the capacity to provide covered services to all enrollees, as specified in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide* (42 CFR 438.207(b)(1)):

- a. Maintains a region-wide network of providers offering an appropriate range of services in sufficient numbers to meet the access standards established by the Agency; and
- b. Maintains a sufficient number, mix and geographic distribution of providers, including providers who are accepting new Medicaid patients as specified in s 1932(b)(5) of the Social Security Act, as enacted by s 4704(a) of the Balanced Budget Act of 1997.

7. Timely Access Standards

- a. The Dental Plan shall contract with and maintain a provider network sufficient to comply with timely access standards as specified in this Contract.
- b. In accordance with 42 CFR 438.206(c)(1), the Dental Plan shall establish mechanisms to ensure network providers comply with timely access requirements, monitor regularly to determine compliance, and take corrective action if there is a failure to comply.
- c. The Dental Plan shall ensure that PDP services and referrals to participating dentistry specialists are available on a timely basis, as follows:
 - (1) Urgent care services – within twenty-four (24) hours of a request for services that

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do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization;

- (2) Routine Sick Patient Care – within seven (7) days;
 - (3) Primary Dental Care – within thirty (30) days; and
 - (4) Follow-up Dental Services – within thirty (30) days after assessment.
- d. Quarterly, the Dental Plan shall review a statistically valid sample of average appointment wait times to ensure services are in compliance with this **Sub-Section A.**, above and report the results to the Agency as specified in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*. (42 CFR 438.206(c)(1)(iv), (v), and (vi))

8. Network Adequacy Measures

- a. The Dental Plan shall collect regional data on the following measures in order to evaluate its provider network and to ensure that the covered services are reasonably accessible.
- b. The Dental Plan shall comply with the regional standards for each measure as specified in **Table 4**, Provider Network Provider Standards, in this **Section**.
- c. The Dental Plan shall submit the results of the network adequacy standards specified in the Dental Program Provider Network Standards Table, **Table 5**, below to the Agency quarterly as specified in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*.
- d. The Agency reserves the right to require Statewide Medicaid Dental Plans to collect data and report results on additional network adequacy standards.

TABLE 5										
DENTAL PROGRAM PROVIDER NETWORK STANDARDS										
Measure:	Standard	Region								
		A	B	C	D	E	F	G	H	I
The percentage of Primary Dental Providers that offer office hours between 8:00 a.m. and 5:00 p.m. in the enrollee’s time zone, Monday through Friday and in addition to these hours, offer additional after-hours appointment availability, as defined in Section XVI. , Definitions and Acronyms.		40	40	45	45	45	40	45	45	45
The percentage of Primary Dental Providers that offer weekend appointment availability (Saturday and/or Sunday)		20	30	40	40	40	30	25	40	40

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9. Waiver

- a. If the Dental Plan is unable to demonstrate network adequacy for either timely or geographic access standards and provides evidence that a certain provider(s) is not available to meet the network standard, the Dental Plan may submit a waiver request for review and approval by the Agency. The Dental Plan shall augment its network as such providers become available in order to meet the network adequacy requirements.
- b. The Dental Plan shall submit a waiver request in a manner and format approved by the Agency.
- c. Nothing in this **Section** relieves the Dental Plan of its obligation to provide adequate and timely access to medically necessary services for its enrollees with reasonable promptness.

B. Network Management

1. General Provisions

- a. The Dental Plan shall develop and maintain procedures to evaluate the Dental Plan's provider network to ensure that covered services are available and accessible, at a minimum, in accordance with the access standards in this Contract. (42 CFR 438.207(b); 42 CFR 438.206)
- b. If the Dental Plan declines to include individual or group providers in its provider network, the Dental Plan shall provide written notice to the affected provider(s) of the reason for its decision. (42 CFR 438.12(a)(1))
- c. The Agency shall contract with an independent vendor to conduct network adequacy reviews for the purpose of auditing provider networks, including, but not limited to, conducting secret shopper activities and other activities to verify provider networks as identified by the Agency. The vendor will conduct systematic and continuous testing of the provider network databases maintained by the Dental Plan to confirm accuracy, confirm that providers are accepting enrollees, and confirm that enrollees have access to services, and provide the Agency with analytics, dashboard, and other reports as determined by the Agency. Payments shall include compensation of the vendor and necessary attendant administrative costs of the Agency directly related to the audit activities.
 - (1) The Dental Plan shall pay to the Agency the expenses of the Agency's network review vendor at the rates established by the Agency proportionate to the Dental Plan's enrolled population.
 - (2) The Dental Plan shall pay the Agency within twenty-one (21) days after presentation by the Agency of the detailed account of the charges and expenses.
 - (3) The Dental Plan's failure to pay the Agency shall result in liquidated damages as specified in **Section XIII.**, Liquidated Damages.

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2. Annual Network Development Plan

- a. The Dental Plan shall develop and maintain an annual network development plan. The Dental Plan shall submit this plan by September 1 of each Contract year to the Agency.
- b. The Dental Plan's annual network development plan shall include:
 - (1) The Dental Plan's processes and methods to develop, maintain, and monitor an appropriate provider network that is sufficient to provide adequate access to all services covered under this Contract.
 - (2) A descriptive analysis of provider reasons for declining to join or departing the Dental Plan's provider network during the Contract year, including the number of providers, provider reasons identified, and actionable strategies to address provider reasons.
 - (3) A description of network design by region and county for each population served by the Dental Plan.
 - (4) The Dental Plan's processes to monitor and reduce the appointment no-show rate for PDPs. As best practices are identified, the Agency shall require implementation by the Dental Plan. This information shall be provided to the Dental Plan during the readiness review process.
 - (5) See **Section I.**, General Overview, **Sub-Section D.**, Prioritizing Provider Recruitment, Retention, and Training, **Item 2.**, Reducing Administrative Barriers to Participation of Dental Providers, **Sub-Item a.**, for additional provisions related to the provider Gold Card program.
- c. The Dental Plan's annual network development plan shall include a description or explanation of the current status of the network by each covered service at all levels, including:
 - (1) Immediate short-term interventions to address network gaps, including the process for enrollees to access services;
 - (2) Long-term interventions to resolve network gaps and an evaluation of the effectiveness of those interventions to resolve network gaps and barriers;
 - (3) Methods for accessing a non-participating provider to address any potential gaps, including a description of the Dental Plan's provider outreach strategy;
 - (4) The extent to which the Dental Plan utilizes teledentistry services to resolve network gaps;
 - (5) Ongoing activities for network development, including network management functions delegated to subcontractors.

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- d. The Dental Plan’s annual network development plan shall include an organizational flowchart that outlines relationships between internal departments, including all committees and committee membership, by department/area, where this coordination occurs.
- e. The Dental Plan’s annual network development plan shall include the results of “secret shopper” activities, including those prescribed by the Agency, and how those results are used to monitor and maintain the provider network.
- f. The Dental Plan’s annual network development plan shall include a description of coordination with provider associations and other outside organizations.
- g. The Dental Plan’s annual network development plan shall include a description of the overall monitoring strategy of subcontractors delegated for network management functions, including how those monitoring results are used to ensure continuous oversight across all provider network functions between the Dental Plan and its subcontractors.
- h. The Dental Plan’s annual network development plan shall include updates on the strategies proposed in the prior year’s plan including an explanation of the method used to evaluate the network and reference to the success of proposed interventions and/or the need for re-evaluation.
- i. In addition to the above provisions, see **Section I.**, General Overview, **Sub-Section D.**, Prioritizing Provider Recruitment, Retention, and Training, **Item 2.**, Reducing Administrative Barriers to Participation of Dental Providers, **Sub-Item b.**, Dental Provider Network Requirements, for additional provisions related to the provider network.
- j. The Dental Plan’s annual network development plan shall include a description or explanation of the current status of the network by each covered service at all levels, including:
 - (1) The assistance and communication tools provided to PDPs when they refer enrollees to dentistry specialists and the methods used to communicate the availability of this assistance to the providers;
 - (2) Providers having a sedation permit (moderate sedation, general anesthesia, or pediatric moderate sedation); and
 - (3) Specialty Providers.
- k. In addition to the above provisions, see **Section I.**, General Overview, **Sub-Section D.**, Prioritizing Provider Recruitment, Retention, and Training, **Item 2.**, Reducing Administrative Barriers to Participation of Dental Providers, **Sub-Item a.**, Gold Card Program for High-Quality Providers, for provider Gold Card program requirements.

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3. Regional Network Changes

- a. The Dental Plan shall have procedures to address changes in the Dental Plan network that negatively affect the ability of enrollees to access services, including access to a culturally diverse provider network.
- b. The Dental Plan shall provide the Agency with documentation of compliance with access requirements at any time there has been a significant change in the Dental Plan's regional network that would affect adequate capacity and services.
- c. The Dental Plan shall notify the Agency within seven (7) business days of any adverse changes to its regional provider network, of any change that would cause more than five percent (5%) of enrollees in the region to change the location where services are received or rendered.
- d. In addition to the requirements of **Section VII.**, Provider Network and Services, **Sub-Section B.**, Network Management, the Dental Plan shall notify the Agency within seven (7) business days of a decrease in the total number of PDPs by more than five percent (5%).

C. Provider Credentialing and Contracting

1. General Provisions

- a. The Dental Plan shall be responsible for the credentialing and recredentialing of its provider network.
- b. If the Dental Plan has delegated credentialing and/or recredentialing to a subcontractor, the agreement must ensure that all providers are credentialed in accordance with the Dental Plan's and the Agency's credentialing requirements as found in **Section VII.**, Provider Network and Services, **Sub-Section C.**, Provider Credentialing and Contracting.
- c. The Agency reserves the right to require the Dental Plan to utilize the Agency's provider enrollment and/or credentialing vendor in coordinating for Dental Plan on-boarding and credentialing. The FX Provider Enrollment System includes a streamlined credentialing process in which the Dental Plan is required to participate to lower the administrative burden to providers.
- d. The Dental Plan shall participate in workgroups with other Dental Plans, the Agency, and additional stakeholders to focus on reducing program redundancies in the provider on-boarding process.
- e. If the Dental Plan fails to comply with the requirements of this Section, the Dental Plan may be subject to sanctions pursuant to Section XII., Sanctions and Corrective Action Plans, or liquidated damages pursuant to Section XIII., Liquidated Damages, as determined by the Agency.

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2. Credentialing and Recredentialing

- a. The Dental Plan shall ensure that all providers are eligible for participation in the Medicaid program, consistent with provider disclosure, screening, and enrollment requirements. (42 CFR 455.100-106; 42 CFR 455.400-470)
- b. The Dental Plan shall obtain and maintain a contractual relationship with CAQH for its ProView® product throughout the life of the Contract.
- c. The Dental Plan shall ensure all providers have a current provider agreement with the Agency, as prescribed by the Agency.
- d. The Dental Plan shall fully enroll/on-board all providers it chooses to contract within sixty (60) days. The Dental Plan shall submit the date it receives full and complete provider applications to the Agency on the PNV file. The Agency shall use the Dental Plan's PNV file submissions to monitor compliance with this provision.

If the Dental Plan fails to comply with the requirements of this provision, the Dental Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

- e. The Dental Plan shall require each provider to have an NPI in accordance with s. 1173(b) of the Social Security Act, as enacted by s. 4707(a) of the Balanced Budget Act of 1997. The provider agreement shall require providers to submit all NPI numbers to the Dental Plan. The Dental Plan shall file the providers' NPI numbers as part of its provider network file to the Agency or its agent, as set forth in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*. The Dental Plan need not obtain an NPI from an entity that does not meet the definition of "health care provider" found at 45 CFR 160.103.
- f. The Dental Plan shall deem providers with a valid Limited Enrolled or Fully Enrolled agreement with the Agency as having met all requirements described below:
 - (1) Proof of each provider's current license or authority to do business, including documentation of provider qualifications, as specified in the service-specific policy; if the provider is located in Georgia or Alabama, the provider's license and permit must be current and applicable to the respective state in which the provider is located;
 - (2) No revocation, moratorium, or suspension of the provider's license by the licensing authority in this or any state, if applicable;
 - (3) No sanctions imposed on the provider by Medicare or Medicaid, without proof of reinstatement or other documentation that all obligations under the sanction have been met;

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- (4) Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106); and
 - (5) A level II background check pursuant to s. 409.907, F.S.
- g. In order to receive payment for covered services, non-participating providers must have a Medicaid provider identification number in the FMMIS.
- h. The Dental Plan may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to sixty (60) days but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of the sixty (60)- day period without enrollment of the provider, and notify affected enrollees. [42 CFR 438.602(b)(2)]
- i. The Dental Plan is authorized to recoup any payments made under this Contract if the provider does not successfully complete the credentialing process within sixty (60) days and the delay is not caused by the Dental Plan.
- j. The Dental Plan's credentialing and recredentialing procedures shall be in writing and include the following:
- (1) Formal delegations and approvals of the credentialing process;
 - (2) A designated credentialing committee;
 - (3) Identification of providers who fall under its scope of authority;
 - (4) A process that provides for the verification of the credentialing and recredentialing criteria required under this Contract;
 - (5) Approval of new providers and imposition of sanctions, termination, suspension, and restrictions on existing providers;
 - (6) Identification of quality deficiencies that result in the Dental Plan's restriction, suspension, termination, or sanctioning of a provider.
- k. The Dental Plan shall establish and verify additional provider credentialing and recredentialing.
- l. If a provider is currently suspended or terminated from the Florida Medicaid program whether by contract or sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider. Suspension and termination are described further in Rule 59G-9.070, F.A.C.
- m. The Dental Plan shall submit provider disclosures and notifications to the federal DHHS OIG and to MPI in accordance with ss. 1128, 1156, and 1892, of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1, as described in

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Section IX., Administration and Management, **Sub-Section F.**, Fraud and Abuse Prevention, **Item 6.**, Reporting and Disclosure Requirements.

- n. The Dental Plan's credentialing and recredentialing processes must include verification of the following additional requirements for PDPs:
- (1) Valid Drug Enforcement Administration certificates, where applicable.
 - (2) A good standing report on a site visit survey. For each provider, documentation in the Dental Plan's credentialing files regarding the site survey shall include the following:
 - (a) Evidence that the Dental Plan has evaluated the provider's facilities using the Dental Plan's organizational standards;
 - (b) Evidence that the provider's office meets criteria for access for persons with disabilities and that adequate space, supplies, proper sanitation, smoke-free facilities, and proper fire and safety procedures are in place; and
 - (c) Evidence that the Dental Plan has evaluated the provider's enrollee record keeping practices at each site to ensure conformity with the Dental Plan's organizational standards.
 - (3) An attestation by the provider as to the correctness/completeness of the provider's application.
 - (4) Statement regarding any history of loss or limitation of privileges or disciplinary activity as described in s. 456.039, F.S.
 - (5) A statement from each provider applicant regarding the following:
 - (a) Any physical or behavioral health problems that may affect the provider's ability to provide health care; and
 - (b) Any history of chemical dependency/substance abuse.
 - (6) Current curriculum vitae or completed credentialing application, which includes at least five (5) years of work history.
 - (7) Proof of the provider's medical school graduation, completion of residency or other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency, and other postgraduate training, if applicable.
 - (8) Evidence of specialty board certification, if applicable.

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- o. The Dental Plan shall recredential its providers at least every three (3) years using information from ongoing provider monitoring.

3. Minority Recruitment and Retention Plan

The Dental Plan shall implement and maintain a minority recruitment and retention plan in accordance with s. 641.217, F.S. The Dental Plan shall have procedures for the implementation and maintenance of such a plan. The minority recruitment and retention plan shall be company-wide for all product lines.

4. Prohibition Against Discriminatory Practices

- a. The Dental Plan shall not discriminate with respect to participation, reimbursement, or indemnification as to any participating or nonparticipating provider who is acting within the scope of the provider's license or certification under applicable State law. If the Dental Plan declines to include individual or groups of providers in its provider network, the Dental Plan shall provide written notice to the affected provider(s) of the reason for its decision. (42 CFR 438.12(a)(1))
- b. The Dental Plan shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments. (42 CFR 438.12(a)(2); 42 CFR 438.214(c))
- c. The Dental Plan shall not discriminate or take punitive action against a provider that requests an expedited resolution or supports an enrollee's plan appeal.

5. Provider Agreement Requirements

- a. The Dental Plan shall submit all provider agreement templates for Agency review to determine compliance with Contract requirements. The Dental Plan shall submit to the Agency, upon request, individual provider agreements as required by the Agency. If the Agency determines, at any time, that a provider agreement is not in compliance with a Contract requirement, the Dental Plan shall promptly revise the provider agreement to bring it into compliance. In addition, the Dental Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, and/or liquidated damages pursuant to **Section XIII.**, Liquidated Damages.
- b. The Dental Plan shall ensure all provider agreements comply with Chapter 641.315, F.S., 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106.
- c. All provider agreements and amendments executed by the Dental Plan shall be in writing, signed, and dated by the Dental Plan and the provider, and shall meet the following requirements:
 - (1) Not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient regarding:

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- (a) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - (b) Any information the enrollee needs to decide among all relevant treatment options.
 - (c) The risks, benefits, and consequences of treatment or non-treatment.
 - (d) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. (42 CFR 438.102(a)(1));
- (2) Not prohibit a provider from advocating on behalf of the enrollee in any part of the grievance and appeal system or UM process, or individual authorization process to obtain necessary services; (42 CFR 438.402(c)(1)(i)-(ii); 42 CFR 438.408)
 - (3) Require providers to offer hours of operation that are no less than the hours of operation offered to commercial Dental Plan enrollees or comparable Medicaid FFS recipients if the provider serves only Medicaid recipients (42 CFR 438.206(c)(1));
 - (4) Require providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with special health care needs, including physical or intellectual and developmental disabilities (42 CFR 438.206(c)(3));
 - (5) Specify covered services, including applicable prior authorization requirements, acceptable billing codes, and populations to be served under the provider agreement;
 - (6) Specify the Dental Plan's process and timing for updating its claim processing system when the Agency's fee schedules are updated, whether based upon the effective date or promulgated date of the fee schedule change, and for reprocessing claims;
 - (7) Require providers to meet timely access standards pursuant to this Contract;
 - (8) Require all direct service providers to complete abuse, neglect, and exploitation training, including training to identify victims of human trafficking;
 - (9) Include provisions for the provider to ensure immediate transfer to another provider if the enrollee's health or safety is in jeopardy;
 - (10) Require providers of transitioning enrollees to cooperate in all respects with providers of other Dental Plans to assure maximum health outcomes for enrollees;
 - (11) Provide for continuity of care for the course of treatment in the event a provider agreement terminates during the course of an enrollee's treatment;

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- (12) Require the provider to look solely to the Dental Plan for compensation for services rendered, with the exception of cost sharing and patient responsibility (if applicable);
- (13) For agreements with ambulatory surgical centers, address the method of payment for anesthesiologists practicing in an ambulatory surgical center, whether through direct arrangements between the Dental Plan and the anesthesiologist or by requiring the ASC to reimburse the anesthesiologist, as determined by the Dental Plan;
- (14) Require the provider to participate with the Dental Plan's peer review, grievance, QI, and UM activities, as directed by the Dental Plan;
- (15) Shall provide a rate and process for reimbursement to the provider for medical or dental health record copies requested of the provider subject to retrospective review as permitted in **Section V.**, Service Administration, **Sub-Section H.**, Authorization of Services, **Item 2.**, Utilization Management Program Description. If a rate is not specified in the provider agreement, reimbursement will be made according to the Centers for Medicare & Medicaid Services' (CMS) rate of twelve cents (**\$0.12**) per page or up to fifteen dollars (**\$15**) maximum per record.
- (16) Include the monitoring and oversight activities the Plan shall follow, including monitoring of services rendered to enrollees, by the Dental Plan;
- (17) Identify the measures, metrics, and frequency of measurement that shall be used by the Dental Plan to monitor the quality and performance of the provider;
- (18) Require that any marketing materials related to this Contract that are displayed by the provider be submitted to the Agency for written approval before use;
- (19) Require an adequate record system be maintained for recording services, charges, dates, and all other commonly accepted information elements for services rendered to the Dental Plan's enrollees;
- (20) Require that records be maintained for a period not less than ten (10) years from the close of this Contract and retained further if the records are under review or audit until the review or audit is complete. (42 CFR 438.3(u)) Prior approval for the disposition of records must be requested and approved by the Dental Plan if the provider agreement is continuous;
- (21) Require providers to cooperate fully with the Agency (or its designee), CMS, the OIG, the Comptroller General, and Attorney General's Office for the inspection, evaluation, and auditing of any records or documents (medical or financial) of the Dental Plan or its subcontractors at any time, related to this Contract (42 CFR 438.3(h));
- (22) Require providers to cooperate fully in any investigation by the Agency, MPI, MFCU or other State or federal entity and in any subsequent legal action that shall result from such an investigation involving this Contract;

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- (23) Include the specific reports and clinical information required by the Dental Plan for QI or other administrative purposes out of claims processing;
- (24) Require providers to submit timely, complete, and accurate claims to the Dental Plan in accordance with the requirements of **Section IX.**, Administration and Management, **Sub-Section D.**, Information Management and Systems, at a minimum;
- (25) Require compliance with the background screening requirements of this Contract;
- (26) Require compliance with HIPAA privacy and security provisions (42 CFR 438.224);
- (27) Require providers to submit notice of withdrawal from the network at least ninety (90) days before the effective date of such withdrawal;
- (28) Specify that any provider whose participation is terminated pursuant to the provider agreement for any reason shall utilize the applicable appeals procedures outlined in the provider agreement. No additional or separate right of appeal to the Agency or the Dental Plan is created as a result of the Dental Plan's act of terminating, or decision to terminate, any provider under this Contract.
- (29) Require an exculpatory clause, which survives provider agreement termination, including breach of provider agreement due to insolvency, which assures that neither Medicaid enrollees nor the Agency shall be held liable for any debts of the provider;
- (30) Require that the provider secure and maintain during the life of the provider agreement workers' compensation insurance (complying with the Florida workers' compensation law) for all of its employees connected with the work under this Contract unless such employees are covered by the protection afforded by the Dental Plan;
- (31) Require all providers to notify the Dental Plan in the event of a lapse in general liability or medical malpractice insurance, or if assets fall below the amount necessary for licensure under Florida Statutes;
- (32) Contain a clause indemnifying, defending, and holding the Agency and the Dental Plan's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the provider agreement. This clause must survive the termination of the provider agreement, including breach due to insolvency. The Agency shall waive this requirement for itself, but not Dental Plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the provider is a State agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers shall be approved in writing by the Agency;

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- (33) Specify the process for a network provider to report to the Dental Plan when the network provider has received an overpayment, to return the overpayment to the Dental Plan within sixty (60) days after the date on which the overpayment was identified, and to notify the Dental Plan in writing of the reason for the overpayment; (42 CFR 438.608(d)(2));
- (34) Specify that any contracts or agreements entered into by the provider for purposes of carrying out any aspect of this Contract shall include assurances that the individuals who are signing this Contract or agreement are so authorized and that it includes all the requirements of this Contract; and
- (35) If copayments are waived as an expanded benefit, prohibit the provider from charging enrollees copayments for covered services; and if copayments are not waived as an expanded benefit, require the amount paid to providers shall be the contracted amount, less any applicable copayments.

In addition to the above provisions, see **Section I.**, General Overview, **Sub-Section D.**, Prioritizing Provider Recruitment, Retention, and Training, **Item 2.**, Reducing Administrative Barriers to Participation of Dental Providers, **Sub-Item a.**, Gold Card Program for High-Quality Providers, for provider Gold Card program requirements.

- d. No provider agreement that the Dental Plan enters into with respect to performance under this Contract shall in any way relieve the Dental Plan of any responsibility for the provision of services or duties under this Contract. The Dental Plan shall assure that all services and tasks related to the provider agreement are performed in accordance with the terms of this Contract. The Dental Plan shall identify in its provider agreement any aspect of service that shall be delegated by the provider.
- e. The Dental Plan shall execute provider agreements pending the outcome of the provider enrollment process. The Dental Plan shall terminate a network provider immediately upon notification from the Agency that the network provider cannot be enrolled, or upon expiration of the sixty (60)-day period without enrollment of the provider and notify affected enrollees in accordance with 42 CFR 438.602(b)(2).
- f. The Dental Plan shall include the following additional provisions in its Dental Plan provider agreements:
 - (1) For a DPIP, include a statement that the Dental Plan shall make no specific payment directly or indirectly under a DPIP to a provider as an inducement to reduce or limit, medically necessary services to an enrollee, and that incentive plans shall not contain provisions that provide incentives, monetary or otherwise, for withholding medically necessary care;
 - (2) Require that all providers agreeing to participate in the network as PDPs fully accept and agree to responsibilities and duties associated with the PDP designation;

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- (3) If the provider has been approved by the Dental Plan to provide services through teledentistry, specify that the provider be required to have protocols to prevent fraud and abuse. The provider must implement teledentistry fraud and abuse protocols that address:
 - (a) Authentication and authorization of users;
 - (b) Authentication of the origin of the information;
 - (c) The prevention of unauthorized access to the system or information;
 - (d) System security, including the integrity of information that is collected, program integrity and system integrity; and
 - (e) Maintenance of documentation about system and information usage; and
- (4) For contracts with public health providers, require such providers to contact the Dental Plan before providing dental care services to enrollees and provide the Dental Plan with the results of the office visit, including test results.

6. Network Performance Management

- a. The Dental Plan shall monitor the quality and performance of each participating provider.
- b. The Dental Plan shall monitor participating providers on performance measures specified and collected by the Agency, as well as additional measures agreed upon by the provider and the Dental Plan as documented in the provider agreement.
- c. Except as otherwise provided in this Contract, the Dental Plan shall limit the providers in its network based on credentials, quality indicators, and price.
- d. The Dental Plan shall have procedures for imposing provider sanctions, restrictions, suspensions and/or terminations.
- e. The Dental Plan shall develop and implement an appeal procedure for providers against whom the Dental Plan has imposed sanctions, restrictions, suspensions and/or terminations.

7. Provider Termination and Continuity of Care

- a. The Dental Plan shall comply with all State and federal laws regarding provider termination.
- b. The Dental Plan shall not pay, employ, or contract with individuals on the State or federal exclusions lists.

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- c. At least sixty (60) days before the effective date of the suspension or termination of a provider from the network, unless otherwise specified in this **Section**, the Dental Plan shall:
 - (1) Notify the provider and enrollees that received services from the provider within the past six (6) months; and
 - (2) Provide reason(s) to the Agency of a for-cause termination.
- d. If an enrollee is receiving care from any provider who becomes unavailable to continue to provide services, the Dental Plan shall notify the enrollee in writing within ten (10) days from the date the Dental Plan becomes aware of such unavailability. The requirements to provide notice prior to the effective dates of termination shall be waived in instances where a provider becomes physically unable to care for enrollees due to illness, death, or leaving the enrollee's region of residence and fails to notify the Dental Plan, or when a provider fails credentialing. Under these circumstances, notice shall be issued immediately upon the Dental Plan's becoming aware of the circumstances.
- e. The Dental Plan shall provide immediate notice to the provider, the enrollee, and the Agency in a case in which an enrollee's health is subject to imminent danger or a provider's ability to practice medicine or otherwise provide services is effectively impaired by an action by the Board of Medicine or another governmental agency. The Dental Plan shall develop and implement a plan for transitioning enrollees to another provider.
- f. The Dental Plan shall allow enrollees to continue receiving medically necessary services from a not-for-cause terminated provider and shall process provider claims for services rendered to such enrollees until the enrollees select another provider, for a minimum of sixty (60) days after the termination of the provider's Contract. Notwithstanding the provisions in this **Section**, a terminated provider will refuse to continue to provide care to an enrollee who is abusive or noncompliant.
- g. For continuity of care under this **Section**, the Dental Plan and the terminated provider will continue to abide by the same terms and conditions as existed in the terminated Contract.
- h. The Dental Plan shall report provider terminations, suspensions, and denials, including documentation of enrollee notification and additions as specified in **Section XV.**, *Accountability*, and the *Managed Care Plan Report Guide*.
- i. The Dental Plan shall notify enrollees in accordance with the provisions of this Contract and State and federal law regarding provider termination. (42 CFR 438.10(f)(1))

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D. Provider Services

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1. General Provisions

- a. The Dental Plan shall establish and maintain a formal provider relations function to respond timely and adequately to inquiries, questions, and concerns from participating providers.
- b. The Dental Plan shall provide sufficient information and procedural guidelines to all providers in order to operate in full compliance with this Contract and all applicable federal and State laws and regulations.
- c. The Dental Plan shall monitor provider compliance with Contract requirements and take Contract action when needed to ensure compliance.

2. Provider Handbook and Bulletin Requirements

- a. The Dental Plan shall issue a provider handbook to all providers at the time provider credentialing is complete.
- b. The Dental Plan may choose not to distribute the provider handbook via surface mail, provided it submits a written notification to all providers that explains how to obtain the handbook from the Dental Plan's website and how the provider can request a hard copy from the Dental Plan at no charge.
- c. The Dental Plan shall keep all provider handbooks and bulletins up to date and in compliance with State and federal laws. The provider handbook shall serve as a source of information regarding Dental Plan-covered services, procedures, statutes, regulations, telephone access, and special requirements, to ensure all Contract requirements are met.
- d. The Dental Plan shall provide at least thirty (30) days' advance notice to providers of changes to its provider handbooks that impact service authorization, claims payment, or grievance and appeals processes.
- e. The Dental Plan's provider handbook shall include, at a minimum, the following information:
 - (1) Description of the Medicaid program and the Statewide Medicaid Prepaid Dental Program;
 - (2) Emergency service responsibilities;
 - (3) Provider responsibilities;
 - (4) Requirements regarding background screening;
 - (5) Requirements regarding the recredentialing process;
 - (6) Description of where to obtain service-specific coverage requirements and medical necessity criteria;

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- (7) Description of how to obtain prior authorization and referral procedures, including required forms;
- (8) Information on the Dental Plan's CPIO programs;
- (9) Information on accessing Dental Plan-sponsored training and education opportunities;
- (10) Enrollee record standards for providers;
- (11) Description of where to obtain claims submission protocols and standards, including instructions and all information required for a clean or complete claim;
- (12) Protocols for submitting claims data;
- (13) Requirements regarding marketing activities and marketing prohibitions;
- (14) Procedures that address the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the Dental Plan to file a provider complaint, including complaints about claims issues, and the complaint review process;
- (15) Information on identifying and reporting abuse, neglect, and exploitation of enrollees, including information on identifying victims of human trafficking;
- (16) Enrollee rights and responsibilities (42 CFR 438.100); and
- (17) Required procedural steps in the Dental Plan's enrollee grievance process, including the address, telephone number, and office hours of the grievance staff; the enrollee's right to request continuation of benefits while utilizing the grievance and appeal system in accordance with 42 CFR 438.414; and information about the State review process for Title XXI MediKids enrollees and Title XXI CMS Health Plan enrollees. The Dental Plan shall specify telephone numbers to call to present a complaint, grievance, or appeal on behalf of an enrollee. Each telephone number shall be toll-free within the caller's geographic area and provide reasonable access to the Dental Plan without undue delays.
- (18) Procedures to obtain authorization of any medically necessary service to enrollees under the age of twenty-one (21) years when the service is not listed in the service-specific Florida Medicaid Coverage Policy or the associated Florida Medicaid fee schedule, or is not a covered service of the Dental Plan; or the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.
- (19) Information on accessing dental-related services excluded from coverage under the Dental Plan Contract. (See **Section V.**, Service Administration, **Section D.**, Excluded Services.)
- (20) The Dental Plan's responsibilities; and

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(21) Provider requirements for the use of teledentistry.

- f. The Dental Plan shall disseminate bulletins as needed to incorporate any needed changes to the provider handbook.

3. Provider Education and Training

- a. The Dental Plan shall make available training to all providers and their staff regarding the requirements of this Contract, including any Contract amendments and special needs of enrollees.
- b. The Dental Plan shall conduct initial training within thirty (30) days of placing a newly contracted provider, or provider group, on active status. The Dental Plan also shall conduct ongoing training, as deemed necessary by the Dental Plan or the Agency, in order to ensure compliance with this Contract.
- c. For a period of at least twelve (12) months following the implementation of this Contract, the Dental Plan shall conduct monthly education and training for all provider types identified by the Dental Plan through its monitoring and QI processes, and claims submission and payment processes, which shall include, but not be limited to, an explanation of common claims submission errors and how to avoid those errors. Such a period shall be extended as determined necessary by the Agency.
- d. The Dental Plan shall ensure all participating and direct service providers required to report abuse, neglect, or exploitation of vulnerable adults under ss. 39.201 and 415.1034, F.S., obtain training on these subjects.
- e. The Dental Plan shall conduct outreach, education, and training with PDPs and dentistry specialists on best practices for serving enrollees on the iBudget Waiver or Waitlist as identified by the Agency.
- f. See **Section I.**, General Overview, **Sub-Section D.**, Prioritizing Provider Recruitment, Retention, and Training, **Item 1.**, Investments in Provider Training, for additional provider training provisions.

4. Toll-Free Provider Help Line

- a. The Dental Plan shall operate a toll-free telephone help line to respond to provider questions, comments, and inquiries.
- b. The Dental Plan shall develop provider help line procedures that address personnel hiring and training, staffing ratios, hours of operation, response standards, monitoring of calls via recording or other means, and compliance with additional Dental Plan standards.
- c. The provider help line must be staffed twenty-four hours per day, seven days a week (24/7) to respond to prior authorization requests.

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- d. This provider help line shall have staff to respond to provider questions in all other areas, including but not limited to the provider complaint system and provider responsibilities, between the hours of 8 a.m. and 7 p.m. in the provider's time zone, Monday through Friday, excluding State holidays. The Dental Plan shall ensure that, after regular business hours, the provider help line (not the prior authorization line) is answered by an automated system with the capability to provide callers with information about operating hours and instructions about how to verify enrollment for an enrollee with an emergency or urgent medical condition. This requirement shall not be construed to mean that the provider must obtain verification before providing emergency services and care.
- e. The Dental Plan shall maintain provider call center performance metrics at the following levels throughout the Contract term, measured monthly:
- (1) The Dental Plan shall ensure that at least ninety percent (90%) of calls are answered within thirty (30) seconds. (Service Level)
 - (2) The Dental Plan shall ensure that at least seventy-five percent (75%) of calls are resolved within the first call (without internal hard transfer or soft internal conference call or barge-in). (First Call Resolution)
 - (3) The Dental Plan shall ensure that the average hold time after a call is answered shall not exceed ninety (90) seconds. (Average Hold Time)
 - (4) The Dental Plan shall ensure that the average quality monitoring score resulting from call monitoring of all call center agents must be ninety-five percent (95%) or greater. (Quality Assurance (QA) Monitoring)
 - (5) The Dental Plan shall ensure that the average speed of answer is not to exceed thirty (30) seconds. (Average Speed of Answer (ASA))
 - (6) The Dental Plan shall ensure that the percentage of inbound phone calls made to a call center that are abandoned by the enrollee or their representative before speaking to an agent is no more than three percent (3.0%). (Call Abandonment)
 - (7) The Dental Plan shall ensure that the percentage of calls that are not allowed into the system, as reported by the telecom provider, is no more than 0.5 percent (0.5%). (Blockage Rate – Telecom Provider)
 - (8) The Dental Plan shall ensure that the percentage of calls that make into the system that are forced disconnects, as reported by the ACD reporting software is no more than zero percent (0.0%). (Blockage Rate – System Reported)

If the Dental Plan fails to comply with the requirements of this **Section**, the Dental Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

5. Provider Complaint System

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The Dental Plan shall establish and maintain a provider complaint system that permits a provider to dispute the Dental Plan's policies, procedures, or any aspect of a Dental Plan's administrative functions, including proposed actions, claims/billing disputes, and service authorizations.

- a. The Dental Plan shall not delegate any aspect of the provider complaint system to its subcontractors, unless otherwise specified in the provisions below.
- b. As a part of the provider complaint system, the Dental Plan shall:
 - (1) Have dedicated staff for providers to contact via telephone, electronic mail, regular mail, or in person, to ask questions, file a provider complaint and resolve problems;
 - (2) Identify staff specifically designated to receive and process provider complaints;
 - (3) Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider agreement provisions, collecting all pertinent facts from all parties and applying the Dental Plan's written procedures; and
 - (4) Ensure that Dental Plan executives with the authority to require corrective action are involved in the provider complaint process.
- c. The Dental Plan's process for provider complaints concerning claims issues shall be in accordance with s. 641.3155, F.S. The Dental Plan shall comply with all terms and conditions set forth in any orders and instructions issued by the Agency as a result of the claim dispute resolution process.
- d. For provider complaints concerning non-claims issues, the Dental Plan shall:
 - (1) Allow providers forty-five (45) days from the date the issue occurred to file a complaint for issues that are not about claims;
 - (2) Within three (3) business days of receipt of a complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution;
 - (3) Within thirty (30) days of receipt of a non-claim complaint, document the reason the complaint is unresolved and provide written notice of the status to the provider. Written notice of the status of the complaint must be provided to the provider every thirty (30) days thereafter until the complaint is resolved, using the Notice of Status Letter Template provided by the Agency; and
 - (4) Resolve all complaints within ninety (90) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.
- e. For provider complaints concerning claims issues, the Dental Plan shall:

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- (1) Allow providers ninety (90) days from the date of final determination of the primary payer to file a complaint for claims issues;
 - (2) Within three (3) business days of receipt of a claim complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution;
 - (3) Within thirty (30) days of receipt of a claim complaint, document the reason the complaint is unresolved and provide written notice of the status to the provider. Written notice of the status of the complaint must be provided to the provider every thirty (30) days thereafter until the complaint is resolved, using the Notice of Status Letter Template provided by the Agency.
 - (4) Provide written notice of the status of Agency submitted claim issues to the Agency within fifteen (15) business days of receipt. For Agency-submitted claim issues that require additional time to research, the Dental Plan must submit a written request to the Agency within three (3) business days of receipt of the complaint and shall include:
 - (a) An explanation for the need of an extension; and
 - (b) The expected time needed beyond fifteen (15) days for research and response.Approval of an extension is contingent upon Agency review.
 - (5) Resolve all denied claims complaints within sixty (60) days of receipt, in accordance with s. 641.3155, F.S., and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.
 - (6) Resolve all other claim-related complaints within ninety (90) days from the date of receipt and provide written notice of the disposition, including the basis of the resolution to the provider, within three (3) business days of resolution.
- f. The Dental Plan shall utilize the Agency's contracted dispute resolution vendor, as described in s. 408.7057, F.S., for managing, addressing, and resolving provider complaints related to claims issues. The process shall comply with s. 641.3155, F.S. The Dental Plan shall comply with all terms and conditions set forth in any orders and instructions issued by the Agency as a result of the claim dispute resolution process.
- g. The Dental Plan shall also distribute the provider complaint system procedures, including claims issues, to non-participating providers upon request. The Dental Plan may distribute a summary of these procedures, if the summary includes information about how the provider may access the full procedures on the Dental Plan's website. This summary shall also detail how the provider can request a hard copy from the Dental Plan at no charge.
- h. The Dental Plan shall maintain a complete and accurate record of all complaints and

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shall make such records available upon request of the Agency.

- i. The Dental Plan is prohibited from discriminating or taking punitive action against a provider for making a complaint to the Agency in good faith.
- j. The Dental Plan shall report provider complaints as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

E. Claims and Provider Payment

1. General Provisions

- a. The Dental Plan shall process claims and pay providers in compliance with the federal and State requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., whichever is more stringent.
- b. The Dental Plan shall have claims payment performance metrics, including those for quality, accuracy, and timeliness. The Dental Plan shall also include a process for measurement and monitoring, and for the development and implementation of interventions for improvement in regard to claims processing and claims payment. The Dental Plan shall make documentation of such metrics available for Agency review upon request.
- c. The Dental Plan shall use electronic transmission of claims, transactions, notices, documents, forms, and payments to the greatest extent possible by the Dental Plan.
- d. The Dental Plan shall provide an itemized accounting of the individual claims included in the payment to a provider, including the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement, and the identification of the Dental Plan.
- e. The Dental Plan shall comply with Rule 59G-1.052, F.A.C. with regard to payment of third-party liability and Medicare co-insurance and deductibles for covered services.
- f. The Dental Plan shall not deny Medicare crossover claims solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three (3) years.
- g. The Dental Plan shall not pay for the following:
 - (1) Items or services furnished by an individual or entity during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend payments; (42 CFR 438.608(a)(8); 42 CFR 455.23);
 - (2) Any expenditures related to items or services for which funds shall not be used under the Assisted Suicide Funding Restriction Act of 1997; (s. 1903(i) of the Social Security Act) and

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- (3) Items or services furnished by a provider during a period where the Agency has determined there is reliable evidence of circumstances giving rise to the need for a withholding of payments, which involves, fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients. (s. 409.913(25)(a), F.S.)
- h. The Dental Plan shall incorporate into its claim processing and claims payment system the NCCI editing programs for the HCPCS/CPT codes to promote correct coding and control coding errors, except for allowable NCCI edits exclusions in accordance with the claims processing requirements of 42 CFR 433.116 and 45 CFR 95, subpart F.
- i. For provider network agreements relying on fee-for-service fee schedules, the Dental Plan shall program the new or updated codes in its claim processing systems based upon the effective date of the code change as posted on the Agency's website. The Dental Plan shall pay claims correctly based upon the code effective date to ensure there are no gaps in covered services or payment.
- j. The Dental Plan shall submit an aging claims summary as specified in **Section XV.**, *Accountability*, and the *Managed Care Plan Report Guide*, and in the manner and format determined by the Agency.
- k. For dually eligible enrollees, the Dental Plan shall not require an explanation of benefits prior to payment for services that are not covered by Medicare (e.g., dentures).
- l. The Agency shall ensure that no payment is made to a provider other than by the Dental Plan for services available under this Contract, except when these payments are specifically provided for in Title XIX of the Social Security Act, in 42 CFR Chapter IV, or when the Agency has adjusted the capitation rates paid under this Contract to make payments for graduate medical education. (42 CFR 438.60)
- m. In the event the Agency establishes systems and processes to collect submitted claims data, including denied claims, from the providers directly, the Dental Plan shall be capable of sending and receiving any claims information directly to the Agency in standards and timeframes specified by the Agency within sixty (60) days' notice. The Dental Plan shall also work cooperatively with the Agency during any transition period for network providers to move to submitting claims through the State instead of directly to the Dental Plan.
- n. The Dental Plan shall not deny claims for the provision of emergency services and care submitted by a non-participating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred sixty-five (365) days.
- o. Notwithstanding the requirements set forth for coverage of emergency services and care, the Dental Plan shall approve all claims for emergency services and care by non-participating providers pursuant to the requirements set forth in s. 641.3155, F.S., and 42 CFR 438.114.

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- p. The Dental Plan shall reimburse IHCPs, whether participating in the network or not, for covered managed care services provided to Indian enrollees who are eligible to receive services from the IHCP either at a negotiated rate between the Dental Plan and the IHCP or, if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made to a participating provider which is not an IHCP, in accordance with the American Recovery and Reinvestment Act of 2009 and 42 CFR 438.14(b).
- q. Pursuant to Section 2702 of the ACA, the Florida Medicaid State Plan and 42 CFR 434.6(12) and 447.26, the Dental Plan shall deny payments for other provider-preventable conditions.

2. Timely Claims Payment

- a. For all electronically submitted claims for services, the Dental Plan shall:
 - (1) Within twenty-four (24) hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim.
 - (2) Within fifteen (15) days after receipt of a non-nursing facility/non-hospice claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of denial reasons or codes and additional information or documents necessary to process the claim.
 - (3) Pay or deny the contested claim within ninety (90) days after receipt of the claim. Failure to pay or deny the claim within one hundred twenty (120) days after receipt of the claim creates an uncontestable obligation for the Dental Plan to pay the claim. (s. 641.3155(3)(e), F.S.)
- b. For all non-electronically submitted claims for services, the Dental Plan shall:
 - (1) Within fifteen (15) days after receipt of the claim, provide acknowledgment of receipt of the claim to the provider or designee or provide the provider or designee with electronic access to the status of a submitted claim.
 - (2) Within twenty (20) days after receipt of the claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.
 - (3) Pay or deny the contested claim within one hundred twenty (120) days after receipt of the claim. Failure to pay or deny the claim within one hundred forty (140) days after receipt of the claim creates an uncontestable obligation for the Dental Plan to pay the claim.
- c. The Dental Plan shall comply with the following standards regarding timely claims processing for all providers:
 - (1) The Dental Plan shall pay seventy-five percent (75%) of all clean claims

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submitted within seven (7) days.

- (2) The Dental Plan shall pay one hundred percent (100%) of all clean claims submitted within fifteen (15) days.
- d. The Dental Plan shall reimburse providers for the delivery of authorized services as described in s. 641.3155, F.S., including but not limited to:
 - (1) The provider must mail or electronically transfer (submit) the claim to the Dental Plan within six (6) months after:
 - (a) The date of service or discharge from an inpatient setting; or
 - (b) The date that the non-participating provider was furnished with the correct name and address of the Dental Plan, if applicable.
 - (2) When the Dental Plan is the secondary payer and the primary payer is an entity other than Medicare, the Dental Plan shall require the provider to submit the claim to the Dental Plan within ninety (90) days after the final determination of the primary payer, in accordance with the Medicaid Provider General Handbook. When the Dental Plan is the secondary payer and the primary payer is Medicare, the Dental Plan shall require the provider to submit the claim to the Dental Plan in accordance with timelines established in the Medicaid Provider General Handbook.

3. Accurate Claims Payment

- a. The Dental Plan shall maintain a claim payment accuracy percentage of ninety-five percent (95%) or higher for each measure of accuracy established by the Agency.
- b. The Dental Plan shall submit a claim payment accuracy report as specified in **Section XV.**, *Accountability*, and the *Managed Care Plan Report Guide*, and in the manner and format determined by the Agency.

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Section VIII. Quality

A. Quality Improvement

1. General Provisions

- a. The Dental Plan shall have a Quality Improvement (QI) program that ensures enhancement of quality of care and emphasizes improving the quality of patient outcomes, including establishing metrics for monitoring the quality and performance of each participating provider. The Dental Plan shall evaluate the provider's performance and determine continued participation in the network as specified in **Section VIII.**, Quality.
- b. The Agency shall be responsible for establishing standards and requirements for QI, including performance measures, targets, improvement plans, satisfaction surveys and enrollee record reviews, and providing instructions to Dental Plans through the *Managed Care Plan Report Guide* referenced in **Section XV.**, Accountability, and the Performance Measures Specifications Manual. The Agency shall change these targets and/or change the timelines associated with meeting the targets. The Agency shall make these changes with sixty (60) days' advance notice to the Dental Plan.
- c. The Agency shall be responsible for contracting with an External Quality Review Organization (EQRO) and conducting other QI activities, including but not limited to audits of enrollee records, enrollee plans of care, provider credentialing records, service provider reimbursement records, contractor personnel records, and other documents and files as required under this Contract.
- d. The Agency shall be responsible for establishing incentives to high-performing Dental Plans and take appropriate action in accordance with the terms of this Contract if the Dental Plans do not meet acceptable QI and performance indicators. (42 CFR 438.6(b)).
- e. The Dental Plan shall identify and track adverse incidents and shall review and analyze adverse incidents to identify and address/eliminate potential and actual quality of care and/or health and safety issues. The Dental Plan shall make such tracking available to the Agency upon request.
- f. The Dental Plan and its QI plan shall demonstrate specific interventions in its care coordination/case management to better manage and promote positive enrollee outcomes for enrollees with complex needs, in long-term care settings, with disabilities, and/or needing specialized services (e.g. sedation or anesthesia). The Dental Plan's written procedures shall address components of effective coordination/case management including but not limited to: anticipation, identification, monitoring, measurement, evaluation of needs, and effective action to promote quality of care; and the provision of enhanced care coordination and management for high-risk populations.

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- g. The Dental Plan and its QI plan shall demonstrate a health outcome improvement strategy to include coordination of care between the Dental Plan and the MMA Plans to ensure positive performance on dental quality performance scores (Healthcare Effectiveness Data and Information Set (HEDIS), Child Core Set, and CMS-416). This plan shall also reflect a focus on reducing utilization of preventable emergency department services for the treatment of dental conditions.
- h. The Dental Plan shall submit performance measure data as specified by the Agency and in the manner and format prescribed by the Agency.
- i. The Agency reserves the right to publish any data or information regarding Dental Plan performance under this Contract. The information will be shared in a manner that allows recipients to compare reliably the performance of each plan and may be posted on a monthly, quarterly, or yearly basis as the Agency deems necessary and at the sole discretion of the Agency. The Dental Plan shall be required to provide a link to the Agency's publications on its website as applicable.
- j. All information, whether data or documents, and reports that contain or make references to said Information, involving or arising out of this Contract is owned by the Agency. The Dental Plan is expressly prohibited from sharing or publishing the Agency information and reports without the prior written consent of the Agency. In the event of a dispute regarding the sharing or publishing of information and reports, the Agency's decision on this matter shall be final and not subject to change.

2. Oral Health Promotion and Disease Prevention

The Dental Plan shall demonstrate a plan:

- a. To assess enrollee health risks and health-related social needs to conduct health promotion and disease prevention outreach which must include targeted interventions to address populations that lack proficiency in the English language.
- b. To pursue engagement of enrollees through broad and targeted outreach to positively impact oral health education and awareness of benefits and services. This shall include innovative communication methods and technologically advanced resources, including, but not limited to the use of social media, texting, and smartphone application platforms.
- c. To track missed and cancelled appointments in order to target outreach to enrollees with repeated occurrences.
- d. To monitor network use and assist enrollees in finding dental providers.
- e. To facilitate collaborative outreach with community-based organizations.
- f. To ensure enrollees have access to evidence-based/best practice educational programs with a specific focus on improving rates of preventive dental utilization and providing early disease intervention.

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3. Enrollees with Special Health Care Needs

Pursuant to 42 CFR 438.208(c) the Dental Plan shall implement mechanisms for identifying, assessing, and ensuring the existence of a treatment plan for enrollees with special health care needs.

- a. Mechanisms to comprehensively assess each enrollee identified by the State as having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.
- b. A treatment plan for enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment plan shall be:
 - (1) In accordance with any applicable State quality assurance and utilization review standards; and
 - (2) Reviewed and revised upon reassessment of functional need, at least every twelve (12) months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee per s.441.301(c)(3) of this chapter.
- c. Pursuant to 42 CFR 438.208(c)(4), for enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with 42 CFR 438.208(c)(2)) to need a course of treatment or regular care monitoring, each Dental Plan must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

4. Accreditation or Certification

- a. The Dental Plan must be accredited by a nationally recognized accrediting body or have initiated the accreditation process within one (1) year after this Contract was executed.
 - (1) If the Dental Plan is not accredited or has not initiated the accreditation process within one (1) year, all enrollee assignments to the Dental Plan shall be suspended until the Dental Plan is accredited by a nationally recognized body (42 CFR 438.332(a)).
 - (2) If the Dental Plan is not accredited within eighteen (18) months after executing this Contract, the Agency may terminate this Contract for failure to comply with this Contract.
- b. In accordance with 42 CFR 438.332, the Dental Plan shall authorize its accrediting body to provide the Agency a copy of its most recent accreditation review, including: its accreditation status, survey type, and level (as applicable); recommended actions or improvements, corrective action plans, and summaries of findings; and the expiration date of accreditation.

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5. Quality Improvement Program

- a. The Dental Plan shall have an ongoing QI program that objectively and systematically evaluates access to care and the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to enrollees, thereby promoting quality of care and quality patient outcomes in service performance to its enrollees. (42 CFR 438.330(a)(1) and (3); 42 CFR 438.330(b)(4); 42 CFR 438.340)
- b. The Dental Plan's governing body shall oversee and evaluate the impact and effectiveness of its QI program. (42 CFR 438.330(e)(2); 42 CFR 438.310(c)(2)) The role of the Dental Plan's governing body shall include providing strategic direction to the QI program, as well as ensuring the QI plan is incorporated into processes throughout the Dental Plan.
- c. The Dental Plan shall cooperate with the Agency and the EQRO. The Dental Plan shall use the methodology and standards for QI set by the Agency.

6. Quality Improvement Program Committee

- a. The Dental Plan shall have a QI program committee, which includes:
 - (1) The Dental Director, as chair or co-chair;
 - (2) Provider representation (either through providers serving on the committee or through a provider liaison position, such as a representative from the network management department); and
 - (3) Other committee representatives shall be selected to meet the needs of the Dental Plan.
- b. Individual staff members may serve in multiple roles on the committee if they also serve in multiple positions within the Dental Plan.
- c. At a minimum, the committee must meet quarterly. The Dental Plan shall maintain minutes of all QI program committee and sub-committee meetings and make the minutes available for Agency review on request.
- d. The Dental Plan's QI program committee shall be responsible for development and implementation of a written QI plan, which incorporates the strategic direction provided by the Dental Plan's governing body.

7. Quality Improvement Plan

- a. The Dental Plan shall develop and maintain a written QI plan and submit its QI plan to the Agency initially prior to implementation and by November 1 of subsequent years.
- b. The QI plan shall include a description of:
 - (1) The Dental Plan positions assigned to the QI program committee, including a

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description of why each position was chosen to serve on the committee and the roles each position is expected to fulfill. The resumes of QI program committee members shall be made available upon the Agency's request;

- (2) The QI program committee structure, including development of subcommittees and task forces, and the committee's role in monitoring and evaluating of quality and appropriateness of care provided to enrollees;
- (3) The mechanism within the Dental Plan for the governing body to provide strategic direction for the QI program and for the QI program committee to communicate with the governing body;
- (4) Specific training about quality that shall be provided by the Dental Plan to staff serving in the QI program committee. At a minimum, the training shall include protocols developed by CMS regarding quality. CMS protocols may be obtained from:

<https://www.medicaid.gov/medicaid/quality-of-care/index.html>.

- (5) The Dental Plan's guiding philosophy for quality management, including any nationally recognized, standardized approach that is used (e.g., PDCA, Rapid Cycle Improvement, FOCUS-PDCA, Six Sigma). Selection of performance indicators and sources for benchmarking also shall be included in addressing the following specific components of the QI plan:
 - (a) Methods for assessment of the quality and appropriateness of care provided to enrollees with timely resolution of problems and new or continued improvement activities, including but not limited to:
 - (i) Service availability and accessibility;
 - (ii) Quality of services in accordance with acceptable professional practice standards;
 - (iii) Network quality;
 - (iv) Care planning and care coordination;
 - (v) Enrollee safety;
 - (vi) Utilization review processes;
 - (vii) Grievance and appeals; and
 - (viii) Adverse/critical incident reporting

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- (b) The process to direct and analyze periodic review of enrollee service utilization patterns (including detection of underutilization and overutilization of services); (42 CFR 438.330(b)(3))
- (c) Monitoring and evaluation of provider network quality, including but not limited to:
 - (i) Credentialing and recredentialing processes;
 - (ii) Provider performance measurement;
 - (iii) Metrics for monitoring the quality and performance of participating providers related to their continued participation in the network.
- (6) The process for selecting evaluation and study design procedures; and
- (7) A standard describing the process the QI program shall use to review and suggest new and/or improved QI activities.
- (8) The Dental Plan's QI plan shall describe the process for annual QI activities evaluation, the evaluation results of the prior year's QI activities, and any subsequent revisions to the QI plan.
 - (a) The Dental Plan's program description and program evaluation shall identify priority areas for improvement that align with the Agency's goals and priorities.
 - (b) The Dental Plan shall conduct an analysis of the degree to which improvement was achieved for each priority area, including an analysis of the effectiveness.
- c. The Dental Plan shall submit its updated QI plan, including the findings from its annual QI program evaluation to the Agency by November 1 of each Contract year.

8. EQRO Coordination Requirements

The Dental Plan shall cooperate with and provide all information requested by the EQRO. (42 CFR 438.350)

B. Performance Measures

1. General Provisions

- a. The Dental Plan shall meet Agency-specified performance targets for all PMs as specified in this Contract.
- b. The Agency may add or remove PM requirements, including performance targets and timelines associated with meeting the targets, with sixty (60) days' advance notice.

2. Required Performance Measures

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- a. The Dental Plan shall collect statewide data on enrollee PMs, as defined by the Agency and as specified in the Performance Measures Table, **Table 6**, below, the *Managed Care Plan Report Guide* and Performance Measures Specifications Manual.
- b. The Dental Plan shall report results of PMs to the Agency as specified in **Section XV.**, Accountability, the *Managed Care Plan Report Guide*, and Performance Measures Specifications Manual.
- c. The Dental Plan shall collect data and report on the following performance measures, certified via a National Committee for Quality Assurance (NCQA) certified HEDIS auditor.

TABLE 6	
PERFORMANCE MEASURES	
Child Core Set	
1.	Oral Evaluation, Dental Services – (OEV-CH)
2.	Sealant Receipt on Permanent First Molars (SFM-CH)
3.	Topical Fluoride for Children (TFL-CH)
Dental Quality Alliance	
4.	Adults with Diabetes --- Oral Evaluation (OEVD)
5.	Ambulatory Care Sensitive Emergency Department (ED) Visits for Dental Caries in Children (EDV-CH)
6.	Ambulatory Care Sensitive ED Visits for Non-Traumatic Dental Conditions in Adults (EDV-A)
7.	Caries Risk Documentation (CRD)
8.	Follow-Up after ED Visits for Dental Caries in Children (EDF-CH)
9.	Follow-Up after ED Visits for Non-Traumatic Dental Conditions in Adults (EDF-A)
10.	Oral Evaluation During Pregnancy (O EVP)
11.	Treatment Services (Pediatric) (TRT-CH)
Agency-defined, based on CMS-416	
12.	Preventive Dental Services - (PDENT)

- d. The Dental Plan shall submit the first Performance Measure Report to the Agency no later than July 1, 2026, covering the measurement period of calendar year 2025. Measures should be collected based on the technical specifications for the measure, across the current Contract and the previous Dental Plan Contract, as applicable. All contractually required performance measures must be reported by region and statewide.
- e. Beginning with the Performance Measures Report that is due to the Agency no later than July 1, 2026, covering the measurement period of calendar year 2025, the Dental Care Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated

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Damages, as determined by the Agency.

- f. The Agency shall calculate each Dental Plan's Preventive Dental Services (PDENT) measure using encounter data and/or data that the Dental Plan reports on its CMS-416 reports. The Dental Plan does not need to calculate and report on this measure as part of their annual performance measure submission.
- g. Beginning with the Performance Measures Report that is due to the Agency no later than July 1, 2026, covering the measurement period of calendar year 2025, the Dental Plan shall report on the following required performance measures statewide, stratified by: age, sex, race, ethnicity, primary language, whether the enrollee received a Social Security Administration determination of disability for purposes of Social Security Income, and geography. The Dental Plan shall continue to report these measures by region.
 - (1) Oral Evaluation, Dental Services
 - (2) Sealant Receipt on Permanent First Molars
 - (3) Topical Fluoride for Children
- h. The Agency may require that the Dental Plan submit performance measures stratified by other factors, and may add performance measures to be stratified, with at least sixty (60) days' notice.
- i. The Agency may calculate certain measures for the Dental Plan. If the Agency will be calculating and reporting certain measures for the Dental Plan, the Agency will provide sixty (60) days' notice and the Dental Plan will not be required to calculate and report the measures to the Agency.

3. Well-Child Visit Performance Measures

The Dental Plan shall achieve a preventive dental services rate corresponding to the following schedule for those enrollees who are continuously eligible for EPSDT for ninety (90) continuous days. This rate shall be based on the dental visit data reported by the Dental Plan in its CMS-416 audited report and/or supporting encounter data and shall be calculated by dividing line 12b by line 1b from the CMS-416 report, excluding children under the age of one (1). Beginning with the report for federal fiscal year (FFY) 2024-25, failure to meet or exceed the preventive dental services rates established in the Plan-specific **Attachment I**, Scope of Services of this Contract may result in a corrective action plan in addition to the liquidated damages and sanctions provided in this **Exhibit**.

4. Agency-Calculated Performance Measures

- a. The Agency shall calculate the following performance measure for the Dental Plan in the Agency-Calculated Performance Measures Table, **Table 7**, below.

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TABLE 7	
AGENCY-CALCULATED PERFORMANCE MEASURES	
Solventum Potentially Preventable Events (PPEs)	
1.	Potentially Preventable Dental-related Emergency Department Visits

- b. The Dental Plan shall comply with the minimum performance standards established by the Agency for the Agency-Calculated Performance Measures(s) specified above. The Dental Plan shall achieve at least a two percent (2%) reduction each year of the Contract until the Dental Plan achieves the performance standards established by the Agency.
- c. If the Dental Plan fails to comply with the requirements of this **Section**, the Dental Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.
- d. Due to contract year 2024-2025 being transition years across contracts, the Agency may calculate and publicly report the measures in **Table 7**, Agency-Calculated Performance Measures, and shall label such performance measures as “transition year” measures.

5. Quality Assessment and Performance Improvement Program

- a. By July 1 of each Contract year, the Dental Plan shall deliver to the Agency a report on performance measure data and a certification by a NCQA certified HEDIS auditor that the performance measure data reported for the previous year are fairly and accurately presented. The HEDIS auditor shall certify the report, and the auditor must certify the actual file submitted to the Agency.
- b. The Dental Plan shall submit performance measure data as specified by the Agency and in the manner and format prescribed by the Agency.
- c. The Agency may grant extensions to the due date for up to thirty (30) days and require a signed, dated, written request by the Dental Plan CEO or designee. The Agency must receive the request before the report’s due date and the delay must be due to unforeseen and unforeseeable factors beyond the Dental Plan’s control. Extensions shall not be granted on oral requests.
- d. The Dental Plan shall use a software vendor who has achieved full HEDIS Measure Certification Status from NCQA for the current reporting year to calculate its PM rates each year.
- e. The Agency shall consider deficient a report that contains a “not reportable” (NR) designation due to bias for any or all measures by the HEDIS auditor or that contains a “false” designation.

6. Publication of Performance Measures

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The Dental Plan shall publish its results for HEDIS and other measures on the Dental Plan's website in a manner that allows recipients to compare reliably the performance of Dental Plans. The Dental Plans shall meet this requirement by including information about the comparison of performance measures conducted by the Agency and providing a link to the Agency's applicable website page.

C. Performance Improvement Projects

1. General Provisions

- a. The Dental Plan shall develop, implement, and monitor PIPs in accordance with 42 CFR 438.240(d)(1). The Dental Plan shall achieve significant improvement to the quality of care and service delivery, through ongoing measurement of performance using objective quality indicators and ongoing interventions, sustained over time.
- b. By January 1 of each Contract year, the Agency shall determine and notify the Dental Plan if there are changes in the number and types of PIPs the Dental Plan shall perform for the coming Contract year.
- c. The Dental Plan's PIP methodology must comply with the most recent protocol set forth by CMS, Implementation of PIPs. CMS protocols shall be obtained at: <https://www.medicare.gov/medicare/quality-of-care/medicare-managed-care/external-quality-review/index.html>
 - (1) The Dental Plan shall include a statistically valid sample size for each PIP.
 - (2) Populations selected for study under the PIP shall be specific to this Contract and shall not include Medicaid recipients from other states, or enrollees from other lines of business.
 - (3) If the Dental Plan contracts with a separate entity for management of particular services, PIPs conducted by the separate entity shall not include enrollees for other Dental Plans served by that entity.
 - (4) The Dental Plan shall include breakouts of particular populations for PIP measurements and interventions as directed by the Agency.
- d. Improvement must be measured through comparison of a baseline measurement and an initial re-measurement following application of an intervention. Change must be statistically significant at the ninety-five percent (95%) confidence level and must be sustained for two (2) additional re-measurement periods.
- e. The Agency shall consider PIPs that have successfully achieved sustained improvement, as approved by the Agency, to be complete, and such PIPs shall not meet the requirement for one (1) of the number of PIPs required by the Agency, although the Dental Plan shall wish to continue to monitor the performance target as part of its overall QI program. In this event, the Dental Plan shall select a new PIP and submit it to the Agency for approval. (42 CFR 438.330(d)(2); 42 CFR 438.330(d)(2)(iv))

2. Performance Improvement Projects

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For additional provisions relating to PIPs, see **Section I.**, General Overview, **Sub-Section E.**, Prioritizing Florida’s Vulnerable Citizens, **Item 7.**, Quality Measures.

3. PIP Proposals

- a. The Dental Plan shall submit its measurement periods and methodologies to the Agency for approval before initiation of the PIP. Within thirty (30) days of Contract execution, the Dental Plan shall submit to the Agency, in writing:
 - (1) The initial proposed PIP topics and their indicators;
 - (2) A brief summary of the baseline data and time period that the Dental Plan shall use for each indicator for each of the proposed PIPs.
 - (3) An estimate of how many Dental Plan enrollees shall be in the eligible/affected population for each PIP.
 - (4) A brief rationale for why the Dental Plan has selected each proposed PIP topic.
- b. The Dental Plan shall submit to the Agency in writing a final proposal for each planned PIP no later than ninety (90) days after the execution of this Contract.
- c. Each initial PIP proposal shall be submitted using the most recent version of the EQRO PIP validation form. The Dental Plan may obtain instructions for using the form to submit PIP proposals and updates from the Agency.
- d. Activities 1 through 6 of the EQRO PIP validation form must be addressed in the PIP proposal. These activities are listed at <http://www.myfloridaeqro.com/pips.aspx>.
- e. In the event the Dental Plan elects to modify a portion of the PIP proposal after initial Agency approval, the Dental Plan shall submit a written request to the Agency for prior approval.
- f. The Agency reserves the right to mandate specific PIP topics and performance indicators and will provide the Dental Plan with information required to complete their PIPs as needed.

4. Annual PIP Submission

- a. The Dental Plan shall submit ongoing PIPs by October 1 of each Contract year to the Agency for review and approval. (42 CFR 438.330(c)(1) and (2)) The Agency shall provide the PIPs to the EQRO for validation.
- b. The Dental Plan shall update the EQRO PIP validation form in its annual submission to reflect the Dental Plan’s progress. The Dental Plan is not required to transfer ongoing PIPs to a new, updated EQRO form, unless directed by the Agency.
- c. The Dental Plan shall submit the Agency-approved EQRO PIP validation form to the EQRO upon its request for validation. The Dental Plan shall not make changes to the Agency-approved PIP being submitted to the EQRO unless expressly permitted and approved by the Agency in writing.

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5. Quarterly PIP Progress Reports

In addition to annual submissions, the Dental Plan shall submit quarterly updates on PIP progress to the Agency on January 1, April 1, and July 1 of each Contract year. Fourth quarter updates should be submitted as part of the Dental Plan's annual PIP submission. Quarterly updates should, at a minimum, include the following elements:

- a. Progress on intervention activities;
- b. Preliminary data results; and
- c. Evaluations of effectiveness

6. EQRO Validation

The Dental Plan's PIPs shall be subject to review and validation by the EQRO. The Dental Plan shall comply with any recommendations for improvement requested by the EQRO, subject to approval by the Agency.

D. Satisfaction and Experience Surveys

1. Enrollee Satisfaction Survey

- a. The Dental Plan shall conduct an annual survey of enrollees using an adapted version of the Consumer Assessment of Health Care Providers and Systems (CAHPS) Dental Plan Survey.
- b. The Dental Plan shall follow the Survey Administration Guidelines below:
 - (1) The Dental Plan shall contract with a qualified, Agency-approved, NCQA-certified survey vendor to administer the surveys. The minimum sample size is five thousand (5,000), with a target of four hundred and eleven (411) completed surveys. The survey should be administered according to the NCQA mixed methodology (two- wave mail protocol with telephone follow-up of at least three (3) but no more than six (6) attempts).
 - (2) To be included in the survey sample, enrollees must have been enrolled in the Dental Plan for at least six (6) months with no more than a one (1)-month gap in enrollment.
 - (3) The Dental Plan shall have its sample validated by an NCQA-certified HEDIS Auditor.
 - (4) If the Dental Plan would like to add questions to the survey, those questions shall be added to the end of the CAHPS Dental Plan Survey. Additional questions must be submitted to the Agency contract manager for review and approval prior to being included in the survey.
- c. The Dental Plan shall submit a written proposal for survey administration and reporting to the Agency by December 1 of each Contract year. The proposal shall include the following:

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- (1) Identification of survey administrator and evidence of the survey administrator's NCQA certification as a CAHPS survey vendor;
 - (2) Sampling methodology;
 - (3) Administration protocol;
 - (4) Analysis plan;
 - (5) Reporting description;
 - (6) Copy of the survey tool; and
 - (7) Cover letters and/or postcards.
- d. The Dental Plan shall provide the survey results to the Agency, in accordance with the survey results reporting templates and instructions from the Agency, along with an action plan.
- e. The Agency shall specify the survey requirements including survey specifications, applicable supplemental item sets and Agency-defined survey items. Annually, by October 15 of each Contract year, the Agency shall determine and notify the Dental Plan if there are changes in survey requirements.
- f. The Dental Plans shall report CAHPS dental survey results to the Agency by September 1 of each year beginning with the September 1, 2025, reporting.
- g. By October 1 of each Contract year, the Dental Plan shall submit its CAHPS dental survey vendor's final report to the Agency. The Dental Plan's action plan to address the results of the CAHPS survey shall be submitted in the Member Satisfaction Improvement Report by October 15 of each Contract year.
- h. The Dental Plan shall submit a CAP, as required by the Agency, within thirty (30) days of the request from the Agency to address any deficiencies identified in the annual CAHPS survey.
- i. The Dental Plan shall use the results of the annual CAHPS dental survey to develop and implement plan-wide activities designed to improve enrollee satisfaction. Activities conducted by the Dental Plan pertaining to improving enrollee satisfaction resulting from the annual enrollee satisfaction survey must be reported to the Agency on a quarterly basis in the Member Satisfaction Improvement Report.
- j. In addition to the core survey, the Dental Plan shall include the following item in its CAHPS survey.
- (1) How would you rate the number of dentists you had to choose from?

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Response options: Excellent, Very Good, Good, Fair, Poor, No Experience

2. Provider Satisfaction Survey

- a. The Dental Plan shall conduct an annual Provider Satisfaction Survey. The Dental Plan shall submit a written provider satisfaction survey plan to the Agency for written approval within ninety (90) days after initial Contract execution and by January 1 of each Contract year, thereafter. (42 CFR 438.66(c)(5))
- b. The proposal shall include the following:
 - (1) Copy of the survey tool, using a four-point Likert scale and including the following domains:
 - (a) Provider relations and communication
 - (b) Authorization processes, including denials and appeals.
 - (c) Timeliness of claims payment and assistance with claims processing
 - (d) Complaint resolution process
 - (e) Care coordination/case management support.
 - (2) Sampling methodology
- c. The Agency reserves the right to require a specific survey tool, survey questions and/or survey methodology and to provide minimum qualifications for survey vendors.
- d. The Dental Plan shall conduct the survey, compile, and analyze its survey results, and provide the survey results to the Agency with an action plan to address the results of the Provider Satisfaction Survey by September 1 of each Contract year for the previous calendar year, beginning with the September 1, 2025, reporting.
- e. The Dental Plan shall submit a CAP, as required by the Agency, within thirty (30) days of the request from the Agency to address any deficiencies identified in the annual Provider Satisfaction Survey.

E. Enrollee Record Requirements

1. General Provisions

- a. The Dental Plan shall ensure maintenance of a Dental Plan's enrollee record for each enrollee in accordance with this **Section** and with 42 CFR 431 and 42 CFR 456. Plan enrollee records shall include documents related to the quality, quantity, appropriateness, and timeliness of services performed under this Contract.
- b. In addition to the requirements of this **Sub-Section**, the Dental Plan shall ensure the following documentation is included in the plan enrollee record:

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- (1) A copy of the completed screening instrument in the plan enrollee record and provides a copy to the enrollee.
- (2) Documentation in the plan enrollee record of referral services, including reports resulting from the referral.
- (3) Documentation in the plan enrollee record of post-stabilization dental care services provided in response to emergency care encounters.
- (4) Documentation for services provided through teledentistry, including:
 - (a) A brief explanation of the use of teledentistry in each progress note;
 - (b) Documentation of teledentistry equipment used for the particular covered services provided; and
 - (c) A signed statement from the enrollee or the enrollee's authorized representative indicating their choice to receive services through teledentistry. This statement may be for a set period of treatment or one (1)-time visit, as applicable to the service(s) provided.

2. Enrollee Record Review Strategy

- a. By June 1 of each Contract year, the Dental Plan shall submit a written strategy for conducting enrollee record reviews for Agency approval. The strategy shall include, at a minimum:
 - (1) Designated staff to perform this duty;
 - (2) Process for establishing inter-rater reliability with Dental Plan and provider enrollee record reviews;
 - (3) Method for identifying Dental Plan and provider enrollee records for review;
 - (4) Anticipated number of reviews for a statistically significant sample of enrollee records maintained by the Dental Plan, its subcontractors, and providers;
 - (5) The tool that the Dental Plan shall use to review each record;
 - (6) Record review deficiencies and how results shall be utilized in process improvement(s); and
 - (7) How the Dental Plan shall link the information compiled during the review to other Dental Plan functions (e.g., QI, recertification, peer review).
- b. The Dental Plan shall conduct provider enrollee record reviews of all providers with a pattern of complaints regarding poor quality of service and providers with poor quality outcomes.

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- c. The Dental Plan shall distribute the standards, which must include all provider enrollee record documentation requirements addressed in this Contract, to all providers.

3. Standards for Dental Plan Enrollee Records

- a. The Dental Plan shall develop and maintain enrollee records meeting the documentation standards set forth in Rule 59G-1.054, F.A.C., below:
- (1) Include the enrollee's identifying information, including name, enrollee identification number, date of birth, gender, and legal guardianship (if any);
 - (2) Include information relating to the enrollee's use of tobacco, alcohol, and drugs/substances;
 - (3) Reflect the primary language spoken by the enrollee and any translation needs of the enrollee;
 - (4) Identify enrollees needing communication assistance in the delivery of health care services;
 - (5) Include copies of any completed consent or attestation form(s) used by the Dental Plan, including enrollee consent for teledentistry services;
- b. If the Dental Plan is not yet fully accredited by a nationally recognized accrediting body, the Dental Plan shall establish processes for Dental Plan and provider enrollee record review that meet or exceed nationally recognized accrediting body enrollee record review standards.

4. Standards for Provider-Specific Enrollee Records

The Dental Plan shall ensure that its network of providers follows the enrollee record standards set forth in Rule 59G-1.054, F.A.C.

F. Provider-Specific Performance Monitoring

1. General Provision

The Dental Plan shall monitor the quality and performance of each participating provider. At the beginning of this Contract period, the Dental Plan shall notify all its participating providers of the metrics used by the Dental Plan for evaluating the provider's performance and determining continued participation in the network.

2. Peer Review

- a. The Dental Plan shall have a peer review process that results in:
- (1) Review of a provider's practice methods and patterns, morbidity/mortality rates, and all complaints and grievances filed against the provider;

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- (2) Evaluation of the appropriateness of care rendered by providers;
- (3) Implementation of corrective action(s) when the Dental Plan deems it necessary to do so;
- (4) Development of policy recommendations to maintain or enhance the quality of care provided to enrollees;
- (5) Reviews that include the appropriateness of diagnosis and subsequent treatment, maintenance of a provider's enrollee records, adherence to standards generally accepted by a provider's peers and the process and outcome of a provider's care;
- (6) Education of enrollees and Dental Plan staff about the peer review process, so that enrollees and the Dental Plan staff can notify the peer review authority of situations or problems relating to providers.

3. Monitoring Activities

The Dental Plan shall comply with monitoring activities requirements as specified in the Contract.

G. Additional Quality Management Requirements

1. Incident Reporting Requirements

- a. As part of the Dental Plan's quality management requirements, the Dental Plan shall implement and maintain a risk management program.
- b. The Dental Plan shall develop and implement an incident reporting and management system for adverse incidents.
- c. The Dental Plan shall require participating service providers and direct service providers to report adverse incidents to the Dental Plan.
- d. The Dental Plan shall provide appropriate training and take corrective action as needed to ensure its staff, participating providers, and direct service providers comply with critical incident requirements.
- e. The Dental Plan shall immediately report to DCF's Central Abuse Hotline any suspected cases of abuse, neglect or exploitation of enrollees, in accordance with ss. 39.201 and 415.1034, F.S. The Dental Plan shall maintain documentation related to the reporting of such events in a confidential file, separate from the Dental Plan enrollee record. Such files shall be made available to the Agency upon request.
- f. The Dental Plan shall report a summary of adverse incidents to the Agency, as specified in **Section XV.**, Accountability, and in the *Managed Care Plan Report Guide*, and in the manner and format determined by the Agency.
- g. The Dental Plan shall require providers to report adverse incidents to the Dental Plan

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within forty-eight (48) hours of the incident.

2. The Dental Plan shall not require provider submission of adverse incident reports from health maintenance organizations and health care clinics reporting in accordance with s. 641.55, F.S.

3. **Agency Monitoring**

The Dental Plan shall furnish specific data requested by the Agency in order to conduct monitoring of the Dental Plan's compliance with this Contract.

H. Continuity of Care in Enrollment

1. The Dental Plan shall provide continuity of care for new enrollees transitioning into the Dental Plan. In the event a new enrollee is receiving prior authorized ongoing course of treatment with any dental provider, the Dental Plan shall be responsible for the costs of continuation of such course of treatment without any form of authorization and regardless of provider network affiliation, for up to ninety (90) days after the effective date of enrollment. The Dental Plan shall reimburse non-participating providers at the rate they received for dental services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of thirty (30) days, unless said provider agrees to an alternative rate.
2. The Dental Plan shall provide continuation of services until the enrollee's PDP reviews the enrollee's treatment plan, in accordance with
3. For all enrollees, written documentation of prior authorization of ongoing dental services shall include the following, provided that the services were prearranged prior to enrollment with the Dental Plan:
 - a. Prior existing orders;
 - b. Provider appointments (including rescheduled appointments for service completion);
 - c. Prior Authorizations; and
 - d. Treatment plan/plan of care.
4. The Dental Plan shall not delay service authorization if written documentation is not available in a timely manner. However, the Dental Plan is not required to approve claims for which it has received no written documentation.
5. The following services may extend beyond the ninety (90) day continuity of care period, and the Dental Plan shall continue the entire course of treatment with the enrollee's current provider as described below:
 - Active Orthodontia -- The Dental Plan shall ensure, in conjunction with Medicaid eligibility, continuity of care for active orthodontia until completion of care and reimbursement to providers, regardless of provider network affiliation.

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A. General Provisions

1. The Agency is responsible for administering the Medicaid program. The Agency shall administer contracts, monitor Dental Plan performance, and provide oversight in all aspects of Dental Plan processes.
2. The Agency shall be responsible for the administration of the FMMIS and contracting with the State's fiscal agent to exchange data with Dental Plans and enroll Medicaid providers. The Agency is responsible also for the administration of programs for Florida's Medicaid Electronic Health Record Incentive Program, the Florida Health Information Network and other efforts to provide information and resources relating to HIT and HIE, as well as collecting data and statistics for the purpose of developing public policy and promoting the transparency of consumer health care information through <http://www.floridahealthfinder.gov/index.html>.
3. The Agency shall be responsible for establishing standards and requirements to ensure receipt of complete and accurate data for program administration as required to determine compliance with Title XIX of the Social Security Act, the Balanced Budget Act of 1997, 42 CFR 438, and Chapters 409 and 641, F.S. The Agency shall be responsible for establishing systems, processes, standards, and requirements, including but not limited to encounter data collection and submission, and providing instructions to Dental Plans through the Medicaid Companion Guides and Pharmacy Payer Specifications, located on the Agency's fiscal agent website. The Agency shall be responsible for validating and reporting encounter data in accordance with 42 CFR 438.818.
4. The Agency shall be responsible for coordinating Medicaid overpayment and abuse prevention, detection, and recovery efforts. The Attorney General's office is responsible for investigating and prosecuting Medicaid fraud. The Agency shall operate the MPI program, which includes but is not limited to such monitoring as may be done by desk reviews or on site as determined by the Agency. Various Agency bureaus may conduct these reviews and the Agency shall provide appropriate notice for requesting documents as needed and for conducting on-site reviews, as well as providing Dental Plans with the result of such reviews. The Agency, Bureau of MPI, audits and investigates providers suspected of overbilling or defrauding the Florida Medicaid Program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation to the MFCU. The Agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate.
5. The Dental Plan shall be responsible for the administration and management of all aspects of this Contract, including but not limited to delivery of services, provider network, provider education, claims resolution and assistance, and all subcontracts, employees, agents, and services performed by anyone acting for or on behalf of the Dental Plan.
6. The Dental Plan shall have a centralized executive administration and must ensure adequate staffing and information systems capability to ensure the Dental Plan shall

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appropriately manage financial transactions, record keeping, data collection, and other administrative functions, including the ability to submit any financial, programmatic, encounter data, or other information required by this Contract.

B. Organizational Governance and Staffing

1. General Provisions

- a. The Dental Plan shall be responsible for the administration and management of all aspects of this Contract, including all subcontracts, employees, agents, and services performed by anyone acting for or on behalf of the Dental Plan.
- b. The Dental Plan shall have a centralized executive administration, which shall serve as the contact point for the Agency, except as otherwise specified in this Contract.
- c. The Dental Plan shall ensure adequate staffing and information systems capability to ensure the Dental Plan shall appropriately manage financial transactions, record keeping, data collection, and other administrative functions, including the ability to submit any financial, programmatic, and encounter data, or other information required by the Agency, and to comply with the HIPAA and the HITECH Act.
- d. The Dental Plan shall be located in the U.S. (42 CFR 438.602(i))
- e. The Dental Plan shall meet all requirements for doing business in the State of Florida.
- f. The Dental Plan shall submit any changes to its approved organizational chart to the Agency for prior approval. If any member of the minimum staffing is terminated or becomes unavailable for any reason, the Dental Plan shall submit to the Agency the resume of the proposed replacement(s) and offer the Agency the chance to review the qualifications of the proposed applicant(s).
- g. The Agency reserves the right to disapprove proposed applicant(s) with reason.

2. Minimum Staffing

The positions described below represent the minimum management staff required for the Dental Plan. The Dental Plan shall notify the Agency of changes in the staff positions indicated below, within five (5) business days of the changes in staffing. The Dental Plan shall not delegate minimum staffing positions.

- a. The Dental Plan shall designate a full-time Contract Manager to work directly with the Agency. The Contract Manager shall be a full-time employee of the Dental Plan and shall dedicate one hundred percent (100%) of their time employed with the Dental Plan to this Contract. The Contract Manager shall have the authority to administer the day-to-day business activities of this Contract, including revising processes or procedures and assigning additional resources as needed to maximize the efficiency and effectiveness of services required under this Contract. The Dental Plan Contract Manager shall meet in person, or by telephone, at the request of the Agency. The Contract Manager shall be located in the State of Florida.

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- b. The Dental Plan shall designate a full-time Dental Director who is a dentist licensed in the State of Florida with experience providing services to the populations served under this Contract. The Dental Director shall be a full-time employee of the Dental Plan and shall dedicate one hundred percent (100%) of their time employed with the Dental Plan to this Contract. The Director shall oversee and be responsible for the proper provision of covered services to enrollees, the quality management program, and the grievance and appeal system. The Dental Director shall be located in the State of Florida.
- c. The Dental Plan shall designate a full-time Compliance Officer, qualified by knowledge, training, and experience in health care or risk management, to promote, implement, and direct the overall compliance program and to oversee the Dental Plan's compliance with non-discrimination requirements in this Contract. The Compliance Officer shall be a full-time employee of the Dental Plan and shall dedicate one hundred percent (100%) of their time employed with the Dental Plan to this Contract. The Compliance Officer shall exhibit knowledge of relevant regulations, provide expertise in compliance processes, and be qualified to design, implement, and oversee a fraud and abuse program designed to ensure program integrity through fraud and abuse prevention and detection, which identifies and addresses emerging trends of fraud, abuse, and waste pursuant to this Contract and State and federal law. The Compliance Officer shall be located in the State of Florida.
- d. The Dental Plan shall designate a Special Investigations Unit (SIU) Manager, qualified by training and experience in health care fraud and abuse prevention and detection. The SIU Manager shall oversee the Medicaid Dental Plan's fraud and abuse detection and prevention efforts and work with Medicaid Program Integrity and the Medicaid Fraud Control Unit as needed with regard to any audits and investigations of providers. The Special Investigations Unit Manager shall be located in the State of Florida.
- e. The Dental Plan shall have a designated employee, qualified by training and experience, to serve as a liaison with the Managed Care Plans in the MMA program in order to promote the most optimal outcomes in terms of integrating and coordinating the SMMC (medical, behavioral health, and long-term care) benefits with the Statewide Medicaid Prepaid Dental Program delivery system. This employee will serve as a point of contact for the MMA Plans in helping to resolve operational (e.g., sharing of data/information) and care coordination concerns/issues; and will work directly with the Agency on strategic planning efforts to advance the Agency's goals in coordinating dental and SMMC benefits, as well as reporting on any operational or care coordination issues.

If the Dental Plan fails to comply with the requirements of this **Section**, the Dental Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

- f. The Dental Plan shall designate a staff for each of the following functional areas within the Agency:
 - (1) Medicaid Quality;

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- (2) Medicaid Recipient/Provider Assistance;
 - (3) Medicaid Policy;
 - (4) Medicaid Data Analytics;
 - (5) Medicaid Finance;
 - (6) Claims and Encounter Data;
 - (7) Program Integrity; and
 - (8) Subcontractor Oversight.
- g. The Dental Plan shall establish a staffing model that maintains a staff-to-enrollee ratio as prescribed by the Agency. At a minimum, the following positions are required in the staffing model:
- (1) Claims Resolution Staff;
 - (2) Provider Relations Staff;
 - (3) Recipient Relations Staff;
 - (4) Utilization and Authorization Staff; and
 - (5) Quality Initiative Staff.

The staff in these positions shall be full-time employees of the Dental Plan, dedicated one hundred percent (100%) to this Contract, and located in the State of Florida.

- h. The Dental Plan shall submit a staff-to-enrollee ratio report in the manner and format determined by the Agency, specified in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*.

6. Dental and Professional Support Staff

The Dental Plan shall have an adequate number of dental and professional support staff, sufficient to conduct daily business in an orderly manner, including having enrollee services staff directly available during business hours for enrollee services consultation, as determined through management and medical reviews. The Dental Plan shall maintain an adequate number sufficient dental and professional support staff, available twenty-four hours per day, seven days a week (24/7), to handle emergency services and care inquiries from enrollees and caregivers.

7. Care Coordination/Case Management Staff

The Dental Plan shall have sufficient care coordination/case management staff, qualified by training, experience, and certification/licensure to conduct the Dental Plan's care coordination/case management functions.

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8. Staff Training and Education

The Dental Plan shall make available to the Agency the Dental Plan schedule and curriculum for all internal staff, subcontractor, provider, and enrollee training sessions (via web-based or in person) and shall allow Agency staff to attend each training session.

9. Non-discrimination Compliance Requirements

- a. The Dental Plan shall comply with all applicable federal and State civil rights laws, regulations, rules and policies, including but not limited to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the ADA of 1990, Section 1557 of the Patient Protection and Affordable Care Act (ACA), and the Age Discrimination Act of 1975.
- b. The Dental Plan shall develop a non-discrimination compliance plan. The Dental Plan shall be responsible for initial and ongoing training regarding the non-discrimination compliance plan to all Dental Plan staff. The Dental Plan shall maintain documented proof of such training and provide such proof to the Agency upon request.
- c. The Dental Plan's non-discrimination compliance plan shall include written procedures that demonstrate non-discrimination in the provision of services to enrollees. The policy shall also demonstrate non-discrimination in the provision of language assistance services for enrollees with limited English proficiency and those requiring communication assistance in alternative formats. See **Section IV.**, Enrollee Services, **Sub-Section B.**, Enrollee Material.

10. Emergency Management Plan

- a. Before implementation of this Contract and by May 1st of each Contract year, the Dental Plan shall submit to the Agency an emergency management plan specifying what actions the Dental Plan shall conduct to ensure the ongoing provision of covered services in a disaster. The emergency management plan shall include a risk assessment, procedures to comply with this Contract during disasters, a communication plan specific to enrollees and providers during disasters, and training schedules for plan staff.
- b. The Dental Plan shall perform at least one mock-disaster exercise per Contract year and report the results to the Agency when requested.
- c. The Dental Plan shall comply with the following provisions when a disaster is declared by a Governor's Executive Order and confirmed by the Agency.
 - (1) Furnish covered services to an enrollee without any form of authorization, without regard to whether such services are provided by a participating or non-participating provider, and without regard to service limitations;
 - (2) Implement a readily available claims payment process to ensure providers are paid for services rendered before, during, and after the disaster, as medically necessary; and
 - (3) Publish guidance via website for enrollees and providers before, during, and after

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the disaster on how to receive services, contact information for emergencies, payment processes and any other information required by the Agency.

- d. If the Dental Plan fails to comply with the requirements of this **Section**, the Dental Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

I. Subcontracts

1. General Provisions

- a. The Dental Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract and shall delegate performance of work required under this Contract to a subcontractor. The Dental Plan shall submit any proposed delegation to the Agency for prior written approval. The Dental Plan shall submit all subcontracts for Agency review at least ninety (90) days before the proposed effective date of the subcontract or change. If the submission is for management of a covered service, the Dental Plan shall include the following in its submission to the Agency in a manner prescribed by the Agency:

- (1) Draft subcontract that complies with the subcontract requirements specified in this **Section**, **Standard Contract**, 42 CFR 438.230(c)(1)(i), and 42 CFR 438.3(k);
- (2) Test PNV file as proof of provider network adequacy
- (3) Copy of applicable licensure, if appropriate;
- (4) Enrollee materials in publication ready formats as specified in the Contract;
- (5) The population covered by the subcontract;
- (6) Provider materials in publication ready formats as specified in the Contract;
- (7) Model provider agreement template as specified in **Section VII.**, Provider Network and Services; and
- (8) Approximate number of impacted enrollees

If the Agency determines, at any time, that a subcontract does not comply with a Contract requirement, the Dental Plan shall promptly revise the subcontract into compliance. In addition, the Dental Plan shall be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, and/or liquidated damages pursuant to **Section XIII.**, Liquidated Damages.

- b. All subcontracts must comply with 42 CFR 438.230, 42 CFR 438.3(k), 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106 and all applicable Medicaid laws and regulations, including applicable sub regulatory guidance and Contract provisions, and any other applicable State or federal law.

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- c. The Dental Plan shall identify the service(s) and/or goods covered by the subcontract, as applicable.
- d. All subcontracts must contain provisions wherein the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*.
- e. No subcontract that the Dental Plan enters into with respect to performance under this Contract shall, in any way, relieve the Dental Plan of any responsibility for the performance of duties under this Contract. The Dental Plan shall assure that all tasks related to the subcontract are performed in accordance with the terms of this Contract and shall provide the Agency with its monitoring schedule for all Agency-approved subcontractors by December 1 of each Contract year.
- f. All executed subcontracts and amendments used by the Dental Plan under this Contract shall be in writing, signed, and dated by the Dental Plan.
- g. The Dental Plan shall immediately advise the Agency of the insolvency of a subcontractor or of the filing of a petition in bankruptcy by or against a principal subcontractor.
- h. The Dental Plan agrees to prohibit the blanket use of case rate (i.e., flat rate) payment arrangements in agreements between subcontractors and providers. The Dental Plan shall require subcontractors to utilize value-based purchasing arrangements to the fullest extent.
- i. The Dental Plan shall have a contingency plan for each subcontract to provide for continuity of care should the subcontractor cease to provide services that are the subject of the subcontract.
- j. Upon implementation of the Contract, the Dental Plan agrees to maintain arrangements with its Agency-approved subcontractors for the first two (2) full Contract years of the Contract period. The Dental Plan may seek the Agency's written permission to waive this provision of the Contract and provide documentation and evidence that the subcontractor no longer meets eligibility requirements to deliver services under this Contract or the subcontractor's authorization, administrative, or reimbursement practices are jeopardizing enrollees' access to care. The Agency may grant written permission at its sole discretion.
- k. Dental Provider Incentive Program (DPIP)
 - (1) See **Section I.**, General Overview, **Sub-Section C.**, Prioritizing Quality and Value, **Item 2.**, Value-Based Purchasing (VBP) Programs, **Sub-Item e.**, Provider Participation in VBP Agreements with the Dental Plan, for additional provisions related to the DPIP.
 - (2) All model and executed subcontracts and amendments used by the Dental Plan under this Contract shall include a statement that the Dental Plan shall make no

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specific payment directly or indirectly under a DPIIP to a subcontractor as an inducement to reduce or limit medically necessary services to an enrollee, and affirmatively state that all incentive plans do not provide incentives, monetary or otherwise, for the withholding of medically necessary care. (42 CFR 422.208(c)(1); 42 CFR 438.3(i)) If the DPIIP places a dental provider or dental provider group at substantial financial risk (pursuant to 42 CFR 422.208(a)(d)) for services that the dentist or dental provider group does not furnish itself, the Dental Plan shall assure that all dentists and dental provider groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with 42 CFR 422.208(c)(2). The Dental Plan shall provide assurances to the Secretary of DHHS that the requirements of 42 CFR 422.208 are met in accordance with 42 CFR 422.210(a).

2. Subcontractor Eligibility

- a. All subcontractors must be eligible for participation in the Medicaid program; however, the subcontractor is not required to participate in the Medicaid program as a provider.
- b. If a subcontractor was involuntarily terminated from the Medicaid program other than for purposes of inactivity, that entity is not considered an eligible subcontractor.
- c. The Dental Plan shall not delegate provider network management to a subcontractor that meets both of the following:
 - (1) The subcontractor is owner or has controlling interest in any provider(s) included in the network; and
 - (2) The subcontractor limits enrollee choice of network providers through a requirement for a referral/authorization process to access network providers.

3. Subcontract Content Requirements

- a. Payment - The Dental Plan shall make payment to all subcontractors pursuant to all State and federal laws, rules and regulations, including Part IV of 409, F.S., 641.3155, F.S., 42 CFR 238.230, 42 CFR 447.46, and 42 CFR 447.45(d)(2), (3), (5) and (6), in addition to sub regulatory guidance and the provisions of this Contract.
 - (1) All model and executed subcontracts and amendments used by the Dental Plan under this Contract shall meet the following requirements:
 - (a) Identify conditions and method of payment;
 - (b) Provide for full disclosure of the method and amount of compensation or other consideration to be received from the Dental Plan;
 - (c) Require any claims processing vendors to maintain accurate enrollee and provider information, including provider agreements reflecting the correct reimbursement rate and provider specialty, in order to ensure the correct adjudication of claims and proper payment to providers;

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- (d) Require any payment to a provider be accompanied by an itemized accounting of the individual claims included in the payment, including but not limited to the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement, and the identification of the Dental Plan;
 - (e) Require an adequate record system be maintained for recording services, charges, dates, and all other commonly accepted information elements for services rendered to the Dental Plan;
 - (f) Specify that the Dental Plan shall assume responsibility for cost avoidance measures for third party collections in accordance with **Section XI.**, Financial Requirements.
- (2) If the Dental Plan delegates claims processing and payment or enters into a risk-bearing contract, the Dental Plan agrees to:
- (a) Require the subcontractor(s) to submit quarterly unaudited and annual audited financial statements to the Dental Plan. The quarterly unaudited financial statements shall be submitted to the Dental Plan within sixty (60) days of the end of the quarter and annual audited financial statements shall be submitted within one hundred twenty (120) days of the end of the calendar year.
 - (b) Provide the Agency, upon request, with copies of the financial statements, including documentation of the Dental Plan's financial review. Failure to obtain required financial statements shall result in liquidated damages as specified in **Section XIII.**, Liquidated Damages.
 - (c) Notify the Agency within two (2) days of discovery, if based on the Dental Plan's review of financial statements or other information, the Dental Plan has reason to believe that the subcontracted vendor is insolvent or becoming insolvent. Failure to notify the Agency within two (2) days shall result in liquidated damages as specified in **Section XIII.**, Liquidated Damages.
 - (d) Require the subcontractor to maintain either an:
 - (i) Insolvency account to meet its obligations. The insolvency account shall be funded in an amount equal to two percent (2%) of the annual contract value. In the event that the subcontractor has filed for bankruptcy or has otherwise been determined to be insolvent by a regulating entity, the insolvency account may be drawn upon solely by the Dental Plan to disburse funds to meet Medicaid financial obligations incurred by the subcontractor under the Contract between the Dental Plan and subcontractor. Documentation of the insolvency account, including account balances and governing agreements, shall be provided to the Agency upon request; or

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- (ii) Irrevocable Standby Letter of Credit (LOC), with the Dental Plan as the beneficiary. The value of the LOC shall be at least two percent (2%) of the annual subcontract value and shall allow the Dental Plan to draw upon the LOC should the subcontracted vendor fail to perform under the subcontract. The issuing bank shall be a federally guaranteed financial institution licensed to do business in Florida and must be acceptable to the Agency. Copies of the LOC shall be provided to the Agency.

If the Dental Plan fails to comply with the requirements of this provision, the Dental Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

- b. Monitoring and Inspections - All model and executed subcontracts and amendments used by the Dental Plan under this Contract shall meet the following requirements with respect to provisions for monitoring and inspections:
 - (1) Provide that the Agency, CMS, the DHHS Inspector General, the Comptroller General or their designees, and DHHS have the right to audit, evaluate, or inspect the subcontractor's premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's subcontractor, pertaining to any aspect of services and activities performed, or determination of amounts payable under the Dental Plan's Contract with the State. In accordance with 42 CFR 438.230(c)(3)(iii), the subcontractor shall agree that the right to audit exists through ten (10) years from the final date of this Contract period or from the date of completion of any audit, whichever is later;
 - (2) Provide that the subcontractor shall make available for purposes of an audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems relating to its Medicaid enrollees pertinent to this Contract by the Agency, CMS, the DHHS Inspector General, the Comptroller General or their designees, and DHHS; (42 CFR 438.3(h); s. 1903(m)(2)(A)(iv) of the Social Security Act).
 - (3) Require full cooperation in any investigation by the Agency, MFCU, CMS, the DHHS Inspector General, the Comptroller General, or their designees, or other State or federal entity or any subsequent legal action that shall result from such an investigation
 - (4) In addition to record retention requirements for practitioner or provider licensure, require subcontractors to retain, as applicable, the following information in accordance with 42 CFR 438.3(u): enrollee grievance and appeal records in 42 CFR 438.416; base data in 42 CFR 438.5(c); MLR reports in 42 CFR 438.8(k); and the data, information, and documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608, and 42 CFR 438.610 for a period not less than ten (10) years from the close of this Contract and retained further if the records

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are under review or audit until the review or audit is complete. (Prior approval for the disposition of records must be requested and approved by the Dental Plan if the subcontract is continuous.); (42 CFR 438.3(h))

- (5) Provide for monitoring and oversight by the Dental Plan and the subcontractor to provide assurance that all licensed dental providers are credentialed in accordance with the Dental Plan's and the Agency's credentialing requirements as found in **Section VII.**, Provider Network and Services, if the Dental Plan has delegated the credentialing to a subcontractor;
 - (6) Provide for monitoring of services rendered to Dental Plan enrollees through the subcontractor.
- c. Protective Clauses - All model and executed subcontracts and amendments used by the Dental Plan under this Contract shall meet the following requirements with respect to protective clauses:
- (1) Require safeguarding of information about enrollees according to 42 CFR Part 438.224.
 - (2) Require an exculpatory clause, which survives subcontract termination, including breach of subcontract due to insolvency, which assures that enrollees or the Agency shall not be held liable for any debts of the subcontractor.
 - (3) Contain a clause indemnifying, defending and holding the Agency, its designees, and the Dental Plan's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the subcontract agreement. This clause must survive the termination of the subcontract, including breach due to insolvency. The Agency shall waive this requirement for itself, but not Dental Plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the subcontractor is a State agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers must be approved in writing by the Agency.
 - (4) Require that the subcontractor secure and maintain, during the life of the subcontract, workers' compensation insurance for all of its employees connected with the work under this Contract unless such employees are covered by the protection afforded by the Dental Plan. Such insurance shall comply with Florida's Workers' Compensation Law.
 - (5) Specify that if the subcontractor delegates or subcontracts any functions of its contract with the Dental Plan, that the subcontract or delegation shall include all the requirements of this Contract.
 - (6) Make provisions for a waiver of those terms of the subcontract, which, as they pertain to Medicaid recipients, are in conflict with the specifications of this Contract.

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- (7) Provide for revoking delegation, or imposing other sanctions, if the subcontractor's performance is inadequate.
 - (8) Provide that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. (42 CFR 438.210(e))
 - (9) Provide that the subcontractor shall establish, enforce, and monitor solvency requirements that provide assurance of the subcontractor's ability to meet its obligations.
 - (10) Require that the subcontractor timely notify the Dental Plan of changes in directory information.
 - (11) Provide details about the following as required by Section 6032 of the federal Deficit Reduction Act of 2005:
 - (a) The False Claims Act;
 - (b) The penalties for submitted false claims and statements;
 - (c) Whistleblower protections; and
 - (d) The entity's role in preventing and detecting fraud, waste and abuse, and each person's responsibility relating to detection and prevention.

(42 CFR 438.608(a)(6); s. 1902(a)(68) of the Social Security Act)
 - (12) The Dental Plan subcontracts with providers shall ensure that providers are obligated to cooperate with recovery efforts, including participating in audits and repay overpayments.
- d. The Dental Plan shall require its subcontractors to co-brand all communications with enrollees and providers to ensure it is clear that the Dental Plan is aware of and endorses the content contained within the communication.
- If the Dental Plan fails to comply with the requirements of this provision, the Dental Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.
- e. All subcontracts for claims adjudication activities shall comply with 42 CFR 438.8(k)(3).
 - f. Termination Procedures - In accordance with the requirements of the **Standard Contract, Section III.**, The Vendor and Agency Hereby Mutually Agree, **Sub-Section A.**, Termination, all provider agreements and subcontracts shall contain termination procedures.

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- g. Marketing - All subcontracts specify that the subcontractor shall comply with the marketing requirements specified in **Section III.**, Marketing.
- h. All subcontracts shall require subcontractors to submit notice of termination at least ninety (90) days before the effective date of such withdrawal.
- i. Encounter Data - All model and executed subcontracts and amendments used by the Dental Plan under this Contract shall require subcontractors to submit timely, complete, and accurate encounter data to the Dental Plan in accordance with the requirements of **Section IX.**, Administration and Management, **Sub-Section D.**, Information Management Systems.

(2) Other Contract Requirements

Subcontractors are subject to background checks. The Dental Plan shall consider the nature of the work a subcontractor or agent shall perform in determining the level and scope of the background checks in accordance with s. 408.809, F.S.

(3) Minority Business Enterprises

The State supports and encourages supplier diversity and the participation of small and minority business enterprises in State contracting, both as vendors and as subcontractors. The Agency supports diversity in its Procurement Program and requests that all subcontracting opportunities afforded by this Contract enthusiastically embrace diversity. The award of subcontracts should reflect the full diversity of the citizens of the State of Florida. Respondents can contact the Office of Supplier Diversity online at <http://osd.dms.state.fl.us/> for information on minority vendors who shall be considered for subcontracting opportunities.

J. Information Management and Systems

1. General Provisions

The Dental Plan shall have information management processes and information systems of sufficient capacity that enable it to meet Agency and federal reporting requirements, other Contract requirements, and all applicable Agency policies, State and federal laws, rules and regulations, including HIPAA. The Dental Plan shall be responsible for establishing connectivity to the Agency's/State's wide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable Agency and/or State policies, standards and guidelines, as well as coordinating activities and developing cohesive systems strategies across vendors and agencies.

- a. Systems Functions - The Dental Plan shall have information management processes and information systems that collect, analyze, integrate, and report data, enabling the Dental Plan to meet Agency and federal reporting requirements. (42 CFR 438.242(a) and (b); s. 6504(a) of the ACA)

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- b. Systems Capacity - The Dental Plan's system(s) shall possess capacity sufficient to handle the workload projected for the begin date of implementation of this Contract and shall be scalable and flexible as to be adapted as needed, within negotiated timeframes, in response to changes in Contract requirements, increases in enrollment estimates, etc.
- c. Email System - The Dental Plan shall provide a continuously available electronic mail communication link (email system) with the Agency. This system shall be:
 - (1) Available from the workstations of the designated Dental Plan contacts.
 - (2) Capable of attaching and sending documents created using software products other than the Dental Plan's systems, including the Agency's currently installed version of Microsoft Office and any subsequent upgrades as adopted. The electronic mail system shall include encryption capabilities compliant with FIPS 140-2.
- d. HIPAA Compliance - The Dental Plan shall ensure it meets all federal regulations regarding required standard electronic transactions and standards for privacy and individually identifiable health information as identified in the HIPAA of 1996 and the HITECH Act of 2009 and associated regulations.
- e. Data Security - The Dental Plan shall conduct all activities in compliance with 45 CFR 164 Subpart C to ensure data security, including, but not limited to encryption of all information that is confidential under Florida or federal law, while in transmission and while resident on portable electronic media storage devices. Encryption is required and shall be consistent with FIPS, and/or the NIST publications regarding cryptographic standards.
- f. The Agency shall conduct an initial IT security score risk scan on the Dental Plan, as well as periodic or continuous security monitoring through an information security rating service, at the Agency's expense, to enable the Agency to effectively measure and mitigate the Dental Plan's security risks. The Dental Plan will work with the Agency's Security Rating Score Provider to define the relevant vendor assets providing Agency services. If the Dental Plan fails to maintain a B or higher security rating score, the Dental Plan shall be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages.
- g. Participation in Information Systems Work Groups/Committees - The Dental Plan shall meet as requested by the Agency, to coordinate activities and develop cohesive systems strategies across vendors and agencies.
- h. Connectivity to the Agency/State Network and Systems - The Dental Plan shall be responsible for establishing connectivity to the Agency's/State's wide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable Agency and/or State policies, standards, and guidelines. The Dental Plan shall notify the Agency of termination of any staff with access to the Agency's network within twenty-four (24) hours of the termination.

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- i. Security Training - Dental Plan staff that have access connectivity to the Agency's data communications network shall be required to complete Agency Security Awareness Training and Agency HIPAA Training. The Dental Plan shall sign an Acceptable Use Acknowledgement Form and submit the completed form to the Agency's Information Security Manager. The requirements described in this **Item** must be completed before access to the Agency's network is provided.
- j. The Dental Plan shall adhere and comply with the Agency's Division of IT standards regarding SSL Web interface(s) and TLS.
- k. The Dental Plan shall adhere to the Driver Privacy Protection Act rules that address a memorandum of understanding and security requirements as well as other requirements contained in Rule.
- l. The Dental Plan shall conform to current and updated publications of the principles, standards, and guidelines of the FIPS, the NIST publications, including but not limited to Cybersecurity-Framework and most recent NIST.SP.800-53r4.
- m. The Dental Plan, its employees, subcontractors and agents shall provide immediate notice to the Agency Information Security Manager ("ISM") in the event it becomes aware of any security breach and any unauthorized transmission or loss of any or all of the data collected or created for or provided by the Agency ("State Data") or, to the extent the Dental Plan is allowed any access to the Agency's information technology ("IT") resources, provide immediate notice to the ISM, of any allegation or suspected violation of security procedures of the Agency. Except as required by law and after notice to the Agency, the Dental Plan shall not divulge to third parties any confidential information obtained by the Dental Plan or its agents, distributors, resellers, subcontractors, officers or employees in the course of performing this Contract work according to applicable rules, including, but not limited to, Rule 60GG-2, Florida Administrative Code (FAC) and its successor regulation, security procedures, business operations information, or commercial proprietary information in the possession of the State or the Agency. After the conclusion of this Contract unless otherwise provided herein, the Dental Plan shall not be required to keep confidential information that is publicly available through no fault of the Dental Plan, material that the Dental Plan developed independently without relying on the State's confidential information, or information that is otherwise obtainable under State law as a public record.
- n. The Dental Plan shall report to the Agency in the manner and format obtained from the Agency, within twenty-four (24) of discovery of any security incident, as defined in Section XVI., Definitions, of this Attachment.
- o. If the Dental Plan fails to comply with the security incident reporting requirements of this Contract, the Dental Plan shall be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans.
- p. The Dental Plan shall employ traffic and network monitoring software and tools on a continuous basis:

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- (1) To identify obstacles to optimum performance.
- (2) To identify email and Internet spam and scams and restrict or track user access to appropriate websites.
- (3) To identify obstacles to detect and prevent hacking, intrusion, and other unauthorized use of the Dental Plan's resources.
- (4) To prevent adware or spyware from deteriorating system performance.
- (5) To update virus blocking software daily and aggressively monitor for and protect against viruses.
- (6) To monitor bandwidth usage and identify bottlenecks that impede performance.
- (7) To provide methods to flag recipient data to exclude PHI from data exchanges as approved by the State, and to comply with recipient rights under the HIPAA privacy law for: 1) Requests for restriction of the uses and disclosures on PHI (45 CFR 164.522(a)); 2) Requests for confidential communications (45 CFR 164.522(B)); and (3)) Requests for amendment of PHI (45 CFR 164.526). The Dental Plan shall also enter into a BAA with the Agency. The provisions of the BAA apply to HIPAA requirements and in the event of a conflict between the BAA and the provisions of this **Sub-Section**, the BAA shall control. (See **Standard Contract**).

2. Data and Document Management Requirements

a. Adherence to Data and Document Management Standards

- (1) The Dental Plan's systems shall conform to the standard transaction code sets specified in this Contract.
- (2) The Dental Plan's systems shall conform to HIPAA and HITECH standards for data and document management.
- (3) The Dental Plan shall collaborate with the Agency in the management of standard transaction code sets specific to the Agency. Furthermore, the Dental Plan shall collaborate with the Agency in the development and implementation planning of future standard code sets not specific to HIPAA or other federal efforts and shall conform to these standards as stipulated in the plan to implement the standards.

- b. Data Model and Accessibility. Dental Plan systems shall be SQL and/or ODBC compliant. Alternatively, the Dental Plan's systems shall employ a relational data model in the architecture of its databases in addition to a relational database management system to operate and maintain them.

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- c. Data and Document Relationships. The Dental Plan shall house indexed images of documents used by enrollees and providers to transact with the Dental Plan in the appropriate database(s) and document management systems so as to maintain the logical relationships between certain documents and certain data.
- d. Information Retention. Information in the Dental Plan's systems shall be maintained in electronic form for three (3) years in live systems and for an additional ten (10) years in archival systems. Enrollee grievance and appeal records (42 CFR 438.416) base data (42 CFR 438.5(c)), MLR reports (42 CFR 438.8(k)), and the data, information, and documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608, and 42 CFR 438.610 shall be maintained for a period of no less than ten (10) years in accordance with 42 CFR 438.3(u) in live and/or archival systems, or longer for audits or litigation as specified elsewhere in this Contract.
- e. Information Ownership. All information, whether data or documents, and reports that contain or make references to said Information, involving or arising out of this Contract is owned by the Agency. The Dental Plan is expressly prohibited from sharing or publishing the Agency information and reports without the prior written consent of the Agency. In the event of a dispute regarding the sharing or publishing of information and reports, the Agency's decision on this matter shall be final and not subject to change.

3. System and Data Integration Requirements

- a. Adherence to Standards for Data Exchange
 - (1) The Dental Plan's systems shall be able to transmit, receive and process data in HIPAA-compliant formats.
 - (2) The Dental Plan's systems shall be able to transmit, receive and process data in the Agency-specific formats and/or methods.
 - (3) The Dental Plan's systems shall conform to future federal and/or Agency-specific standards for data exchange, including HIPAA-compliant data formats, within one hundred twenty (120) days of the standard's effective date or, if earlier, the date stipulated by HHS, CMS, or the Agency. The Dental Plan shall partner with the Agency in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal efforts. Furthermore, the Dental Plan shall conform to these standards as stipulated in the Agency agreed-upon plan to implement such standards.
- b. HIPAA Compliance Checker. All HIPAA-conforming transactions between the Agency and the Dental Plan shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker application.

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- c. Data and Report Validity and Completeness. The Dental Plan shall institute processes to ensure the validity and completeness of the data, including reports, it submits to the Agency. At the Agency's discretion, the Dental Plan shall be subject to general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that shall be audited include, but are not limited to: enrollee ID, date of service, assigned Medicaid provider ID, category and subcategory (if applicable) of service, diagnosis codes, procedure codes, revenue codes, date of claim processing, and (if and when applicable) date of claim payment. Control totals shall also be reviewed and verified.
- d. State/Agency Website/Portal Integration. Where deemed that the Dental Plan's web presence shall be incorporated to any degree to the Agency's or the State's web presence (also known as a portal), the Dental Plan shall conform to any applicable Agency or State standard for website structure, coding, and presentation.
- e. Functional Redundancy with Agency Systems. The Dental Plan's systems shall be able to transmit and receive transaction data to and from Agency Systems as required for the appropriate processing of claims and any other transaction that could be performed by either system.
- f. Data Exchange in Support of the Agency's Program Integrity and Compliance Functions. The Dental Plan's systems shall be capable of generating files in the prescribed formats for upload into Agency systems used specifically for program integrity and compliance purposes.
- g. Address Standardization. The Dental Plan's system(s) shall possess mailing address standardization functionality in accordance with U.S. Postal Service conventions.
- h. Eligibility and Enrollment Data Exchange Requirements
 - (1) The Dental Plan shall receive process and update enrollment files sent daily by the Agency or its agent(s).
 - (2) The Dental Plan shall update its eligibility/enrollment databases within twenty-four (24) hours after receipt of said files.
 - (3) The Dental Plan shall transmit to the Agency or its agent, in a periodicity schedule, format, and data exchange method to be determined by the Agency, specific data it shall garner from an enrollee including third party liability data.
 - (4) The Dental Plan shall be capable of uniquely identifying a distinct Medicaid recipient across multiple systems within its span of control.

4. Systems Availability, Performance, and Problem Management Requirements

- a. Availability of Critical Systems Functions. The Dental Plan shall ensure that critical systems functions available to enrollees and providers, functions that if unavailable would have an immediate detrimental impact on enrollees and providers, are available

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- twenty-four hours per day, seven days per week (24/7), except during periods of scheduled system unavailability agreed upon by the Agency and the Dental Plan. Unavailability caused by events outside of a Dental Plan's span of control should be addressed in a Business Continuity plan. The Dental Plan shall make the Agency aware of the nature and availability of these functions prior to extending access to these functions to enrollees and/or providers.
- b. Availability of Data Exchange Functions. The Dental Plan shall ensure that the systems and processes within its span of control associated with its data exchanges with the Agency and/or its agent(s) are available and operational according to specifications and the data exchange schedule.
 - c. Availability of Other Systems Functions. The Dental Plan shall ensure that at a minimum, all other system functions and information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m., in the time zone where the user is located, Monday through Friday.
 - d. Problem Notification
 - (1) Upon discovery of any problem within its span of control that shall jeopardize or is jeopardizing the availability and performance of all systems functions and the availability of information in said systems, including any problems affecting scheduled exchanges of data between the Dental Plan and the Agency and/or its agent(s), the Dental Plan shall notify the applicable Agency staff via phone, fax, and/or electronic mail within one (1) hour of such discovery. In its notification, the Dental Plan shall explain in detail the impact to critical path processes such as enrollment management and claims submission processes.
 - (2) The Dental Plan shall provide appropriate Agency staff information on system unavailability events, as well as status updates on problem resolution. At a minimum, these updates shall be provided on an hourly basis and made available via electronic mail and/or telephone.
 - e. Recovery from Unscheduled System Unavailability. Unscheduled system unavailability caused by the failure of systems and telecommunications technologies within the Dental Plan's span of control shall be resolved, and the restoration of services implemented, within forty-eight (48) hours of the official declaration of system unavailability.
 - f. Exceptions to System Availability Requirement. The Dental Plan shall not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the Dental Plan's span of control.

Information Systems CAP. If at any point there is a problem with a critical systems function, at the request of the Agency, the Dental Plan shall provide to the Agency full written documentation that includes a CAP that describes how problems with critical systems functions shall be prevented from occurring again. The CAP shall be delivered to the Agency within five (5) business days of the problem's occurrence. Failure to submit a CAP and to show progress in implementing the CAP shall make the Dental

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Plan subject to sanctions, in accordance with **Section XII.**, Sanctions and Corrective Action Plans.

g. Business Continuity-Disaster Recovery (BC-DR) Plan

- (1) Regardless of the architecture of its systems, the Dental Plan shall develop, maintain, and be continually ready to invoke a BC-DR plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed. The BC-DR plan shall limit service interruption to a period of twenty-four (24) hours and shall ensure compliance with all contractual requirements. The records backup standards and BC-DR plan shall be developed and maintained for the entire Contract period.
- (2) The BC-DR plan shall include a strategy for restoring day-to-day operations, including alternative locations for the Dental Plan to operate. The BC-DR plan shall maintain database backups in a manner that eliminates service disruptions or data loss due to system or program failures or destruction.

The Dental Plan's BC-DR plan shall be submitted to the Agency. If the approved plan is unchanged from the previous year, the Dental Plan shall submit a certification to the Agency that the prior year's plan is still in place May 1st of each Contract year. Changes in the plan are due to the Agency within ten (10) business days after the change.

- (3) At a minimum, the Dental Plan's BC-DR plan shall address the following scenarios:
 - (a) The central computer installation and resident software are destroyed or damaged;
 - (b) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage;
 - (c) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of data maintained in a live or archival system;
 - (d) System interruption or failure resulting from network, operating hardware, software, or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but do prevent access to the system, i.e., cause unscheduled system unavailability; and
 - (e) Malicious acts, including malware or manipulation.
- (4) The Dental Plan shall periodically, but no less than annually, by April 30 of each Contract year, perform comprehensive tests of its BC-DR plan through simulated disasters and lower-level failures in order to demonstrate to the Agency that it can restore system functions by being ISO22301 certified (Business Continuity

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Management) or comparable standard (contingent upon Agency approval) certified.

- (5) Outbound mail gateways used by the Dental Plan shall be configured to only send emails to the Agency over an encrypted connection (currently, TLS). Additionally, all incoming mail gateways must be configured to accept encrypted connections (TLS) as the Agency shall only be transmitting mail across such connections.
- (6) In the event that the Dental Plan fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Contract, the Dental Plan shall be required to submit to the Agency a CAP in accordance with **Section XII.**, Sanctions and Corrective Action Plans, that describes how the failure shall be resolved. The CAP shall be delivered within ten (10) business days of the conclusion of the test.

h. Data Security

- (1) The Dental Plan, its employees, subcontractors, and agents shall provide immediate notice within one hour to the Agency ISM in the event it becomes aware of any security breach and any unauthorized transmission or loss of any or all of the data collected or created for or provided by the Agency (State Data) or, to the extent the Dental Plan is allowed any access to the Agency's IT resources, provide immediate notice to the ISM, of any allegation or suspected violation of security procedures of the Agency. Except as required by law and after notice to the Agency, the Dental Plan shall not divulge to third parties any confidential information obtained by the Dental Plan or its agents, distributors, resellers, subcontractors, officers, or employees in the course of performing contract work according to applicable rules, including, but not limited to, Rule 60GG-2, F.A.C., and its successor regulation, security procedures, business operations information, or commercial proprietary information in the possession of the State or the Agency. After the conclusion of this Contract unless otherwise provided herein, the Dental Plan shall not be required to keep confidential information that is publicly available through no fault of the Dental Plan, material that the Dental Plan developed independently without relying on the State's confidential information, or information that is otherwise obtainable under State law as a public record.

In the event of loss of any State Data or record where such loss is due to the negligence of the Dental Plan or any of its subcontractors or agents, the Dental Plan shall be responsible for recreating such lost data in the manner and on the schedule set by the Agency at the Dental Plan's sole expense, in addition to any other damages the Agency shall be entitled to by law or this Contract. In the event lost or damaged data is suspected, the Dental Plan shall perform due diligence and report findings to the Agency and perform efforts to recover the data. If it is unrecoverable, the Dental Plan shall pay all the related costs associated with the remediation and correction of the problems engendered by any given specific loss. Further, failure to maintain security that results in certain data release shall subject the Dental Plan to liquidated damages for failure to comply with s. 501.171, F.S., together with any costs to the Agency of such

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breach of security caused by the Dental Plan. If State Data shall reside in the Dental Plan's system, the Agency shall conduct, or request the Dental Plan conduct at the Dental Plan's expense, an annual network penetration test or information security audit of the Dental Plan's system(s) on which State Data resides. State-owned Data shall be processed and stored in data centers that are located only in the forty-eight (48) contiguous U.S. All successful Dental Plan personnel who shall have access to State-owned Data shall undergo the background checks and screenings described in this Contract. Within the first Contract year of this Contract term, the Dental Plan shall obtain a NIST compliant information security risk assessment conducted by an independent third party unless one has been completed within the year prior to Contract execution.

5. System Testing and Change Management Requirements

- a. Notification and Discussion of Potential System Changes. The Dental Plan shall notify the Agency of the following changes to systems within its span of control at least ninety (90) days before the projected date of the change. If so directed by the Agency, the Dental Plan shall discuss the proposed change with the applicable Agency staff. This includes: (1) software release updates of core transaction systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment, and data management; and (2) conversions of core transaction management systems.
- b. Response to Agency Reports of Systems Problems not Resulting in System Unavailability
 - (1) The Dental Plan shall respond to Agency reports of system problems not resulting in system unavailability according to the following timeframes:
 - (a) Within seven (7) days of receipt, the Dental Plan shall respond in writing to notices of system problems; and
 - (b) Within twenty (20) days, the correction shall be made, or a requirements analysis and specifications document shall be due.
 - (2) The Dental Plan shall correct the deficiency by an effective date to be determined by the Agency.
- c. Valid Window for Certain System Changes. Unless otherwise agreed to in advance by the Agency as part of the activities described in this **Section**, scheduled system unavailability to perform system maintenance, repair, and/or upgrade activities shall not take place during hours that could compromise or prevent critical business operations.
- d. Testing
 - (1) The Dental Plan shall work with the Agency pertaining to any testing initiative as required by the Agency.

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- (2) Upon the Agency's written request, the Dental Plan shall provide details of the test regions and environments of its core production information systems, including a live demonstration, to enable the Agency to corroborate the readiness of the Dental Plan's information systems.
- (3) The Dental Plan shall be required to complete system integration testing with the Agency for enhancements and future initiatives, when needed.

6. Information Systems Documentation Requirements

- a. Types of Documentation. The Dental Plan shall develop, prepare, print, maintain, produce, and distribute distinct system process and procedure manuals, user manuals, and quick-reference guides, and any updates thereafter, for the Agency and other applicable Agency staff.
- b. Content of System Process and Procedure Manuals. The Dental Plan shall ensure that written system process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.
- c. Content of System User Manuals. The system user manuals shall contain information about, and instructions for, using applicable system functions and accessing applicable system data.
- d. Changes to Manuals
 - (1) When a system change is subject to the Agency's written approval, the Dental Plan shall draft revisions to the appropriate manuals prior to Agency approval of the change.
 - (2) Updates to the electronic version of these manuals shall occur in real time; updates to the printed version of these manuals shall occur within ten (10) business days of the update's taking effect.
- e. Availability of/Access to Documentation. All of the aforementioned manuals and reference guides shall be available in printed form and/or online. If so prescribed, the manuals shall be published in accordance with the appropriate Agency and/or State standard.

7. Reporting Requirements

The Dental Plan shall extract and upload data sets, upon request, to an Agency-hosted secure FTP site to enable authorized Agency personnel, or the Agency's agent, on a secure and read-only basis, to build and generate reports for management use. The

Agency and the Dental Plan shall arrange technical specifications for each data set as required for completion of the request.

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8. Community Health Record/Continuity of Care Document/Electronic Enrollee Record and Related Efforts

- a. At such times that the Agency requires, the Dental Plan shall participate and cooperate with the Agency to implement, within a reasonable timeframe, secure, web-accessible, community health records for enrollees.
- b. The design of the vehicle(s) for accessing the community health record/continuity of care document, the health record format, and design shall comply with all HIPAA and related regulations.
- c. The Dental Plan shall also cooperate with the Agency in the continuing development of the State's health care data site (www.FloridaHealthFinder.com).
- d. The Dental Plan shall provide to its staff and volunteers, initial and ongoing/periodic training on this Contract, including but not limited to HIPAA and the HITECH Act regarding the use and safeguarding of PHI.

9. Compliance with Standard Coding Schemes

- a. Compliance with HIPAA-Based Code Sets. Dental Plan systems that are required to or otherwise contain the applicable data type shall conform to the following HIPAA-based standard code sets; the processes through which the data are generated should conform to the same standards as needed; for example:
 - (1) LOINC;
 - (2) HCPCS;
 - (3) Home Infusion EDI Coalition Product Codes;
 - (4) NDC;
 - (5) NCPDP;
 - (6) ICD;
 - (7) DRG;
 - (8) CARC; and
 - (9) RARC.
- b. Compliance with Other Code Sets. Dental Plan systems that are required to or otherwise contain the applicable data type shall conform to the following non-HIPAA-based standard code sets:
 - (1) As described in all Agency Medicaid reimbursement handbooks, for all "covered entities," as defined under HIPAA, and which submit transactions in paper format

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(non-electronic format); and

- (2) As described in all Agency Medicaid reimbursement handbooks for all "non-covered entities," as defined under HIPAA.

10. Data Exchange and Formats and Methods Applicable to Dental Plans

- a. HIPAA-Based Formatting Standards. Dental Plan systems shall conform to the following HIPAA-compliant standards for EDI of health care data effective the first day of implementation in the applicable region(s). The Dental Plan shall submit and receive transactions, ASC X12N or NCPDP (for certain pharmacy transactions), including claims and encounter information, payment and remittance advice, claims status, eligibility, enrollment and disenrollment, referrals and authorizations, coordination of benefits, and premium payment. The implementation specifications for ASC X12N standards shall be obtained from the Washington Publishing Company on the Internet at <http://www.wpc-edi.com/>. Florida specifications shall be obtained on the Florida Medicaid provider portal at: [http://portal.flmmis.com/FLPublic/Provider EDI/Provider EDI CompanionGuides/tabId/62/default.aspx](http://portal.flmmis.com/FLPublic/Provider%20EDI/Provider%20EDI%20CompanionGuides/tabId/62/default.aspx)

Transaction types include, but are not limited to:

- (1) ASC X12N 820 Payroll Deducted & Other Premium Payment
 - (2) ASC X12N 834 Enrollment and Audit Transaction
 - (3) ASC X12N 835 Claims Payment Remittance Advice Transaction
 - (4) ASC X12N 837I Institutional Claim/Encounter Transaction
 - (5) ASC X12N 837P Professional Claim/Encounter Transaction
 - (6) ASC X12N 270/271 Eligibility/Benefit Inquiry/Response
 - (7) ASC X12N 276 Claims Status Inquiry
 - (8) ASC X12N 277 Claims Status Response
 - (9) ASC X12N 278 Utilization Review Inquiry/Response
 - (10) NCPDP D.0 Pharmacy Claim/Encounter Transaction
- b. Methods for Data Exchange
 - (1) The Dental Plan and the Agency and/or its agent shall make predominant use of SFTP and EDI in their exchanges of data.
 - (2) The Dental Plan shall encourage network providers to participate in the Agency's DSM service.

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- c. Agency-Based Formatting Standards and Methods. Dental Plan systems shall exchange the following data with the Agency and/or its agent in formats specified by the Agency:
- (1) Provider network data;
 - (2) Case management fees; and
 - (3) Payments.

11. Smartphone Applications

- a. The Dental Plan shall develop and maintain procedures regarding the use of social networking or smartphone applications (apps).
- b. If the Dental Plan uses apps to allow enrollees direct access to Agency-approved enrollee materials, the Dental Plan shall comply with the following:
- (1) The smartphone application shall disclaim that the app being used is not private and that no PHI or personally identifying information should be published on this application by the Dental Plan or end user; and
 - (2) The Dental Plan shall ensure that software applications obtained, purchased, leased, or developed are based on secure coding guidelines.

12. Social Networking

- a. The Dental Plan shall adhere to the following user requirements for procedure development, permitted uses of apps, and acceptable content for social networking applications/tools in performance of this Contract. These requirements shall apply to all interactions/communications by the Dental Plan or its subcontractors with enrollees, providers, and website requirements, when conducted through social networking applications.
- b. The Dental Plan is vicariously liable for any social networking violations of its employees, agents, volunteers, providers, or subcontractors.
- c. User Requirements
- (1) The Dental Plan's presence on such social networking sites must include an avatar and/or a username that clearly indicates the Dental Plan that is being represented. The Dental Plan shall not use any Agency logo or State of Florida seal on its social media networking sites. When registering for social networking applications, the Dental Plan shall use its email address. The Dental Plan shall seek prior approval of its social media syntax from the Agency if the application/tool requires a username.
 - (2) The enrollee or prospective enrollee, or friend/follower, and not the Dental Plan, must initiate all Social Networking interactions/communications. Any

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communication resulting from such a subscription shall include a link/method to opt-out of the subscription.

- (3) The Dental Plan shall place photographs on pages that are hosted on the site and not linked from outside Web pages. The Dental Plan shall not post information, photos, links/URLs, or other items online that would reflect negatively on any individual(s), its enrollees, the Agency, or the State.
- (4) The Dental Plan shall not tag photographic or video content and must remove all tags placed by others upon discovery.

d. Functionalities

The following functionalities are prohibited:

- (1) Authoring – The ability to create and update content leads to the collaborative work of many rather than just a few Web authors such as in wikis and/or blogs. In wikis, users shall extend, undo, and redo each other’s work. In blogs, posts and the comments of individuals build up over time;
- (2) Tags – Categorization of content by users adding one-word descriptions to facilitate searching, without dependence on pre-made categories;
- (3) Extensions – Software that makes the Web an application platform as well as a document server; and
- (4) Forums – Sites hosted by a company that allow users to create topics (threads) and post comments, questions, etc., that are available for public conversation among all participants in the forum.

K. Encounter Data Requirements

1. General Provisions

- a. Encounter data collection and submission is required from the Dental Plan for all services, including other benefits and expanded benefits, rendered to its enrollees (excluding services paid directly by the Agency on a FFS basis). The Dental Plan shall submit encounter data that meets established Agency data quality standards as defined herein. These standards are defined by the Agency as the receipt of complete, timely, and accurate data and are needed for program administration and to set actuarially sound capitation rates. These standards are closely monitored and enforced. (42 CFR 438.242(b)(1); 42 CFR 438.604(a)(1); 42 CFR 438.606; 42 CFR 438.818)
- b. The Dental Plan shall receive amended standards with advance notice as described in this **Section** for the purposes of continuous QI. The Dental Plan shall make changes or corrections to any systems, processes, or data transmission formats as needed to comply with the Agency’s data quality standards. The Dental Plan shall receive:
 - (1) No notice for Medicaid Companion Guide updates that are informational and/or

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limited to clarification of existing standards or setting an edit from “deny” to “pay.”

- (2) Thirty (30) days’ notice for setting a pay edit to deny or informing the Dental Plan of new CARC and RARC combinations.
- (3) Sixty (60) days’ notice for adding a new and unique plan-related edit.
- (4) Ninety (90) days’ notice of a system change resulting in a process change for the Dental Plan.

The Dental Plan shall be capable of sending and receiving any claims information directly to the Agency meeting the above standards and timeframes.

- c. The Dental Plan shall certify all data to the extent required in 42 CFR 438.606. Such certification must be submitted to the Agency concurrently with the data and must be based on the knowledge, information and belief of the CEO, CFO, Chief Medical Officer or an individual who has written delegated authority to sign for, and directly reports to the CEO or CFO that all data submitted in conjunction with the encounter data and all documents requested by the Agency are accurate, truthful, and complete. (42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c))
- d. The Dental Plan shall have the capacity to identify encounter data anomalies and shall provide a description of that process to the Agency for review and approval.
- e. The Dental Plan shall designate sufficient IT and staffing resources to perform these encounter functions as determined by generally accepted best industry practices.
- f. The Dental Plan shall retain submitted encounter data for a period not less than ten (10) years per 42 CFR 438.3(u).

2. Requirements for Complete, Timely, and Accurate Encounters

The Dental Plan shall establish and maintain a comprehensive automated and integrated encounter data system capable of capturing, storing, and transmitting complete, accurate and timely encounter data to the Agency.

- a. All Dental Plan encounters shall be submitted to the Agency in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P - Professional; D - Dental). The Dental Plan’s encounters shall also follow the standards in the Agency’s 5010 Companion Guides, the Florida D.0 Payer Specification – Encounters and in this **Section**. Encounters must include Dental Plan amounts paid to the providers and shall be submitted for all providers (capitated and non-capitated).
- b. Dental Plan Paid Amount Submissions:
 - (1) Fee-for-Service encounters must include Dental Plan amounts paid to the providers and shall be submitted for all providers even if the amounts paid are zero (0) dollars.

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- (2) Capitated Encounters where a claim is submitted by the rendering provider back to the Dental Plan, must include Dental Plan amounts paid to the provider and shall be submitted for all providers even if the amounts paid are zero (0) dollars.
- (3) Capitated Encounters where the Dental Plan has contracted with another capitated provider, i.e., Physician Group or Network, where no claim was submitted by the contracted Group or Network back to the Dental Plan directly, must include the Dental Plan calculated amounts paid, and shall be submitted for all providers even if the calculated amounts paid are zero (0) dollars.
- c. The Dental Plan shall convert all information that enters its claims system via hard copy paper claims or other proprietary formats to encounter data to be submitted in the appropriate HIPAA-compliant formats.
- d. For any services in which a Dental Plan has entered into capitation reimbursement arrangements with providers, the Dental Plan shall comply with all encounter data submission requirements in this **Section**. The Dental Plan shall require timely submissions from its providers as a condition of the capitation payment.
- e. The Dental Plan shall implement and maintain review procedures to validate encounter data submitted by providers.
- f. The Dental Plan shall submit complete, accurate and timely encounter data to the Agency as defined below.
- g. For all services rendered to its enrollees (excluding services paid directly by the Agency on a FFS basis), the Dental Plan shall submit encounter data, without alteration or omission of provider submitted data, no later than seven (7) days following the date on which the Dental Plan adjudicated the claims. The Dental Plan shall append to the provider-submitted data the Dental Plan data required by the Agency as described in the Medicaid Companion Guides.
- h. The Dental Plan shall provide complete and accurate encounters to the Agency. The Dental Plan shall implement review procedures to validate encounter data submitted by providers.
 - (1) Complete: The Dental Plan shall submit encounters for no less than one hundred percent (100%) of the covered services provided by participating and non-participating providers, as defined in **Item 1.**, General Provisions, **Sub-Item a.**, Encounters, of this **Sub-Section**, including services denied by the Dental Plan. Encounters for which Agency system acceptance is not available are excluded.
 - (2) Timely: The Dental Plan shall submit no less than ninety-five percent (95%) of encounter data no later than seven (7) days following the date on which the Dental Plan adjudicated the claim.
 - (3) Accurate: No less than ninety-five percent (95%) of the Dental Plan's encounter lines submission shall pass FMMIS system edits as specified by the Agency.

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- (4) Resubmission: The Dental Plan shall correct one hundred percent (100%) of encounters that posted denial edits and resubmit within thirty (30) days.
- i. For encounter data acceptance purposes, the Dental Plan must submit valid HIPAA compliant transactions to the Agency, which include active, valid Medicaid provider NPIs or Medicaid IDs.
- j. The Dental Plan shall include the actual amount paid to providers on all encounter data submissions.
- k. The Dental Plan shall work with the Agency to establish an Encounter Claims Clearinghouse to enable Florida providers to submit claims and other EDI transactions directly to the Agency, in addition to, or instead of direct submission to the Dental Plan.

3. Encounter Data Submission

- a. The Dental Plan shall collect and submit encounter data to the Agency's fiscal agent. The Dental Plan shall be held responsible for errors or noncompliance resulting from their own actions or the actions of an agent authorized to act on its behalf.
- b. The encounter data submission standards required to support encounter data collection and submission are defined by the Agency in the Medicaid Companion Guides, Pharmacy Payer Specifications and this **Section**. In addition, encounter data reporting requirements shall be posted on the following websites:

http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_CompanionGuides/tabId/62/Default.aspx

http://portal.flmmis.com/flpublic/Provider_ManagedCare/Provider_ManagedCare_Encounter/Provider_ManagedCare_Pharmacy/tabid/82/desktopdefault+/Default.aspx

- c. The Dental Plan shall implement and maintain review procedures to validate the successful loading of encounter files by the Agency's fiscal agent's EDI clearinghouse. The Dental Plan shall use the EDI response (acknowledgement) files to determine if files were successfully loaded. Within seven (7) days of the original submission attempt, the Dental Plan shall correct and resubmit files that fail to load.
- d. Encounter Resubmission – Adjustments, Reversals or Corrections
 - (1) Within thirty (30) days after encounters fail X12 (EDI) edits or FMMIS system edits, the Dental Plan shall correct and resubmit all encounters for which errors can be remedied.
 - (2) The Dental Plan shall correct and resubmit one hundred percent (100%) of previously submitted X12 encounter data transactions to reflect the most current and accurate payment adjustments or reversals that resulted in a recoupment or additional payment within thirty (30) days of the respective action.

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- e. If the Dental Plan fails to comply with the encounter data reporting requirements of this Contract, the Dental Plan shall be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages.

L. Fraud and Abuse Prevention

1. General Provisions

- a. The Dental Plan shall establish functions and activities governing program integrity in order to reduce the incidence of fraud and abuse and shall comply with all State and federal program integrity requirements, including but not limited to the applicable provisions of the Social Security Act, ss. 1128, 1902, 1903, and 1932; 42 CFR 431, 433, 434, 435, 438, 441, 447, 455; 45 CFR Part 75; Chapters 409, 414, 458, 459, 460, 461, 626, 641 and 932, F.S., and Rules 59A-12.0073, 59G and 69D-2, F.A.C.; 2 CFS Part 200 and 2 CFR 300.1.
- b. The Dental Plan shall have adequate Florida-based staffing and resources to enable the compliance officer to investigate indicia of fraud, abuse, waste and develop and implement CAPs relating to fraud, abuse, waste and overpayment.
- c. The Dental Plan's written fraud and abuse prevention program shall have internal controls and procedures in place that are designed to prevent, reduce, detect, investigate, correct and report known or suspected fraud, abuse, and waste activities. This shall include reporting instances of fraud and abuse pursuant to 42 CFR 438.608, ss. 409.91212, 409.920, 626.989, and 641.3915, F.S.
- d. In accordance with s. 6032 of the federal Deficit Reduction Act of 2005, the Dental Plan shall make available written fraud and abuse policies to all employees. If the Dental Plan has an employee handbook, the Dental Plan shall include specific information about s. 6032, the Dental Plan's policies, and the rights of employees to be protected as whistleblowers.
- e. The Dental Plan shall meet with the Agency periodically, at the Agency's request, to discuss fraud, abuse, neglect, exploitation, and overpayment issues.
- f. The Agency shall impose sanctions and/or liquidated damages for failure to timely comply with the provisions of this **Section**.

2. Compliance Officer

The Dental Plan's compliance officer as described in **Section IX.**, Administration and Management, shall have unrestricted access to the Dental Plan's governing body for compliance reporting, including fraud, abuse, waste and overpayment.

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3. Special Investigation Unit

- a. The Dental Plan shall establish and maintain a special investigative unit to investigate possible acts of fraud, abuse, waste, or overpayment, or shall subcontract such functions.
- b. If a Dental Plan subcontracts for the investigation of fraudulent claims and other types of program abuse by enrollees or service providers, the Dental Plan shall file the following with the Bureau of MPI for approval at least sixty (60) days before subcontract execution:
 - (1) The names, addresses, telephone numbers, email addresses and fax numbers of the principals of the entity with which the Dental Plan wishes to subcontract;
 - (2) A description of the qualifications of the principals of the entity with which the Dental Plan wishes to subcontract; and
 - (3) The proposed subcontract.
- c. The Dental Plan shall submit to MPI such executed subcontracts, attachments, addendums, or amendments thereto, within thirty (30) days after execution.

4. Compliance Plan and Anti-Fraud Plan

- a. The Dental Plan shall submit its compliance plan and anti-fraud plan, including its fraud and abuse procedures, and any changes to these items, to MPI for written approval at least forty-five (45) days before those plans and procedures are implemented. (ss. 409.91212, F.S., and 409.967(2)(g), F.S.) The Dental Plan shall submit these documents via the MPI-MC SFTP site. Failure to implement an MPI approved anti-fraud plan within ninety (90) days shall result in liquidated damages. MPI shall reassess the implementation of the anti-fraud plan every ninety (90) days until MPI deems the Dental Plan to be in compliance. (**Section XIII.**, Liquidated Damages.)
- b. At a minimum, the Dental Plan shall submit its compliance plan to MPI by September 1 of each Contract year. The compliance plan shall comply with 42 CFR 438.608 and include:
 - (1) Written policies, procedures and standards of conduct that articulate the Dental Plan's commitment to comply with all applicable federal and State standards;
 - (2) The designation of a compliance officer and a compliance committee accountable to senior management;
 - (3) Effective training and education of the compliance officer and the Dental Plan's employees;
 - (4) Effective lines of communication between the compliance officer and the Dental Plan's employees;

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- (5) Enforcement of standards through well-publicized statutory and contractual requirements and related disciplinary guidelines;
 - (6) Provision for internal monitoring and auditing; and
 - (7) Provisions for prompt response to detected offenses and for development of corrective action initiatives.
- c. At a minimum, the Dental Plan shall submit its anti-fraud plan to MPI by September 1 of each Contract year. The anti-fraud plan shall comply with s. 409.91212, F.S., and, at a minimum, must include:
- (1) A written description or chart outlining the organizational arrangement of the Dental Plan's personnel who are responsible for the investigation and reporting of possible overpayment, abuse or fraud;
 - (2) A description of the Dental Plan's procedures for detecting and investigating possible acts of fraud, abuse and overpayment;
 - (3) A description of the Dental Plan's procedures for the mandatory reporting of possible overpayment, abuse or fraud to MPI;
 - (4) A description of the Dental Plan's program and procedures for educating and training personnel on how to detect and prevent fraud, abuse, waste and overpayment;
 - (a) At a minimum, training shall be conducted within thirty (30) days of new hire and annually thereafter;
 - (b) The Dental Plan shall have a methodology to verify training occurs as required; and
 - (c) The Dental Plan shall also include Deficit Reduction Act requirements in the training curriculum.
 - (5) The name, address, telephone number, email address and fax number of the individual responsible for carrying out the anti-fraud plan; and
 - (6) A summary of the results of the investigations of fraud, abuse, waste, or overpayment which were conducted during the previous SFY by the Dental Plan's fraud investigative unit. For purposes of this summary, a case includes any action, whether an investigation, audit, provider payment review, provider on-site review, or other provider-specific evaluation. This summary shall include information pertaining to the SFY that concluded immediately prior to the submission of this report. This summary shall include:
 - (a) Total number of cases opened;
 - (b) Total number of cases closed;

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- (c) Total number of cases that remain open as of the last day of the previous SFY;
- (d) Total of overpayments identified for recovery which were identified as waste;
- (e) Total amount of overpayments identified for recovery which were identified as fraud or abuse;
- (f) Total amount of overpayments identified as waste which were actually recovered; and
- (g) Total amount of overpayments identified as fraud or abuse that was actually recovered.

(42 CFR 438.608(a); 42 CFR 438.608(a)(1)(i)-(vii); 42 CFR 438.604(a)(7); 42 CFR 438.606; 42 CFR 438.608(d)(3))

- d. At a minimum, the Dental Plan's compliance plan, anti-fraud plan, and fraud and abuse procedures shall comply with s. 409.91212, F.S., and with the following:
 - (1) Ensure that all officers, directors, managers and employees know and understand the provisions;
 - (2) Include procedures designed to prevent and detect potential or suspected fraud and abuse in the administration and delivery of services under this Contract. Nothing in this Contract shall require that the Dental Plan assure that non-participating providers are compliant with this Contract, but the Dental Plan is responsible for reporting suspected fraud and abuse by non-participating providers when detected;
 - (3) Describe the Dental Plan's organizational arrangement of anti-fraud personnel, their roles and responsibilities, including a description of the internal investigational methodology and reporting protocols. Such internal investigational methodology and reporting protocols shall ensure the unit's primary purpose is for the investigation (or supervision of the investigation) of suspected insurance/Medicaid fraud and fraudulent claims;
 - (4) Describe the method(s), including detailed procedures that include provisions to verify, by sampling or other methods, delivery of services by network providers to enrollees. Such methods include, but are not limited to, electronic verification, biometric technology, sending enrollee explanations of Medicaid benefits, contacting enrollees by telephone, mailing enrollees a questionnaire, contacting a representative sample of enrollees, or sampling enrollees based on business analyses; (42 CFR 438.608(a)(5))
 - (5) Incorporate a description of the specific controls in place for prevention and

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detection of potential or suspected fraud and abuse, including but not limited to:

- (a) An effective pre-payment and post-payment review process, including but not limited to data analysis, claims and other system edits, and auditing of participating providers. (s. 409.967(2)(g), F.S.);
- (b) Provider profiling, credentialing, and recredentialing, and ongoing provider monitoring including a review process for claims and encounters that shall include providers and non-participating providers who:
 - (i) Demonstrate a pattern of submitting falsified encounter data or service reports;
 - (ii) Demonstrate a pattern of overstated reports or up-coded levels of service;
 - (iii) Alter, falsify, or destroy enrollee record documentation;
 - (iv) Make false statements related to credentials;
 - (v) Misrepresent medical information to justify enrollee referrals;
 - (vi) Fail to render medically necessary covered services they are obligated to provide according to their provider agreements;
 - (vii) Charge enrollees for covered services; and
 - (viii) Bill for services not rendered;
- (c) Prior authorization;
- (d) UM;
- (e) Subcontract and provider agreement provisions;
- (f) Provisions from the provider and the enrollee handbooks; and
- (g) Standards for a code of conduct.
(42 CFR 438.608(a)(7))
- (6) Contain provisions pursuant to this **Section** for the confidential reporting of Dental Plan violations to MPI and other agencies as required by law;
- (7) Include provisions for the investigation and follow-up of any reports;

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- (8) Ensure that the identities are protected for individuals reporting in good faith alleged acts of fraud and abuse;
- (9) Require all suspected or confirmed instances of internal and external fraud and abuse relating to the provision of, and payment for, Medicaid services including but not limited to Dental Plan employees/management, providers, subcontractors, vendors, delegated entities, or enrollees under State and/or federal law be reported to MPI within fifteen (15) days of detection, as specified in s. 409.91212, F.S., and in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*. Additionally, any final resolution reached by the Dental Plan shall include a written statement that provides notice to the provider or enrollee that the resolution in no way binds the State of Florida nor precludes the State of Florida from taking further action for the circumstances that brought rise to the matter;
- (10) Require all potential instances of fraud relating to the provision of and payment for Medicaid services including but not limited to Dental Plan employees/management, providers, subcontractors, vendors, delegated entities, or enrollees be reported to the Medicaid Fraud Control Unit as required in 42 CFR 438.608 and this Contract.
- (11) Ensure that the Dental Plan and all providers and subcontractors, upon request and as required by State and/or federal law, shall:
 - (a) Make available to all authorized federal and State oversight agencies and their agents, including but not limited to the Agency, the Florida Attorney General, and DFS any and all administrative, financial and enrollee records and data relating to the delivery of items or services for which Medicaid monies are expended; (42 CFR 438.242(b)(4)) and
 - (b) Allow access to all authorized federal and state oversight agencies and their agents, including but not limited to the Agency, the Florida Attorney General, and DFS to any place of business and all enrollee records and data, as required by State and/or federal law. Access shall be during Normal Business Hours, except under special circumstances when the Agency, the Florida Attorney General, and DFS shall have After Hours admission. The Agency and the Florida Attorney General shall determine the need for special circumstances.
- (12) Ensure that the Dental Plan shall cooperate fully in any investigation by federal and State oversight agencies and any subsequent legal action that shall result from such an investigation;
- (13) Ensure that the Dental Plan does not retaliate against any individual who reports

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violations of the Dental Plan's fraud and abuse procedures or suspected fraud and abuse;

- (14) Not knowingly employ or contract with individuals or entities debarred or excluded from participation in any federal health care program under ss. 1128 and 1128A of the Social Security Act, nor with an individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in 42 CFR 438.610 (a)(1); or subcontractors on the discriminatory vendor list maintained by the Department of Management Services in accordance with s. 287.134, F.S.; (42 CFR 438.808(a) and (b)(2); 42 CFR 431.55(h); 42 CFR 438.610(b); ss. 1128(b)(8) and 1903(i)(2) of the Social Security Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b); State Medicaid Director Letters 6/12/08 and 1/16/09; Executive Order No. 12549)
- (15) On at least a monthly basis check current staff, subcontractors and providers against the federal LEIE and the federal SAM (includes the former Excluded Parties List System (EPLS)) or their equivalent, to identify excluded parties. The Dental Plan shall also check monthly the Agency's listing of suspended and terminated providers at the Agency website below, to ensure the Dental Plan does not include any non-Medicaid eligible providers in its network: http://apps.ahca.myflorida.com/dm_web.

The Dental Plan shall also conduct these checks during the process of engaging the services of new employees, subcontractors and providers and during renewal of agreements and recredentialing. The Dental Plan shall not employ or contract with an entity that is in nonpayment status or is excluded from participation in federal health care programs under ss. 1128 and 1128A of the Social Security Act; (42 CFR 438.214(d)(1))

- (16) Provide details and educate employees, subcontractors and providers about the following as required by s. 6032 of the federal Deficit Reduction Act of 2005:
- (a) The Federal False Claims Act;
 - (b) The penalties and administrative remedies for submitting false claims and statements;
 - (c) Whistleblower protections under federal and State law;
 - (d) The entity's role in preventing and detecting fraud, waste, and abuse;
 - (e) Each person's responsibility relating to detection and prevention; and
 - (f) The toll-free State telephone numbers for reporting fraud and abuse.
- (17) Include procedures specific to prevention and detection of potential or suspected fraud and abuse of teledentistry in its fraud and abuse detection activities.

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5. Retention Policy for the Treatment of Fraud, Abuse, and Waste Recoveries

- a. The Dental Plan shall engage in efforts to recover overpayments. Overpayments may be in the form of fraud, abuse, or waste.
- b. The Agency's retention and distribution policies only apply to recoveries made through Agency investigations, and do not include non-Agency investigations and recoveries. Distribution of recoveries to a Dental Plan pursuant to these provisions may be limited if prohibited by State or federal law.
- c. The Dental plan shall timely report to the Agency's Bureau of MPI the identification of suspected or confirmed fraud, abuse, or waste. (42 CFR 438.608 and s. 409.91212, F.S.)
- d. The Dental Plan shall fully participate as directed by the Agency in fraud investigations, prosecutions, and civil actions pursued by MFCU or other law enforcement/prosecutorial entities.
- e. The Dental Plan may be entitled to a portion of the recoveries made through Agency investigations when:
 - (1) The Dental Plan has timely reported the suspected fraud, abuse, or waste to the Agency;
 - (2) The Dental Plan has participated in the investigation, prosecution, and/or civil action regarding such; and
 - (3) The recovery efforts are not time limited by the provisions of s. 641.3155, F.S.
- f. The Agency may share recoveries made by the Agency with the Dental Plan when the Dental Plan has timely reported the suspected fraud, abuse, or waste to the Agency and the recovery efforts are time limited by the provisions of s. 641.3155, F.S.
- g. The Dental Plan shall not be entitled to recoveries related to overpayments when:
 - (1) The recovery of overpayments is time limited by the provisions of s. 641.3155, F.S., and:
 - (a) The Agency's Bureau of MPI identifies and recovers overpayments related to abuse and waste, except as permitted in **Sub-items d. and e.** above; and
 - (b) The Dental Plan has not properly reported to the Agency the suspected fraud, abuse, or waste; or
 - (2) The Agency identifies and recovers overpayments that are not time limited by the provisions of s. 641.3155, F.S., the Agency has provided notice to the Dental

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Plan of the identification of overpayments, and the Dental Plan does not engage in recovery efforts; or

- (3) The recovery of overpayments is made by MFCU.

6. Reporting and Disclosure Requirements

- a. The Dental Plan shall comply with all reporting requirements as set forth below and in 42 CFR 438.608 and s. 409.91212, F.S.
- b. The Dental plan shall submit disclosures of suspected or confirmed provider fraud through the following process:
- (1) Within five (5) days of the date of detection of suspected or confirmed fraud, the Dental Plan shall provide advanced notice to MPI of the details of the investigative subject (provider), potential fraud scheme, and estimated exposed amount in a manner and format specified by the Agency.
 - (2) Within ten (10) days of submission of advanced notice to MPI, the Dental Plan shall submit a supplemental referral attachment to MPI in a format specified by the Agency.
 - (3) Within the statutorily required reporting period, unless otherwise advised by MPI in writing, the Dental Plan shall report incidents of suspected/confirmed fraud as specified in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*; and
 - (4) The Dental Plan shall refer incidents of suspected/confirmed fraud to MFCU within ten (10) calendar days following submission of the suspected/confirmed fraud report to MPI and submit a copy of the MFCU referral to MPI.
 - (a) The Dental Plan shall temporarily cease any further activities, not limited to overpayment recovery or witness interviews, which could obstruct or impede a criminal investigation, unless MFCU advises the Dental Plan and MPI that the referral is not accepted.
 - (b) The Dental Plan shall resume its activities after the forty-five (45) day period unless otherwise agreed upon between the Dental Plan and MFCU. In such case, MFCU will provide routine investigative updates to the Dental Plan and MPI.
- c. The Dental Plan shall achieve or exceed the Agency-specified performance target for reporting suspected provider fraud cases each SFY to the Medicaid Fraud Control Unit following the required processes as outlined in this Contract and applicable federal and state regulations. The Medicaid Fraud Performance Target Formula, an attachment to Policy Transmittal 2020-64, is hereby incorporated by reference to establish the minimum threshold for the Dental Plan relative to this standard.

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- d. The Dental Plan shall report on a quarterly basis a comprehensive fraud and abuse prevention activity report regarding its investigative, preventive, and detective activity efforts, as specified in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*
- e. The Dental Plan shall, by September 1 of each year, report to MPI its experience in implementing an anti-fraud plan, and on conducting or subcontracting for investigations of possible fraudulent or abusive acts during the prior SFY, as specified in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*. The report must include, at a minimum:
 - (1) The dollar amount of Dental Plan losses and recoveries attributable to overpayment, abuse and fraud; and
 - (2) The number of Dental Plan referrals to MPI.
- f. The Dental Plan shall notify DHHS OIG and MPI within ten (10) business days of discovery of individuals who have met the conditions giving rise to mandatory or permissive exclusions per ss. 1128, 1156, and 1892 of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1.
- g. In accordance with 42 CFR 455.106, the Dental Plan shall disclose to DHHS OIG, with a copy to MPI within ten (10) business days after discovery, the identity of any person who:
 - (1) Has ownership or control interest in the Dental Plan, or is an agent or managing employee of the Dental Plan; and
 - (2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.
 - (3) In addition to the disclosure required under 42 CFR 455.106, the Dental Plan shall also disclose to DHHS OIG with a copy to MPI within ten (10) business days after discovery, the identity of any person described in 42 CFR 1002.3 and 42 CFR 1001.1001(a)(1), and to the extent not already disclosed, to additionally disclose any person who has ownership or control interest in a Dental Plan participating provider, or subcontractor, or is an agent or managing employee of a Dental Plan participating provider or subcontractor, and meets at least one of the following requirements:
 - (4) Has been convicted of a crime as identified in s. 1128 of the Social Security Act and/or conviction of a crime related to that person's involvement in any program under Medicare, Medicaid, or the Title XXI services program since the inception of those programs;
 - (5) Has been denied entry into the Dental Plan's network for program integrity-related reasons; or

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- (6) Is a provider against whom the Dental Plan has taken any action to limit the ability of the provider to participate in the Dental Plan’s provider network, regardless of what such an action is called. This includes, but is not limited to, suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the program or Dental Plan provider network to avoid a formal sanction.

- h. The Dental Plan shall submit the written notification referenced above to DHHS OIG as instructed by the Agency. Document information examples include, but are not limited to, court records such as indictments, plea agreements, judgments, and conviction/sentencing documents.

- i. The Dental Plan shall notify MPI and provide a copy of any corporate integrity or corporate compliance agreements within thirty (30) days after execution of such agreements.

- j. The Dental Plan shall notify MPI and provide a copy of any CAPs required by the DFS and/or federal governmental entities, excluding the Agency, within thirty (30) days after execution of such plans.

- k. The Dental Plan shall query its potential non-provider subcontractors before contracting to determine whether the subcontractor has any existing or pending contract(s) with the Agency and, if any, notify MPI.

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Section X. Method of Plan Payment

Section X. Method of Plan Payment

A. General Provisions

1. The Agency shall deny payments to the Dental Plan for new enrollees when payment for those enrollees is denied by CMS based on the Agency's recommendation in accordance with 42 CFR 438.726(b) and 42 CFR 438.730(e).
2. In accordance with s. 409.967(3), F.S., the Agency shall be responsible for verifying the Dental Plan's ASR as specified in **Section X.**, Method of Plan Payment, in this Contract. The Agency shall contract with independent certified public accountants (CPAs) to conduct compliance audits for the purpose of auditing Dental Plan financial information in order to determine and validate the Dental Plan's ASR.

B. Fixed Price Unit Contract

This is a fixed price (unit cost) Contract awarded through procurement. The Agency, through its fiscal agent, shall make payment to the Dental Plan on a monthly basis for the Dental Plan's satisfactory performance of its duties and responsibilities as set forth in this Contract.

C. Payment Provisions

1. Capitation Rates

- a. The Dental Plan shall be paid the applicable capitation rate for each Medicaid-eligible enrollee whose name appears on the HIPAA-compliant X12 820 file for each month. The total payment amount to the Dental Plan shall depend upon the number of enrollees in each eligibility category and each rate group, as provided for by this Contract, or as adjusted pursuant to this Contract when necessary. The Dental Plan is obligated to provide services pursuant to the terms of this Contract for all enrollees for whom the Dental Plan has received capitation payment or for whom the Agency has assured the Dental Plan that capitation payment is forthcoming. (42 CFR 438.3(c)(2))
- b. In accordance with ss. 409.968, 409.976 and 409.983, F.S., the capitation rates reflect historical utilization and spending for covered services projected forward and shall be risk adjusted for enrollees in each Dental Plan. During the Contract term, the Agency may change the Risk Adjustment Model to reflect the risk of the Dental Plan's membership mix.
- c. Utilization and expenditures for services by a provider outside the U.S. shall not be included in the development of capitation rates.
- d. The rates shall be actuarially sound in accordance with 42 CFR 438.6(c).
- e. The capitation rates shall be included in this Contract.
- f. The Agency shall use, or shall amend and use these rates, only after certification by its actuary and approval by CMS. Inclusion of these rates is not intended to convey or imply any rights, duties or obligations of either party, nor is it intended to restrict,

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restrain or control the rights of either party that shall have existed independently of this **Section** of this Contract.

- g. By signature on this Contract, the parties explicitly agree that this **Section** shall not independently convey any inherent rights, responsibilities or obligations of either party, relative to these rates, and shall not itself be the basis for any cause of administrative, legal or equitable action brought by either party. In the event that the rates certified by the actuary and approved by CMS are different from the rates included in this Contract, the Dental Plan shall accept a reconciliation performed by the Agency to bring payments to the Dental Plan in line with the approved rates. The Agency shall amend and use the CMS-approved rates by notice to the Dental Plan through an amendment to this Contract.
- h. Unless otherwise specified in this Contract, the Dental Plan shall accept the capitation payment received each month as payment in full by the Agency for all services provided to enrollees covered under this Contract and the administrative costs incurred by the Dental Plan in providing or arranging for such services. Any and all costs incurred by the Dental Plan in excess of the capitation payment shall be borne in total by the Dental Plan.
- i. The Agency shall pay the Dental Plan a capitation rate for each newborn enrolled in a Dental Plan, retroactive to the month of birth. (s. 409.977(3), F.S.)
- j. The Dental Plan shall be responsible for payment of all covered dental services provided to newborns.
- k. Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Dental Plan 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 Dental Plan works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Dental Plan will not be paid for that work. If the State paid the Dental Plan 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 must be returned to the State.

2. Rate Adjustments and Reconciliations

- a. The Dental Plan and the Agency acknowledge that the capitation rates paid under this Contract are subject to approval by the federal government.
- b. The Dental Plan and the Agency acknowledge that adjustments to funds previously paid, and to funds yet to be paid, shall be required. Funds previously paid shall be adjusted when capitation rate calculations are determined to have been in error, or when capitation rate payments have been made for enrollees who are determined not to have been eligible for Dental Plan membership during the period for which the capitation rate payments were made. In such events, the Dental Plan and any subcontractor shall report to the State within sixty (60) days when it has identified

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capitation payments or other payments in excess of amounts specified in this Contract. The Dental Plan shall refund any overpayment and the Agency shall pay any underpayment. (42 CFR 438.608(c)(3))

- c. Capitation rates shall be adjusted to reflect budgetary changes in the Medicaid program. The rate of payment and total dollar amount shall be adjusted with a properly executed amendment when Medicaid expenditure changes have been established through the appropriations process and subsequently identified in the Agency's operating budget. Legislatively-mandated changes shall take effect on the dates specified in the legislation. The Agency shall not approve any Dental Plan request for a rate increase unless sufficient funds to support the increase have been authorized in the General Appropriations Act. (s. 409.968(3), F.S.).
- d. In accordance with s. 409.967(3), F.S., the Dental Plan's ASR shall be verified as specified in this Contract.
- e. The Agency shall be responsible for adjusting applicable capitation rates to reflect budgetary changes in the Medicaid program.

3. Errors

The Dental Plan shall carefully prepare all reports and monthly payment requests for submission to the Agency. If after preparation and electronic submission, the Dental Plan discovers an error, including but not limited to errors resulting in capitated payments or other payments in excess of amounts specified in this Contract, either by the Dental Plan or the Agency, the Dental Plan has sixty (60) days from its discovery of the error, or sixty (60) days after receipt of notice by the Agency, to correct the error and re-submit accurate reports. Failure to respond within the sixty (60)-day period shall result in a loss of any money due to the Dental Plan for such errors and/or sanctions against the Dental Plan pursuant to **Section XII.**, Sanctions and Corrective Action Plans.

4. Enrollee Payment Liability Protection

- a. Pursuant to s. 1932(b)(6), Social Security Act (as enacted by s. 4704 of the Balanced Budget Act of 1997), the Dental Plan shall not hold enrollees liable for debts of the Dental Plan, in the event of the Dental Plan's insolvency; (42 CFR 438.106(a))
- b. The Dental Plan shall not hold enrollees liable for payment of covered services provided by the Dental Plan if the Dental Plan has not received payment from the Agency for the covered services, or if the provider, under contract or other arrangement with the Dental Plan, fails to receive payment from the Agency or the Dental Plan; (42 CFR 438.106(b)(1)-(2); 42 CFR 438.3(k); 42 CFR 438.230) and/or
- c. The Dental Plan shall not hold enrollees liable for payments to a provider, including referral providers, that furnished covered services under a contract or other arrangements with the Dental Plan, that are in excess of the amount that normally would be paid by the enrollee if the covered services had been received directly from the Dental Plan. (42 CFR 438.106(c); 42 CFR 438.3(k); 42 CFR 438.230)

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5. Quality Withhold Incentive

See **Attachment II, Section I.**, General Overview, **Sub-Section C.**, Prioritizing Quality and Value, **Item 1.**, Layered Approach to Drive Continued Improvement, **Sub-Item c.**, Quality Withhold Incentive, for enhanced provisions.

6. Achieved Savings Rebate

- a. In order to be eligible to retain up to an additional one percent (1%) of revenue, the Dental Plan must earn twenty (20) points or more for the Oral Evaluation and have scored at least two (2) points for each reportable performance measure.

The Agency reserves the right, during the Contract term, to change the Achieved Savings Rebate One Percent Quality Incentive methodology.

- b. In accordance with 42 CFR 438.6(b)(3)(i)-(iv), 42 CFR 438.340, s. 409.967(3), F.S., and as specified in **Section XV.**, Accountability, and the Statewide Medicaid Prepaid Dental Program Report Guide, the Dental Plan shall submit:

- (1) Quarterly and annual unaudited ASR Financial Reports, and an annual financial statement audit conducted by an independent CPA;
- (2) Quarterly and annual NAIC Financial Statements filed with the OIR and prepared in accordance with statutory accounting principles.

- c. The Dental Plan shall pay to the Agency the expenses of the Agency's ASR audit at the rates established by the Agency. Expenses shall include actual travel expenses, reasonable living expense allowances, compensation of the CPA, and necessary attendant administrative costs of the Agency directly related to the audit/examination.

The Dental Plan shall pay the Agency within twenty-one (21) days after presentation by the Agency of the detailed account of the charges and expenses. Failure to pay shall result in liquidated damages as specified in **Section XIII.**, Liquidated Damages.

- d. The Dental Plan shall make available all books, accounts, documents, files and information that relate to the Dental Plan's Medicaid transactions at a Florida location by the Agency's contracted CPA.

- (1) The Dental Plan shall cooperate in good faith with the Agency and the CPA.
- (2) Records not in the Dental Plan's immediate possession must be made available to the Agency or the CPA in the Florida location specified by the Agency or the CPA within three (3) days after a request is made by the Agency or the CPA. If original records are required, and they cannot be made available in a Florida location as specified herein, the Dental Plan shall make the records available for the CPA to review at the applicable location and shall pay any expenses related to the CPA's review at that location.

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- (3) Failure to comply with such record requests, including failure to provide records, reports, and documentation to the Agency or CPA by the dates requested, shall be deemed a breach of Contract, and the Dental Plan shall be subject to sanctions as specified in **Section XII.**, Sanctions and Corrective Action Plans.
- e. In accordance with s. 409.967(3)(g), F.S., and as specified below, if the Dental Plan exceeds the Agency-defined quality measures as specified in the Contract, the Dental Plan shall retain up to an additional one percent (1%) of its revenue.
 - (1) Dental Plans that meet the quality standards shall retain up to one percent (1%) of ASR-allowed revenue associated with the component for which they meet the quality standards.
 - (2) The Agency shall amend the performance measures and the thresholds required for a Dental Plan to retain up to an additional one percent (1%) of revenue with sixty (60) days' advance notice.
- f. The Agency CPA shall validate the ASR, and the results shall be provided to the Agency. If the CPA validates the ASR submitted by the Dental Plan in accordance with the *Managed Care Plan Report Guide*, these results shall be final and dispositive. If the CPA fails to validate the ASR submitted by the Dental Plan, the Dental Plan shall receive written notice of the CPA's findings and be provided with the opportunity to review and respond to the CPA's findings in writing within the timeframe specified by the Agency. The CPA shall review the Dental Plan's response and issue final results. These results are dispositive.
- g. The Dental Plan shall receive the final results of the audit, and the Dental Plan shall pay the rebate to the Agency within thirty (30) days after the results are provided.
 - (1) The ASR is established by determining pretax income as a percentage of revenues and applying the following income ratios:
 - (a) One hundred percent (100%) of income up to and including five percent (5%) of revenue shall be retained by the Dental Plan.
 - (b) Fifty percent (50%) of income above five percent (5%) and up to ten percent (10%) shall be retained by the Dental Plan, and the other fifty percent (50%) refunded to the State.
 - (c) One hundred percent (100%) of income above ten percent (10%) of revenue shall be refunded to the State.
- h. As further specified in the *Managed Care Plan Report Guide*, for purposes of the ASR, pretax income is defined as pre-tax revenue minus those expenses permitted in the *Managed Care Plan Report Guide*.

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- i. Revenue includes but is not limited to all capitation premium payments made by the State to the Dental Plan. Revenue is to be reduced by the State premium tax or other State assessments based on the premium.
- j. Expenses generally include reasonable and appropriate medical expenses and general and administrative expenses, as determined by the Agency, other than interest expense, of operating the Dental Plan in accordance with the requirements of this Contract. Any State premium tax or other State assessment based on premium that is treated as a reduction to premium revenue cannot be included in the allowable expenses.
- k. In accordance with s. 409.967(3)(h), F.S., the following expenses are not allowable expenses for purposes of determining the pre-tax income subject to the ASR:
 - (1) Payment of ASRs;
 - (2) Any financial incentive payments made to the Dental Plan outside of the capitation rate;
 - (3) Expenses associated with any lobbying or political activities;
 - (4) Cash value or equivalent cash value of bonuses of any type paid or awarded to the Dental Plan's executive staff other than base salary;
 - (5) Reserves and reserve accounts other than those expressly permitted by the Managed Care Plan Report Guide;
 - (6) Administrative costs in excess of actuarially sound maximum amounts set by the Agency; and
 - (7) Other costs excluded in accordance with 42 CFR 438.6.
- l. The actuarially sound maximum amount for administrative costs shall be set by the Agency in consultation with the actuary developing the capitation rates as part of the rate setting process.

Each year, the Agency's actuaries will develop administrative costs per member per month (PMPM) for the Dental program using recent experience as the base period, applying adjustments for anticipated differences in membership mix, economies of scale, changes in administrative cost functions, trend, and other relevant adjustments necessary to project administrative costs during the rate year. For each rate year associated with this Contract, after development of the initial administrative costs, a **3.0% annual reduction** for administrative efficiencies will be applied for the length of time between the base period and the projected rating period (i.e., if the administrative cost base period is January 2023 through December 2023 and the capitation rate year is October 2024 through September 2025, this commitment will be applied for 1.75 years).

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- m. In accordance with s. 409.967(3)(i), F.S., if the Dental Plan incurs a loss in the first Contract year subject to the achieved saving rebate, it shall apply the full amount of such loss as an offset to income in the second Contract year. If the Dental Plan elects to carry forward such a loss, then the life-years of coverage for the first Contract year of coverage shall also carry over to the second Contract year.
- n. In accordance with s. 409.967(3)(j), F.S., if the Agency later determines that the Dental Plan owes an additional rebate, the Dental Plan shall have thirty (30) days after notification by the Agency to make payment. If the Dental Plan fails to pay the rebate, future payments shall be withheld until the entire amount of the rebate is recouped. If the Agency determines that the Dental Plan made an overpayment, the Dental Plan shall be returned the overpayment within thirty (30) days of such determination.
- o. If the Dental Plan purchases or acquires part or all of the business of another Dental Plan, the Dental Plan's information and reports regarding its ASR shall include information for the purchased business, including for that part of the reporting period that was prior to the purchase. If the Dental Plan is unable to include information for the purchased business prior to the purchase date, the Dental Plan shall pay for the cost of the audit for the reporting period prior to the purchase date.
- p. If the Dental Plan's enrollment in a reporting period is fewer than five thousand (5,000) life-years, the Dental Plan shall not owe a rebate for the reporting period. However, the information from that reporting period shall be carried over and included with information for the next reporting period. When the cumulative life-years of such combined reporting periods equal or exceed five thousand (5,000) life-years, the achieved saving rebate calculation shall be performed.
- q. If the Agency determines that payment of an ASR by the Dental Plan would result in the Dental Plan being put at significant risk of insolvency, the Agency shall defer all or a portion of the rebate payment owed by the Dental Plan.
- r. The ASR shall be calculated in accordance with s. 409.967(3)(f), F.S., as illustrated in the Achieved Savings Rebates Table-Effective 8/1/2025 – 12/23/2030, Table, **Table 8**, below.

Note: The following three (3) increments shall be applied to the Dental Plan's (Plan's) pre-tax income (AKA: net operating income [NOI])

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TABLE 8 ACHIEVED SAVINGS REBATES TABLE – EFFECTIVE 01/01/2025 – 12/31/2030			
	NOI Range Category	Amount Dental Plans shall retain	Amount Dental Plans shall be required to refund to the Agency
I	NOI ranging from zero (0) up to and including five percent (5%) of the Dental Plan's premium revenue:	Dental Plans shall retain one hundred percent (100%) of NOI within this range.	Dental Plans shall not be required to refund any of their NOI within this range.
II	NOI above five percent (5%) and up to and including ten percent (10%) of the Dental Plan's premium revenue:	Dental Plans shall retain fifty percent (50%) of the NOI within this range.	Dental Plans shall be required to refund fifty percent (50%) of the NOI within this range.
III	NOI above ten percent (10%) of the Dental Plan's premium revenue:	Dental Plans shall not be allowed to retain any of the NOI within this range.	Dental Plans shall have to refund to the Agency one hundred percent (100%) of the NOI within this range.

Example: If the Dental Plan's premium revenues are **\$1,000,000** and allowed expenses are **\$850,000**, the Dental Plan has a pre-tax net operating income (NOI) of **\$150,000**. The NOI is calculated to be 15% of premium revenue (NOI/Revenue) as illustrated in the NOI Calculation Example Table, **Table 9**, below:

TABLE 9 NOI CALCULATION EXAMPLE				
NOI Range as Percent of Revenue	Plan Retains		Plan Refunds to the State	
0.00% to 5.00% = \$50,000	One hundred percent (100%) of NOI within this range	\$50,000	Zero percent (0.00%) of NOI within this range:	\$0
5.00% to 10.00% = \$50,000	Fifty percent (50%) of NOI within this range	\$25,000	Fifty percent (50%) of NOI within this range:	\$25,000
above 10.00% = \$50,000	Zero percent (0.00%) of NOI within this range	\$0	One hundred percent (100%) of NOI within this range:	\$50,000
TOTAL \$150,000	=	\$75,000		\$75,000

a. Value Based Purchasing (VBP) Programs

See **Section I.**, General Overview, **Sub-Section C.**, Prioritizing Quality and Value, **Item 2.**, Value-Based Purchasing (VBP) Programs, for provisions regarding VBP programs.

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b. Incentive Arrangements

The Agency reserves the right, beginning in the second Contract year, to withhold a percentage of the Dental Plan's capitation rate, with the withhold to be released only if the Dental Plan meets specific performance standards during a timeframe to be specified by the Agency. The Agency shall be responsible for developing the methodology associated with this withhold arrangement in compliance with 42 CFR 438.6(b)(3)(ii).

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The Dental Plan shall meet all financial requirements established by this Contract and report financial information, including but not limited to quarterly and annual financial statements, in accordance with **Section XV.**, Accountability, the *Managed Care Plan Report Guide*, and other Agency instructions. The Dental Plan shall certify that information it submits to the Agency is accurate, truthful, and complete in accordance with 42 CFR 438.606.

A. Insolvency Protection

1. Insolvency Protection Requirements

- a. The Dental Plan shall establish a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in Florida in accordance with s. 1903(m)(1) of the Social Security Act (amended by s. 4706 of the Balanced Budget Act of 1997). The Dental Plan shall deposit into that account five percent (5%) of the capitation payments made by the Agency each month until a maximum total of two percent (2%) of the annualized total current Contract amount is reached and maintained. No interest shall be withdrawn from this account until the maximum Contract amount is reached and withdrawal of the interest shall not cause the balance to fall below the required maximum amount. This provision shall remain in effect as long as the Dental Plan continues this Contract with the Agency.
- b. The restricted insolvency protection account shall be drawn upon with the authorized signatures of two (2) people designated by the Dental Plan and two (2) representatives of the Agency. The Multiple Signature Verification Agreement Form shall be resubmitted to the Agency within thirty (30) days of Contract execution and resubmitted within thirty (30) days after a change in authorized Dental Plan personnel occurs. If the authorized persons remain the same, the Dental Plan shall submit to the Agency an attestation to this effect April 1 of each Contract year to the Agency along with a copy of the latest bank statement. The Dental Plan shall obtain a sample Multiple Signature Verification Agreement form from the Agency or its agent or download from the Agency website at:

https://ahca.myflorida.com/Medicaid/statewide_mc/app_contract_materials.shtml.

The Dental Plan shall submit all such agreements or other signature cards to the Agency for prior approval.

- c. In the event that the Agency determines the Dental Plan is insolvent, the Agency may, in the Agency's sole discretion and without any requirement or obligation, draw upon the amount solely with the two (2) authorized signatures of representatives of the Agency, and the Agency shall disburse funds to meet financial obligations incurred by the Dental Plan under this Contract. A statement of account balance shall be provided by the Dental Plan within fifteen (15) days of the request from the Agency.
- d. If the Agency terminates or does not renew this Contract, the Agency shall release the account balance to the Dental Plan upon receipt of proof of satisfaction of all outstanding obligations incurred under this Contract.

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- e. In the event the Agency terminates or does not renew this Contract and the Dental Plan is insolvent, the Agency may, in the Agency's sole discretion and without any requirement or obligation, draw upon the insolvency protection account to pay any outstanding debts the Dental Plan owes the Agency, including, but not limited to, overpayments made to the Dental Plan and fines imposed under this Contract or, for HMOs, s. 641.52, F.S. and for health insurers, Chapter 624, F.S., for which a final order has been issued. In addition, if the Agency terminates or does not renew this Contract, and the Dental Plan is unable to pay all of its outstanding debts to health care providers, the Agency and the Dental Plan shall agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to the Agency priority over other claims.

2. Insolvency Protection Account Waiver

The Agency shall waive the insolvency protection account in writing when evidence of adequate insolvency insurance and reinsurance is on file with the Agency to protect enrollees in the event the Dental Plan is unable to meet its obligations. (42 CFR 438.6(b)(1))

3. Insolvency Protection Investment Option

- a. At the discretion of and upon written permission granted by the Agency, a Dental Plan that has fully funded their restricted insolvency protection account in accordance with this **Section**, and has met surplus requirements in accordance with this **Section** for the previous six (6) consecutive quarters shall invest the full value of the required insolvency protection account balance in U.S. Treasury Securities (Securities) which are backed by the full faith and credit of the U.S. government through the utilization of a custodial account at a federally guaranteed financial institution licensed to do business in Florida in accordance with s. 1903(m)(1) of the Social Security Act (amended by s. 4706 of the Balanced Budget Act of 1997), and s.409.912, F.S. A listing of approved Securities is specified in the Custodial Investment Insolvency Protection Account Approved Securities Table, **Table 10** below. Securities held in the custodial account shall not be pledged to any entity other than the Agency, and trading on margin shall be prohibited.
- b. The Dental Plan shall safeguard against potential losses in value by depositing an additional amount equal to the estimated decrease in account value that would occur for a one hundred (100) basis points one percent (1%) increase in the Federal Funds rate. The amount of this deposit shall be approved by the Agency upon account inception and can be held in either Securities or cash.
- c. The custodial investment insolvency protection account shall be drawn upon with the authorized signatures of two (2) persons designated by the Dental Plan and two (2) representatives of the Agency. The Multiple Signature Verification Agreement for Custody Arrangements Form shall be submitted to the Agency within thirty (30) calendar days of account execution and resubmitted within thirty (30) calendar days after a change in authorized Dental Plan personnel occurs. If the authorized persons remain the same, the Dental Plan shall submit an attestation to this effect April 1 of

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each Contract year to the Agency along with a copy of the latest bank statement and summary of transactions for the month prior.

- d. The Dental Plan assumes sole responsibility for monitoring the custodial investment insolvency account to ensure the total value of all Securities shall not fall below the required insolvency protection account balance pursuant to this **Section**. The Dental Plan shall submit to the Agency a monthly account valuation within fifteen (15) calendar days after the end of each reporting month. The monthly account valuation shall include a complete transaction history of purchased and/or sold Securities within the reporting period, the custodial investment insolvency protection account balance, and shall take into consideration all factors that shall affect the total value of the custodial investment insolvency protection account. In the event that the total value of the custodial investment insolvency protection account is less than the required insolvency protection account balance at any time, the Dental Plan shall make a capital contribution in the form of cash and/or Securities within five (5) business days equal to the difference between the current value and the required insolvency protection account balance. Documentation evidencing this contribution shall be included with the monthly valuation. Should the Dental Plan fail to maintain the required insolvency protection account balance, the Agency, at its sole discretion, reserves the right to require the Dental Plan to re-establish a restricted insolvency protection account in accordance with **Section XI.**, Financial Requirements, **Sub-Section A.**, Insolvency Protection, **Item 1.**, Insolvency Protection Requirements. (42 CFR 438.604(a)(4); 42 CFR 438.606)
- e. The Agency, at its sole discretion, shall require the Dental Plan to re-establish a restricted insolvency protection account in accordance with this **Section**. The re-established account shall be funded by the liquidated proceeds of all Securities held in the insolvency protection investment account at the time the Agency required its re-establishment, plus any additional cash required to fund the account fully on its opening.
- f. Upon receipt of the executed Multiple Signature Verification Agreement for Custody Arrangements, the Dental Plan shall initiate the purchase or sale of Securities with only the Dental Plan's authorized representatives' signatures, provided that the Securities sold or purchased are in accordance with the Agency's guidelines of approved Securities as listed in the Custodial Investment Insolvency Protection Account Approved Securities Table, **Table 10**, and the transaction results in an equal amount of incoming cash or Securities on the same day of the transaction. Withdrawals from the investment insolvency protection account that do not result in an equal amount of incoming cash or Agency-approved Securities on the same day of the transaction requires the authorized signatures of two (2) Dental Plan representatives and two (2) Agency representatives.
- g. In the event that a determination is made by the Agency that the Dental Plan is insolvent, the Agency shall draw upon or initiate the sale of Securities from the custodial investment insolvency protection account solely with the two (2) authorized signatures of representatives of the Agency and funds shall be disbursed to meet financial obligations incurred by the Dental Plan under this Contract. The Dental Plan shall not initiate any transactions subsequent to notification by the Agency that the

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Agency has determined the Dental Plan to be insolvent. The Dental Plan shall provide a statement of account balance within fifteen (15) calendar days of request of the Agency.

- h. If this Contract is terminated or not renewed, the custodial investment insolvency protection account balance shall be released by the Agency to the Dental Plan upon the receipt of proof of satisfaction for all outstanding obligations incurred under this Contract.
- i. In the event this Contract is terminated, not renewed, and/or the Dental Plan is declared insolvent, the Agency shall draw upon or initiate the sale of Securities from the investment insolvency protection account to pay any outstanding debts the Dental Plan owes the Agency, including but not limited to overpayments made to the Dental Plan, and fines imposed under this Contract or, for HMOs, s. 641.52, F.S., for EPOs, s. 627, F.S., and for health insurers, s. 624, F.S. The Custodial Investment Insolvency Protection Account Approved Securities Table, **Table 10**, below, lists the maturity term and guarantee for the respective Security. In addition, if the above occurs and the Agency, in its sole discretion, determines that it would be in the best interest of the providers for the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the custodial or controlled account, the Dental Plan shall agree to the appointment. An appointed receiver shall give outstanding debts owed to the Agency priority over other claims.

TABLE 10		
CUSTODIAL INVESTMENT INSOLVENCY PROTECTION ACCOUNT APPROVED SECURITIES		
Security	Maturity Term	Guarantee
U.S Treasury Bills	All	Full Faith & Credit of the U.S. Government
U.S. Treasury Notes	Not to Exceed Three (3) Years	Full Faith & Credit of the U.S. Government

B. Surplus

1. Surplus Requirement

- a. The Dental Plan shall maintain at all times in the form of cash and investments allowable as admitted assets by the DFS and restricted funds of deposits controlled by the Agency (including the Dental Plan’s insolvency protection account) or the DFS, a surplus amount equal to the greater of one and one-half million dollars (**\$1.5 million**), ten percent (10%) of total liabilities, or two percent (2%) of the annualized amount of the Dental Plan’s prepaid revenues. In the event that the Dental Plan’s surplus (as defined in **Section XVI.**, Definitions and Acronyms) falls below the amount specified in this paragraph, the Dental Plan is prohibited from engaging in marketing activities, shall not receive new enrollments until the required balance is achieved, or shall have its Contract terminated statewide.

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- b. In lieu of the surplus requirements under this **Section**, the Agency shall consider the following:
- (1) If the organization is a public entity, the Agency shall take under advisement a statement from the public entity that a county supports the Dental Plan with the county's full faith and credit. In order to qualify for the Agency's consideration, the county must own, operate, manage, administer or oversee the Dental Plan, either partly or wholly, through a county department or agency;
 - (2) The State guarantees the solvency of the organization;
 - (3) The organization is a FQHC or is controlled by one (1) or more FQHCs and meets the solvency standards established by the State for such organization pursuant to s. 409.912(2)(b), F.S.; or
 - (4) The entity meets the financial standards for federally approved provider-sponsored organizations as defined in 42 CFR 422.380 through 422.390 and the solvency requirements established in approved federal waivers or Florida's Medicaid State Plan.

C. Interest

Interest generated through investments made by the Dental Plan under this Contract shall be the property of the Dental Plan and shall be used at the Dental Plan's discretion.

D. Third Party Resources

1. Covered Third Party Collections

- a. The Dental Plan shall identify and seek recovery up to the Dental Plan's full legal ability from any third party, as defined by s. 409.901(27), F.S., to pay for services rendered to enrollees under this Contract and notify the Agency when any third-party liability was identified and when recovery was made.

The Dental Plan shall assume full responsibility for all third party recovery actions initiated within one (1) year of identification. All recovery actions not initiated by the Dental Plan within one (1) year of identification shall be pursued by the Agency, at its sole discretion.

- b. The following standards govern third party recoveries:
- (1) If the Dental Plan has determined that third party liability exists for part or all of the services provided to an enrollee by a subcontractor or referral provider, and the third party is reasonably expected to make payment within one hundred twenty (120) days, the Dental Plan shall pay the subcontractor or referral provider only the amount, if any, by which the subcontractor's allowable claim exceeds the amount of the anticipated third party payment; or, the Dental Plan shall assume full responsibility for third party collections for service provided through the subcontractor or referral provider; and

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- (2) The Dental Plan shall not withhold payment for services provided to an enrollee if third party liability or the amount of liability cannot be determined, or if payment shall not be available within a reasonable time, beyond one hundred twenty (120) days from the date of receipt.
- c. When the Agency has a FFS lien against a third party and the Dental Plan has also extended services potentially reimbursable from the same third party, the Agency's lien shall be entitled to priority.
- d. The Dental Plan shall provide necessary data for third party identification and recoveries in a format prescribed by the Agency.

2. Optional Third-Party Recovery Services

- a. The Agency shall, at its sole discretion, offer to provide third party recovery services to the Dental Plan for covered third party collections.
- b. If the Dental Plan elects to authorize the Agency to recover covered third party collections on its behalf, the Dental Plan shall be required to provide the necessary data for recovery in the format prescribed by the Agency.
- c. If the Dental Plan elects to authorize the Agency to recover covered third party collections on its behalf, all recoveries, less the Agency's cost to recover, shall be income to the Dental Plan. The cost to recover shall be expressed as a percentage of recoveries and shall be fixed at the time the Dental Plan elects to authorize the Agency to recover on its behalf.
- d. All funds recovered from third parties shall be treated as income for the Dental Plan.

E. Assignment

1. General Assignment Provisions for the Dental Plan

- a. In compliance with s. 409.969(1), F.S., the Agency shall not approve the assignment or transition of all enrollees within a region to a single Dental Plan.
- b. The Agency may approve assignment of a Contract if all of the following conditions are met:
 - (1) After three (3) full Contract years have passed;
 - (2) If the purchasing entity was awarded a Contract pursuant to the ITN and is in good standing; and
 - (3) If, following the merger, the number of Dental plans in each impacted region remains at or above the statutory minimum.

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c. Good standing

To be in good standing, a Dental Plan shall:

- (1) Not have failed accreditation.
- (2) Not have committed any material violation of the requirements of s. 641.52, F.S.
- (3) Meet the requirements of this Contract.
- (4) Not have been subject to an enrollment freeze at any time under this Contract or a Corrective Action Plan during the past eighteen (18) month period.

d. Notice to the Agency and Transition Plan:

- (1) When a merger or acquisition of a Dental Plan has been approved by the regulatory entity (DFS or OIR), and the conditions listed in (b) and (c) have been met, the Agency may approve assignment or transfer of the appropriate Contract upon the request of the surviving entity of the merger or acquisition if the Dental Plan and the surviving entity have been in good standing with the Agency for the most recent twelve (12) month period, unless the Agency determines that the assignment or transfer would be detrimental to Medicaid recipients or the Medicaid program.
- (2) To request assignment or transfer of its enrollees, the Dental Plan shall notify the Agency at least one hundred eighty (180) days before the anticipated effective date in compliance with s. 409.967(2)(i), F.S. The Dental Plan shall provide the following documentation with its notice. Notice will not be considered complete if all the following are not included concurrent with the notice.
 - (a) Proof of DFS or OIR approval of the acquisition.
 - (b) A list of subcontractors to be utilized by the acquiring entity, if approved.
 - (c) Updated ownership information for the acquiring entity.
 - (d) A detailed transition plan as described by the Agency.
 - (e) Additional documentation as identified by the Agency.
- (3) The Dental Plan requesting the assignment or transfer of its enrollees and the acquiring/merging entity must work with the Agency to develop and implement an Agency-approved transition plan, to include a timeline and appropriate notices to all enrollees and all providers as required by the Agency and to ensure a seamless transition for enrollees, particularly those hospitalized, those requiring care coordination/case management and those with complex medical needs. The notice to enrollees shall contain the same information as required for a notice of termination according to **Section XIV.**, Special Terms and Conditions, **Sub-Section H.**, Termination Procedures. The Dental Plan requesting assignment or transfer of its enrollees shall perform as follows:

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- (a) Notice its enrollees, providers, and subcontractors of the change in accordance with this Contract.
 - (b) Provide the Agency with the data needed, including encounter data, to maintain existing case relationships.
- e. Payment of Associated Costs
- Pursuant to s. 409.967(2)(i)1., F.S., the Dental Plan shall reimburse the Agency for the cost of enrollment changes and other transition activities associated with the assignment of a contract following a merger or acquisition. If more than one (1) Dental Plan providing services under the same program component leaves a region at the same time, the exiting Dental Plan shall share the costs in a manner proportionate to their enrollments. Costs include, but are not limited to, changes to printed materials and staffing associated with increased call volume.
- f. Additional Assignment Provisions
- (1) Except as provided below, or with the prior written approval of the Agency, this Contract and the monies which may become due are not to be assigned, transferred, pledged, or hypothecated in any way by the Dental Plan, including by way of an asset or stock purchase of the Dental Plan, and shall not be subject to execution, attachment or similar process by the Dental Plan or its creditors.
 - (2) Entities regulated by the DFS or OIR must comply with provisions of s. 628.4615, F.S., and receive OIR approval before a merger or acquisition can occur.
 - (3) For the purposes of this Section, a merger or acquisition means a change in controlling interest of a Dental Plan, including an asset or stock purchase.

F. Financial Reporting

1. Financial Reports

- a. The Dental Plan shall submit to the Agency quarterly and annual NAIC Health Statements, quarterly and annual Achieved Savings Rebate Financial Reports, and annual audited financial statements.
- b. The Dental Plan shall submit to the Agency the annual NAIC Health Statement and annual audited financial statements no later than three (3) calendar months after the end of the calendar year. The Dental Plan shall submit the quarterly NAIC Health Statements no later than forty-five (45) days after the end of each calendar quarter. A quarterly NAIC Health Statement is not required for the quarter ending December 31. The quarterly and annual NAIC Health Statement, as well as the annual audited financial statements, shall be prepared using statutory accounting principles. The quarterly and annual Achieved Savings Rebate Financial Report shall be submitted in accordance with **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*.

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- c. The Dental Plan shall submit annual and quarterly financial statements that are specific to the processes of the Dental Plan rather than to a parent or umbrella organization.
- d. The Dental Plan shall submit all financial reports to the Agency in accordance with **Section XV.**, Accountability, and the instructions for Achieved Savings Rebate Financial Reports in the *Managed Care Plan Report Guide*. (42 CFR 438.3(m))

2. Medical Loss Ratio

- a. The Dental Plan shall maintain an annual (January 1 – December 31) medical loss ratio (MLR) of a minimum of eighty-five percent (85%) for the first full calendar year of program operation and subsequent years, beginning January 1, 2025.
- b. The Agency shall calculate the MLR in a manner consistent with 42 CFR 438.8, 45 CFR Part 158, 42 CFR 438.8(k), and s. 409.9122(9)(a), (b), and (c), F.S. Funds provided by Dental Plans to Florida dental schools to underwrite the costs of dental education shall be classified as medical expenditures, provided that the funding supports the provision of dental care to Medicaid recipients and that the dental schools funded by the plans are active providers of care to Medicaid and uninsured patients. To demonstrate ongoing compliance, the Dental Plan shall complete and submit appropriate financial reports, as specified in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*.
- c. The Dental Plan shall submit an attestation with its MLR reporting in compliance with 42 CFR 438.8(k) and (n).
- d. The federal Centers for Medicare & Medicaid Services shall determine the corrective action for non-compliance with this requirement.

G. Inspection and Audit of Financial Records

The State, CMS, and DHHS shall inspect and audit any financial records of the Dental Plan or its subcontractors, as well as financial records from parent companies relating to corporate or administrative charges included on financial reports submitted by the Dental Plan to the Agency. Pursuant to s. 1903(m)(4)(A) of the Social Security Act and the State Medicaid Manual 2087.6(A-B), non-federally qualified Dental Plans shall report to the State, upon request, and to the Secretary and the Inspector General of DHHS, a description of certain transactions with parties of interest as defined in s. 1318(b) of the Social Security Act. The Dental Plan shall make any reports of transactions between the Dental Plans and parties in interest that are provided to the State or other agencies to its enrollees, upon reasonable request. (Section 1903(m)(4)(A)-(B) of the Social Security Act)

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Section XII. Sanctions and Corrective Action Plans

Section XII. Sanctions and Corrective Action Plans

A. Contract Violations and Non-Compliance

1. The Dental Plan shall comply with all requirements and performance standards set forth in this Contract.
2. The Dental Plan agrees that failure to comply with any provisions of this Contract and 42 CFR 438.100 may result in the assessment of sanctions; temporary enrollment limitations, such as temporary enrollment freezes, enrollment algorithm reductions, and/or enrollment caps; and/or termination of this Contract, in whole or in part.
3. The Agency shall be responsible for imposing sanctions for Contract violations or other non-compliance and requiring corrective actions for a violation of or any other non-compliance with this Contract.
4. In the event the Agency identifies a violation of or other non-compliance with this Contract (to include the failure to meet performance standards), the Agency may sanction the Dental Plan pursuant to any of the following, as allowable: s. 409.912 (6), F.S., s. 409.91212, F.S.; Rule 59A-12.0073, F.A.C.; s. 409.967; F.S., 42 CFR Part 438, Subpart I (Sanctions) and ss.1905(t), 1932 and s. 1903(m) of the Social Security Act. The Agency may impose sanctions in addition to any liquidated damages imposed pursuant to **Section XIII.**, Liquidated Damages.
 - a. The Agency shall impose temporary management in accordance with 42 CFR 438.706(a) only if it finds any of the following:
 - (1) There is continued egregious behavior by the Dental Plan, including but not limited to behavior described in 42 CFR 438.700 or that is contrary to any requirements of ss. 1903(m) and 1932 of the Social Security Act;
 - (2) There is substantial risk to enrollees' health; or
 - (3) The sanction is necessary to ensure the health of the Dental Plan's enrollees while improvements are made to remedy violations or until there is an orderly termination or reorganization of the Dental Plan.
 - b. The Dental Plan shall be subject to temporary management and enrollees shall be notified by the Agency of the right to terminate enrollment without cause, when the Dental Plan repeatedly fails to meet substantive requirements in ss. 1903(m) or 1932 of the Social Security Act, or 42 CFR 438.706. (42 CFR 438.706(b))
 - c. The Dental Plan shall be subject to enrollment limitations when the Dental Plan repeatedly fails to meet substantive requirements in **Section V.**, Service Administration; **Section VII.**, Provider Network and Services; and/or **Section VIII.**, Quality, of this Contract.
 - d. If the Agency imposes a civil monetary penalty on the Dental Plan pursuant to 42 CFR 438.704 for charging premiums or charges in excess of the amounts permitted under

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Medicaid, the amount of the overcharge shall be deducted from the penalty and return it to the affected enrollee. (42 CFR 438.704(c))

5. For purposes of this **Section**, violations involving individual, unrelated acts shall not be considered arising out of the same action.
6. In addition to imposing sanctions for a Contract violation or other non-compliance, the Agency may require the Dental Plan to submit to the Agency a CAP within a timeframe specified by the Agency. In the event the Agency identifies a violation of, or other non-compliance with this Contract, to include failure to meet performance standards, the Agency may sanction the Dental Plan pursuant to any of the following, as allowable: s. 409.912(4), F.S., s. 409.91212, F.S.; Rule 59A-12.0073, F.A.C.; s. 409.967; F.S., 42 CFR Part 438, Subpart I (Sanctions) and ss. 1905(t), 1932 and, 1903(m) of the Social Security Act. The Agency may impose sanctions in addition to any liquidated damages imposed pursuant to **Section XIII.**, Liquidated Damages.
7. If the Agency imposes monetary sanctions, the Dental Plan must pay the monetary sanctions to the Agency within thirty (30) days from receipt of the notice of sanction, regardless of any dispute in the monetary amount or interpretation of policy that led to the notice. If the Dental Plan fails to pay, the Agency reserves the right to recover the money by any legal means, including but not limited to the withholding of any payments due to the Dental Plan. If the Secretary, or designee, determines that the Agency should reduce or eliminate the amount imposed, the appropriate amount shall be returned to the Dental Plan within sixty (60) days from the date of a final decision rendered.
8. The Agency shall terminate the Dental Plan Contract and place enrollees into a different Dental Plan or provide Medicaid benefits through other State plan authority, if the Agency determines that the Dental Plan has failed to carry out the substantive terms of its Contract or meet the applicable requirements of ss. 1932, 1903(m), or 1905(t) of the Social Security Act. (42 CFR 438.708(a)-(b))

B. Corrective Action Plans

1. If a CAP is required as determined by the Agency, the Dental Plan's proposed CAP shall be approved or disapproved by the Agency. If the Agency disapproves the CAP, the Dental Plan shall submit a new CAP within ten (10) business days, or an expedited timeframe if required by the Agency, that addresses the concerns identified by the Agency. The Dental Plan shall accept and implement an Agency-defined CAP if required by the Agency.
2. The Agency shall impose a monetary sanction of two hundred dollars (**\$200**) per day on the Dental Plan for each day the Dental Plan does not implement, to the satisfaction of the Agency, the approved CAP.
3. The Agency may impose enrollment limitations on the Dental Plan until the Dental Plan implements, to the satisfaction of the Agency, the approved CAP.

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Section XII. Sanctions and Corrective Action Plans

C. Performance Measure Sanctions

1. The Dental Plan shall be subject to sanctions for failure to achieve minimum performance scores on performance measures specified by the Agency after the first year of poor performance, as specified in this Contract, as applicable. The Agency shall develop performance measures and shall impose monetary sanctions for some or all performance measures. The Agency shall develop performance targets for each performance measure with a methodology for application of the sanction specified by the Agency.
2. The Agency shall sanction the Dental Plan for failure to maintain and/or improve scores on performance measures in accordance with the Performance Measures Sanction Table, Effective as of CY 2025 Performance Measure Reporting (due to the Agency 7/1/2026) Table, **Table 11**, below. The Agency shall impose monetary sanctions and/or CAPs as described above.
3. For each of the performance measures listed below where the Dental Plan’s rate decreases more than two (2) percentage points compared to the previous year, the Dental Plan shall receive a monetary sanction of ten thousand dollars (**\$10,000**).

TABLE 11
PERFORMANCE MEASURES SANCTION TABLE
EFFECTIVE AS OF CY 2025 PERFORMANCE MEASURE REPORTING (DUE TO THE AGENCY 7/1/2026)
1. Oral Evaluation - total
2. Preventive Dental Services
3. Sealant Receipt on Permanent First Molars – at least one (1)
4. Topical Fluoride for Children – total
5. Caries Risk Documentation
6. Follow-up after ED Visits for Dental Caries in Children – seven (7)-day
7. Follow-up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults – seven (7)-day

D. Additional Sanctions

1. Pursuant to s. 409.967(2)(i)2., F.S., if the Dental Plan fails to comply for thirty (30) days with the encounter data reporting requirements as specified in this Contract, the Dental Plan be subject to the following actions on the thirty-first (31st) day:
 - a. The Dental Plan be assessed a fine of five thousand dollars (**\$5,000**) per day for each day of noncompliance; and
 - b. The Dental Plan be notified that the Agency initiate Contract termination procedures on the ninetieth (90th) day unless the Dental Plan comes into compliance before that date.
2. Fraud and Abuse – See **Section IX.**, Administration and Management, **Sub-Section F.**, Fraud and Abuse Prevention.

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3. Pursuant to s. 409.967(2)(i)1., F.S., if the Dental Plan leaves the Contract before the end of this Contract term, the Dental Plan shall reimburse the Agency for the cost of enrollment changes and other transition activities. If more than one (1) Dental Plan providing services under the same program component leave its Contract at the same time, the exiting Dental Plans shall share the costs in a manner proportionate to their enrollments. In addition to payment of costs, all other departing Dental Plans must pay a penalty of twenty-five percent (25%) of that portion of the minimum surplus maintained pursuant to s. 641.225(1), F.S., which is attributable to the provision of coverage to Medicaid enrollees. The Dental Plan shall provide at least one hundred eighty (180) days' notice to the Agency before withdrawing from the Contract. If the Dental Plan withdraws from the Contract before the end of this Contract term, all of the Dental Plan's affiliated Contracts shall be terminated.
4. Pursuant to 42 CFR 438.702(a)(4), after the date the Secretary of DHHS or the Agency notifies the Dental Plan of a determination of a violation of any requirement under ss. 1903(m) or 1932 of the Act the Dental Plan shall be subject to suspension of all new enrollment, including default enrollment.
5. Pursuant to 42 CFR 438.702(a)(5), the Dental Plan shall be subject to suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or the Agency is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

E. Notice of Sanctions

1. Except as noted in 42 CFR Part 438, Subpart I (Sanctions), before imposing any of the sanctions specified in this **Section**, the Agency shall provide written notice to the Dental Plan that explains the basis and nature of the sanction, cites the specific Contract section(s) and/or provision of law and the methodology for calculation of any fine, and the process to dispute sanctions. (42 CFR 438.710(a)(1))
2. If the Dental Plan fails to carry out any substantive terms of this Contract or fails to meet applicable requirements in ss. 1932, 1903(m), or 1905(t) of the Social Security Act, the Agency shall terminate the Dental Plan's Contract for cause.
 - a. Before terminating this Contract, the Agency must provide to the Dental Plan a pre-termination hearing and give advance written notice of intent to terminate, which includes the reason for termination and the time and place of the hearing.
 - b. After the hearing, Dental Plan shall receive written notice of the decision affirming or reversing the proposed termination of this Contract and, if affirmed, the effective date of termination.
 - c. The Agency must notify Dental Plan enrollees of the termination and provide information on their options for receiving Medicaid services following the effective date of termination, which shall include disenrolling from the Dental Plan immediately and without cause.

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3. Unless the Agency specifies the duration of a sanction, a sanction shall remain in effect until the Agency is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.

F. Dispute of a Corrective Action Plan or Sanction

1. To dispute a CAP or a sanction, the Dental Plan shall request that the Agency's Secretary or designee hear and decide the dispute.
 - a. The Dental Plan must submit a written dispute of the CAP or sanction directly to the Agency via an electronic submission process; the Agency will not accept deliveries by U.S. mail, commercial courier service, or hand.
 - (1) The Dental Plan shall submit each written request for dispute to an SFTP site in a file and format specified by the Agency.
 - (2) Each dispute request shall include only one (1) electronic file per submission that includes all the following information:
 - (a) A Dental Plan appeal letter that is addressed to the Secretary or designee and which includes the case and file number from the original compliance action related to the issue being disputed;
 - (b) Exhibit A – the original action letter received from the Agency; and
 - (c) Exhibit B – the Dental Plan's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).
 - (3) The Dental Plan shall submit its dispute request to the Agency by 5:00 P.M., EST on the twenty-first (21st) day after the date of issuance of any CAP or sanction. The Agency will deny any appeals or disputes that are not delivered in the format and timeframes specified by the Agency.
 - b. The Dental Plan waives any dispute not raised within twenty-one (21) days of receiving the CAP or sanction. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving the CAP or sanction, and waives the right to use any materials, data, and/or information not contained in or accompanying the Dental Plan's submission submitted within the twenty-one (21) days following its receipt of the CAP or sanction in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).
 - (1) The Secretary or his/her designee shall decide the dispute under the reasonableness standard, reduce the decision to writing and serve a copy to the Dental Plan. This written decision shall be final.

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- (2) The exclusive venue of any legal or equitable action that arises out of or relating to this Contract, including an appeal of the final decision of the Secretary or his/her designee, shall be Circuit Court in Leon County, Florida; in any such action,

the Dental Plan shall waive its right to a jury trial, and that the Circuit Court can only review the final decision for reasonableness, and Florida law shall apply. In the event the Agency issues any action under Florida Statutes or Florida Administrative Code apart from this Contract, the Dental Plan shall receive notice of the appropriate administrative remedy.

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Section XIII. Liquidated Damages

Section XIII. Liquidated Damages

The Agency shall be responsible for imposing liquidated damages as a result of failure to meet any aspect of the responsibilities of this Contract.

The Dental Plan agrees that failure to meet any aspect of the responsibilities of this Contract shall result in the assessment of damages in accordance with **Section XIII.**, Liquidated Damages.

A. Damages

1. If the Dental Plan breaches this Contract, the Agency shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In some cases, the actual damage to the Agency as a result of the Dental Plan's failure to meet any aspect of the responsibilities of this Contract and/or to meet specific performance standards set forth in this Contract shall be difficult or impossible to determine with precise accuracy. Therefore, in the event of a breach of this Contract, the Dental Plan shall be subject to the imposition of liquidated damages in writing against the Dental Plan. The Dental Plan shall be assessed liquidated damages regardless of whether the breach is the fault of the Dental Plan (including the Dental Plan's subcontractors, agents and/or consultants), provided the Agency has not materially caused or contributed to the breach. The Agency shall impose liquidated damages in addition to any sanctions imposed pursuant to **Section XII.**, Sanctions and Corrective Action Plans.
2. The liquidated damages prescribed in this **Section** are not intended to be in the nature of a penalty but are intended to be reasonable estimates of the Agency's projected financial loss and damage resulting from the Dental Plan's nonperformance, including financial loss as a result of project delays. Accordingly, in the event the Dental Plan fails to perform in accordance with this Contract, the Agency may assess liquidated damages as provided in this **Section**.
3. If the Dental Plan fails to perform any of the services described in this Contract, the Agency may assess liquidated damages for each occurrence listed in, the Liquidated Damages Issues and Amounts Table, **Table 12**. Any liquidated damages assessed by the Agency shall be due and payable to the Agency within thirty (30) days after the Dental Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice. The Agency shall have sole authority to determine the application of an occurrence (e.g., per unit of service, per date of service, per episode of service, per complaint, per enrollee, etc.).
4. The Agency may elect to collect liquidated damages:
 - a. Through direct assessment and demand for payment delivered to the Dental Plan; or
 - b. By deduction of amounts assessed as liquidated damages from, and as set-off against payments then due to the Dental Plan or that become due at any time after assessment of the liquidated damages. The Dental Plan shall be subject to deductions until the Agency has collected the full amount payable by the Dental Plan.
5. The Dental Plan shall not pass through liquidated damages imposed under this Contract to a provider and/or subcontractor unless the provider and/or subcontractor caused the

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damage through its own action or inaction. Nothing described herein shall prohibit a provider and/or a subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction.

6. All liquidated damages imposed pursuant to this Contract, whether paid or due, shall be paid by the Dental Plan out of administrative costs and profits.
7. Subject to legislative approval, the Agency reserves the right to redirect any amounts assessed as liquidated damages towards QI activities that target and support Agency goals or initiatives.
8. To dispute the imposition of liquidated damages, the Dental Plan must request that the Agency's Secretary or designee, hear, and decide the dispute.
 - a. The Dental Plan must submit a written dispute of the liquidated damages directly to the Agency via an electronic submission process; the Agency will not accept deliveries by U.S. mail, commercial courier service, or hand.
 - (1) The Dental Plan shall submit each written request for dispute to an SFTP site in a file and format specified by the Agency.
 - (2) Each dispute request shall include only one (1) electronic file per submission that includes all of the following information:
 - (a) A Dental Plan appeal letter that is addressed to the Secretary or designee and which includes the case and file number from the original compliance action related to the issue being disputed;
 - (b) Exhibit A – the original action letter received from the Agency; and
 - (c) Exhibit B – the Dental Plan's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).
 - (3) The Dental Plan shall submit its dispute request to the Agency by 5:00 P.M., EST. on the twenty-first (21st) day after the date of issuance of any liquidated damage. The Agency will deny any appeals or disputes that are not delivered in the format and timeframes specified by the Agency.
 - b. The Dental Plan waives any dispute not raised within twenty-one (21) days of receiving notice of the imposition of liquidated damages. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving said notice, and waives the right to use any materials, data, and/or information not contained in or accompanying the Dental Plan's submission within the twenty-one (21) days following its receipt of the notice in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).

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9. The Secretary or his/her designee shall decide the dispute under the reasonableness standard, reduce the decision to writing and serve a copy to the Dental Plan. This written decision shall be final.
10. The exclusive venue of any legal or equitable action that arises out of or relating to this Contract, including an appeal of the final decision of the Secretary or his/her designee shall be Circuit Court in Leon County, Florida. In any such action, the Dental Plan shall waive its right to a jury trial, and that the Circuit Court can only review the final decision for reasonableness, and Florida law shall apply. In the event the Agency issues any action under Florida Statutes or Florida Administrative Code apart from this Contract, the Dental Plan shall receive notice of the appropriate administrative remedy.

B. Issues and Amounts

The Dental Plan shall pay the Agency up to the amount for each issue as specified in the Liquidated Damages Issues and Amounts Table, **Table 12**, below. In addition, the Dental shall pay the Agency an additive liquidated damage that shall not be passed down to the Dental Plan’s subcontractor(s) in the amount of one thousand dollars **(\$1,000)** for every occurrence where a contract action is assessed by the Agency for a subcontractor-related issue.

TABLE 12		
LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	CORE PROGRAM ISSUES	DAMAGES
1.	Failure to provide covered services with reasonable promptness.	Two thousand five hundred dollars (\$2,500) per occurrence.
2.	Failure by the Dental Plan to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach as described in this Contract. See also ancillary BAA between the parties.	Five hundred dollars (\$500) per enrollee per occurrence, not to exceed ten million dollars (\$10,000,000) .
3.	Failure to meet plan readiness goals set by the Agency	Five thousand dollars (\$5,000) per occurrence.
4.	Failure to submit a timely notice of involuntary disenrollment to the enrollee as described in this Contract.	One thousand dollars (\$1,000) per occurrence.
5.	Failure to comply with marketing requirements as described in this Contract.	Two thousand five hundred dollars (\$2,500) per occurrence.
6.	Failure to timely report staff or marketing agent violations as described in this Contract.	Two thousand five hundred dollars (\$2,500) per occurrence.
7.	Failure to obtain approval of enrollee materials as required by this Contract.	One thousand dollars (\$1,000) per occurrence.

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#	CORE PROGRAM ISSUES	DAMAGES
8.	Failure to withhold payment to providers ineligible for payment under 42 CFR 455.23, or payment withhold under s. 409.913(25)(a), F.S., or providers with new admissions under a denial of payment for new admissions issued by CMS in accordance with 42 CFR 488.417.	Five hundred dollars (\$500) per occurrence, in addition to two hundred fifty dollars (\$250) for each day the Agency determines that the Dental Plan is not in compliance.
9.	Failure to comply with enrollee notice requirements as described in this Contract (excluding denials, reductions, terminations, or suspensions of services).	Two hundred fifty dollars (\$250) per occurrence.
10.	Failure to comply with time frames for providing Enrollee Handbooks, I.D. cards, and Provider Directories, as required in this Contract.	Five thousand dollars (\$5,000) per occurrence.
11.	Failure to update online and printed provider directory as described in this Contract.	Two thousand five hundred dollars (\$2,500) per occurrence.
12.	Failure to comply in any way with the toll-free enrollee help line requirements as described in this Contract (excluding the failure to respond to individual messages on the automated system of the toll-free enrollee help line in a timely manner as required by the Agency).	Ten thousand dollars (\$10,000) per month, for each month that the Agency determines that the Dental Plan is not in compliance.
13.	Failure to respond to individual messages on the automated system of the toll-free enrollee help line in a timely manner as described this Contract.	Five hundred dollars (\$500) per day, per occurrence.
14.	Failure to timely submit any complete plan as described in this Contract, including, but not limited to a CCP. Note: The Anti-Fraud plan liquidated damages listed in this table is separate and not included in this program issue.	Two hundred fifty dollars (\$250) per day for every day plans are late.
15.	Failure to comply with the grievance and appeal notice requirements described in this Contract.	Two hundred fifty dollars (\$250) per occurrence.
16.	Failure to comply with timeframes for the enrollee grievance and appeal system.	Five hundred dollars (\$500) per occurrence.

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#	CORE PROGRAM ISSUES	DAMAGES
17.	Failure to comply with all orders/official decisions relating to claim disputes, grievances, appeals and/or fair hearings, as they are issued.	Ten thousand dollars (\$10,000) per occurrence.
18.	Failure to provide continuation of services during the pendency of a Medicaid fair hearing and/or the Dental Plan's appeal process where the enrollee has challenged a reduction or elimination of services as required by this Contract, applicable State or federal law, and all court orders governing appeal procedures as they become effective.	The value of the reduced or eliminated services as determined by the Agency for the timeframe specified by the Agency and five hundred dollars (\$500) per day for each day the Dental Plan fails to provide continuation or restoration as required by the Agency.
19.	Failure to submit a fair hearing evidence packet within the timeframe described in this Contract and prehearing instructions.	One thousand dollars (\$1,000) per occurrence.
20.	Failure to provide necessary witnesses for fair hearings in accordance with this Contract.	One thousand dollars (\$1,000) per occurrence.
21.	Failure to attend fair hearings as scheduled in accordance with this Contract.	Two thousand five hundred dollars (\$2,500) per occurrence.
22.	Failure to provide restoration of services after the Dental Plan receives an adverse determination as a result of a Medicaid fair hearing or the Dental Plan's appeal process as required by this Contract, applicable State or federal law and all court orders governing appeal procedures as they become effective.	The value of the reduced or eliminated services as determined by the Agency and five hundred dollars (\$500) per day for each day that the Dental Plan fails to provide continuation or restoration as required by the Agency.
23.	Failure to provide medically necessary services to enrollees under the age of twenty-one (21) years in accordance with this Contract.	Two thousand five hundred dollars (\$2,500) per occurrence.
24.	Failure to use teledentistry coverage provisions as described in this Contract.	One thousand dollars (\$1,000) per occurrence.
25.	Imposition of arbitrary utilization guidelines or other quantitative coverage limits as prohibited in this Contract.	Twenty-five thousand dollars (\$25,000) per occurrence.

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TABLE 12		
LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	CORE PROGRAM ISSUES	DAMAGES
26.	Failure to complete, authorize, and initiate all services specified in the treatment plan for an enrollee within specified timelines as described in this Contract.	Five thousand dollars (\$5,000) per occurrence.
27.	Failure to develop and/or implement a transition plan for recipients including the provision of data to the Agency, as specified in this Contract.	Ten thousand dollars (\$10,000) per occurrence.
28.	Failure to develop and document a treatment or service plan for an enrollee, that shall be documented in writing as described in this Contract.	Five hundred dollars (\$500) per occurrence.
29.	Failure to conduct a Supplemental Assessment as described in this Contract for enrollees on the iBudget Waiver or Waitlist.	Five thousand dollars (\$5,000) per occurrence.
30.	Failure to provide case management or care coordination activities for enrollees as described in this Contract.	One thousand dollars (\$1,000) per occurrence.
31.	Failure to comply with provider network requirements specified in this Contract.	Two thousand five hundred dollars (\$2,500) per occurrence.
32.	Failure to pay the Agency timely for the Dental Plan's charges and expenses as provided by the Agency for compensation of the independent network review vendor as described in this Contract.	One hundred dollars (\$100) per day.
33.	Failure to submit a Provider Network File that meets the Agency's specifications as described in this Contract.	Two hundred fifty dollars (\$250) per occurrence.
34.	Failure to timely report, or provide notice for, significant network changes as described in this Contract.	Five thousand dollars (\$5,000) per occurrence.
35.	Failure to provide access to after hours non-emergent dental services from PDP General Dentists or Pediatric Dentists.	Five hundred dollars (\$500) per occurrence.
36.	Failure to meet provider credentialing requirements, including background screening requirements, specified in this Contract.	Five thousand dollars (\$5,000) per occurrence.

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#	CORE PROGRAM ISSUES	DAMAGES
37.	Failure to comply with licensure or background screening requirements for Dental Plan principals in this Contract.	Five thousand dollars (\$5,000) per occurrence that owner/staff is not licensed or qualified as required by applicable State or local law plus the amount paid to the owner/staff during that period.
38.	Failure to comply with licensure or background screening requirements for subcontractors in this Contract.	Five thousand dollars (\$5,000) per occurrence that subcontractor is not licensed or qualified as required by applicable State or local law plus the amount paid to the subcontractor during that period.
39.	Failure to report notice of provider termination, suspension, or denial of participation in the Dental Plan as described in this Contract.	Five hundred dollars (\$500) per day, per occurrence.
40.	Failure to timely report notice of terminated providers due to imminent danger/impairment as described in this Contract.	Five thousand dollars (\$5,000) per occurrence.
41.	Failure to timely report termination or suspension of providers for cause as described in this Contract.	Two hundred fifty dollars (\$250) per occurrence.
42.	Failure to suspend or terminate providers who become ineligible for Medicaid participation.	Five hundred dollars (\$500) per occurrence, in addition to two hundred fifty dollars (\$250) per day until the provider is suspended or terminated.
43.	Failure to obtain and/or maintain national accreditation as described in this Contract.	Five hundred dollars (\$500) per day for every day beyond the day accreditation status must be in place as described in this Contract.
44.	Failure to cooperate with the Agency's contracted EQRO as described in this Contract.	Five thousand dollars (\$5,000) per occurrence.
45.	Failure to comply with the quality requirements specified in this Contract under Section IX. , Administration and Management.	One thousand dollars (\$1,000) per occurrence.
46.	Failure to submit audited HEDIS, CAHPS, and other performance measures results timely as described in this Contract.	One thousand dollars (\$1,000) per day for every day reports are late.

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#	CORE PROGRAM ISSUES	DAMAGES
47.	Failure to timely submit appropriate PIPs as described in this Contract.	One thousand dollars (\$1,000) per day for every day PIPs are late.
48.	Failure to accurately report PIP data, interventions, or evaluation methods.	Five hundred dollars (\$500) per occurrence
49.	Failure to address previous PIP feedback from the Agency/EQRO prior to subsequent submissions of the PIP.	Five hundred dollars (\$500) per occurrence.
50.	Failure to timely submit enrollee records within time frames requested by the Agency or the EQRO.	One thousand dollars (\$1,000) per occurrence.
51.	Failure to allow an enrollee to obtain a second medical opinion at no expense and regardless of whether the provider is participating or not, as described in this Contract.	Five thousand dollars (\$5,000) per occurrence.
52.	Failure to acknowledge or act timely upon a request for prior authorization in accordance with this Contract.	Two thousand five hundred dollars (\$2,500) per occurrence.
53.	Failure to comply with any of the standards for timely service authorization as specified in this Contract.	Five thousand dollars (\$5,000) per month, for each month that the Agency determines that the Dental Plan is not in compliance, per standard.
54.	Failure to comply with enrollee notice for denials, reductions, terminations, or suspensions of services within the timeframes specified in this Contract as described in this Contract.	Two thousand five hundred (\$2,500) per occurrence.
55.	Failure to make appropriate payment to an eligible dental professional who meets the qualifying DPIP criteria as specified in this Contract.	One thousand dollars (\$1,000) per occurrence, plus one hundred dollars (\$100) per day for each day the dental professional has not received payment.
56.	Failure to implement a proposed strategy outlined in the prior year's Annual Network Development Plan submitted as described in this Contract.	Five thousand dollars (\$5,000) per occurrence
57.	Failure to comply with Gold Card contract requirements for high quality providers.	Five thousand dollars (\$5,000) per occurrence.

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TABLE 12		
LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	CORE PROGRAM ISSUES	DAMAGES
58.	Failure to provide continuity of care and a seamless transition consistent with the services in place prior to the new enrollee's enrollment in the Dental Plan as described in this Contract.	Five thousand dollars (\$5,000) per occurrence.
59.	Failure to comply in any way with Dental Plan staffing requirements as specified in this Contract.	One thousand dollars (\$1,000) per day for each day that staffing requirements are not met.
60.	Failure to timely report changes in Dental Plan staffing as described in this Contract.	One thousand dollars (\$1,000) per occurrence.
61.	Failure to provide no less than thirty (30) days' written notice before making any changes to the administration and/or management procedures and/or authorization, denial, or review procedures, including any delegations, as described in this Contract.	Twenty-five thousand dollars (\$25,000) per occurrence.
62.	Failure of a provider agreement to comply with a requirement of this Contract.	One thousand dollars (\$1,000) per failure per provider agreement.
63.	Failure to receive prior written Agency approval of delegation to a subcontractor.	Twenty-five thousand dollars (\$25,000) per occurrence.
64.	Failure of a subcontract to comply with a requirement of this Contract.	Five thousand dollars (\$5,000) per failure per subcontract.
65.	Failure to maintain and/or provide proof of required insurance as described in this Contract.	Five hundred dollars (\$500) per day.
66.	Failure to comply with subcontract requirements for providers dually offering UM and service provision.	Twenty-five thousand dollars (\$25,000) per occurrence.
67.	Failure to maintain and/or provide proof of the Dental Plan's fidelity bond as required in this Contract.	Five hundred dollars (\$500) per day.

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LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	CORE PROGRAM ISSUES	DAMAGES
68.	Failure by the Dental Plan to execute the appropriate agreements to effectuate transfer and exchange of enrollee PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, BAA or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to this Contract. See also ancillary BAA between the parties.	Five hundred dollars (\$500) per enrollee per occurrence.
69.	Failure by the Dental Plan to ensure that all data containing PHI, as defined by HIPAA, is secured through commercially reasonable methodology in compliance with the HITECH Act, such that it is rendered unusable, unreadable, and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Agency enrollee's PHI as specified in this Contract. See also ancillary BAA between the parties.	One thousand dollars (\$1,000) per enrollee per occurrence. If the State determines credit monitoring and/or identity theft safeguards are needed to protect those enrollees whose PHI was placed at risk by Dental Plan's failure to comply with the terms of this Contract, the Dental Plan shall also be liable for all costs associated with the provision of such monitoring and/or safeguard services.
70.	Failure to annually maintain a top tier security rating score from the Agency's selected information security rating service.	Five thousand dollars (\$5,000) per occurrence and two hundred fifty dollars (\$250) per calendar day, if the Dental Plan does not improve to a top tier security rating score within three (3) months after its initial failure
71.	Failure to complete or comply with CAPs as described in this Contract.	Five hundred dollars (\$500) per day for each day the corrective action is not completed or complied with as required.
72.	Failure to provide notice of noncompliance to the Agency within five (5) days or other Contract-specified period of time in accordance with this Contract.	Five hundred dollars (\$500) per day beginning on the next day after default by the Dental Plan.

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TABLE 12		
LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	CORE PROGRAM ISSUES	DAMAGES
73.	Failure to provide proof of compliance to the Agency within five (5) days of a directive from the Agency or within a longer period of time that has been approved by the Agency	Five hundred dollars (\$500) per day beginning on the next day after default by the Dental Plan.
74.	Failure to comply with claims processing as described in this Contract.	Ten thousand dollars (\$10,000) per month, for each month that the Agency determines that the Dental Plan is not in compliance.
75.	Inaccurate or incorrect system information resulting in inappropriate adjudication of claims and/or incorrect payment.	Five hundred dollars (\$500) per occurrence.
76.	Failure to comply with encounter data submission requirements as described in this Contract (excluding the failure to address or resolve problems with individual encounter records in a timely manner as required by the Agency).	Twenty-five thousand dollars (\$25,000) per occurrence.
77.	Failure to address or resolve problems with individual encounter records in a timely manner as required by the Agency and described in this Contract.	Five hundred dollars (\$500) per day, per occurrence.
78.	Failure to comply with fraud and abuse provisions, including failure to cooperate with the Agency or Law Enforcement entities during investigations, as described in this Contract.	Two thousand dollars (\$2,000) per day per occurrence/issue.
79.	Failure to establish an investigative unit as required in this Contract, by the time the Dental Plan has enrolled its first recipient.	Ten thousand dollars (\$10,000) per occurrence.
80.	Failure to staff the Compliance Officer or Special Investigations Unit Manager position with a qualified individual in accordance with this Contract.	Five thousand dollars (\$5,000) per day starting ninety (90) days from the date of the position vacancy.
81.	Failure to implement an anti-fraud plan as required by this Contract within ninety (90) days of its approval by the Agency.	Ten thousand dollars (\$10,000) per occurrence.

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#	CORE PROGRAM ISSUES	DAMAGES
82.	Failure to cooperate fully with the Agency and/or State during an investigation of fraud or abuse, complaint, or grievances as described in this Contract.	Five hundred dollars (\$500) per incident for failure to cooperate fully during an investigation.
83.	Failure to timely report, or report all required information for, all suspected or confirmed instances of provider or recipient fraud or abuse as required by this Contract.	One thousand dollars (\$1,000) per day, until MPI deems the Dental Plan to be in compliance.
84.	Failure to timely submit an acceptable anti-fraud plan, quarterly fraud and abuse report or the annual report required by this Contract.	One thousand dollars (\$1,000) per day, until MPI deems the Dental Plan to be in compliance.
85.	Failure to comply with the requirement to pay the expenses of the Agency's Achieved Savings Rebate Audit as described in this Contract.	One hundred dollars (\$100) per day.
86.	Failure to achieve and/or maintain insolvency or Irrevocable Standby Letter of Credit (LOC) requirements in accordance with this Contract.	One thousand dollars (\$1,000) per day for each day that insolvency or Irrevocable Standby LOC requirements are not met.
87.	Failure to submit timely to the Agency all items of the monthly account valuation.	Two hundred fifty dollars (\$250) per day.
88.	Failure to purchase Securities in accordance with Agency guidelines.	Two thousand five hundred dollars (\$2,500) per day for every unapproved security purchased until the Security is replaced with an approved Security.
89.	Failure to achieve and/or maintain financial surplus requirements as described in this Contract.	One thousand dollars (\$1,000) per day for each day Contract requirements are not met.
90.	Failure to timely submit complete and accurate quarterly unaudited and audited annual financial statements as described in this Contract.	Five hundred dollars (\$500) per day for each day that reporting requirements are not met.
91.	Failure to require and ensure compliance with ownership and disclosure requirements as required in this Contract.	Five thousand dollars (\$5,000) per provider disclosure/attestation for each disclosure/attestation that is not received timely or is not in compliance with the requirements outlined in 42 CFR Part 455, Subpart B.

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#	CORE PROGRAM ISSUES	DAMAGES
92.	Failure to timely report changes in ownership and control as described in this Contract.	Five thousand dollars (\$5,000) per occurrence.
93.	Failure to timely initiate a background screening via the Clearinghouse for newly hired principals as described in this Contract.	One thousand dollars (\$1,000) per occurrence.
94.	Failure to timely report information about offenses listed in s. 435.04, F.S., as described in this Contract.	One thousand dollars (\$1,000) per occurrence.
95.	Failure to comply with conflict of interest or lobbying requirements as described in this Contract.	Ten thousand dollars (\$10,000) per occurrence.
96.	Failure to disclose lobbying activities and/or conflict of interest as required by this Contract.	One thousand dollars (\$1,000) per day that disclosure is late.
97.	Failure to meet plan readiness review deadlines set by the Agency	Two thousand dollars (\$2,000) per day per occurrence.
98.	Failure to comply with public records laws, in accordance with s. 119.0701, F.S.	Five thousand dollars (\$5,000) per occurrence.
99.	Submission of inappropriate report certifications and/or failure to submit report attestations as described in this Contract.	Five hundred dollars (\$500) per occurrence.
100.	Failure to file required reports timely as described in this Contract.	Five hundred dollars (\$500) per occurrence.
101.	Failure to file accurate reports as described in this Contract.	Two thousand five hundred dollars (\$2,500) per occurrence.
102.	Failure to respond to an Agency request or ad-hoc report for documentation within the time prescribed by the Agency as described in this Contract.	One thousand dollars (\$1,000) per day.
103.	Failure to process enrollment files as specified in the Contract.	One thousand dollars (\$1,000) per occurrence.
104.	Failure to comply with Fair Payment Provisions as described in the Contract.	Five hundred dollars (\$500) per occurrence, in addition to two hundred fifty dollars (\$250) for each day that the Agency determines that the Dental Plan is not in compliance.

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TABLE 12		
LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	CORE PROGRAM ISSUES	DAMAGES
105.	Failure to resolve claims and non-claim complaints within the timeframes described in the Contract.	Five hundred dollars (\$500) per occurrence.
106.	Failure to adhere to Contract timeframes with providers or the Agency as outlined in the Contract.	Five hundred dollars (\$500) per occurrence.
107.	Failure to pay non-participating providers as specified in the Contract.	Five hundred dollars (\$500) per occurrence.
108.	Failure to comply with the provider complaint system notice requirements as outlined in the Contract.	Two hundred fifty dollars (\$250) per occurrence.
109.	Failure to terminate providers who become ineligible for Medicaid participation.	Five thousand dollars (\$5,000) per occurrence, in addition to two hundred fifty dollars (\$250) per day until the provider is terminated.
110.	Failure to submit subcontracts for Agency review at least ninety (90) days before the proposed effective date of the subcontract.	Ten thousand dollars (\$10,000) per occurrence
111.	Failure by the Dental Plan to revise a subcontract into compliance with Contract amendments	Five thousand dollars (\$5,000) per occurrence
112.	Failure to monitor subcontractors pursuant to the requirements of the Contract	Ten thousand dollars (\$10,000) per occurrence
113.	Failure to timely notify the Agency of subcontractor insolvency or petition of bankruptcy	One thousand dollars (\$1,000) per occurrence
114.	Failure by the Dental Plan to notify the Agency of problems with systems functions within one (1) hour and/or update hourly until resolved, as described in the Contract	One thousand dollars (\$1,000) per occurrence.
115.	Failure to submit to the Agency an Emergency Management Plan as described in the Contract.	One thousand dollars (\$1,000) per occurrence.
116.	Failure to comply with emergency management plan requirements as described in the Contract.	Two thousand five hundred dollars (\$2,500) per occurrence.
117.	Failure to comply with inter-rater reliability requirements to ensure consistent application of review criteria for authorization decisions.	One thousand dollars (\$1,000) per month for each month the Agency determines that the Dental Plan is not in compliance.

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TABLE 12		
LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	CORE PROGRAM ISSUES	DAMAGES
118.	Failure to participate in the Agency's dispute resolution process for provider complaints.	Two thousand five hundred dollars (\$2,500) per occurrence
119.	Failure to comply with timeframes for submission of disclosures of suspected or confirmed fraud within five (5) days of the date of detection to Medicaid Program Integrity, as outlined in the Contract.	Five hundred dollars (\$500) per occurrence
120.	Failure to maintain a claim payment accuracy percentage of ninety-five percent (95%) or higher for each measure of accuracy established by the Agency.	Ten thousand dollars (\$10,000) per occurrence
121.	Failure to implement a plan-specific commitment without approval from the Agency.	Five thousand dollars (\$5,000) per occurrence
122.	Failure to obtain Agency approval prior to alteration, discontinuation, or non-performance of a plan-specific commitment.	Five thousand dollars (\$5,000) per occurrence
123.	Failure to submit performance measures as specified in the Report Guide and file layout instructions.	Five thousand dollars (\$5,000) per occurrence.
124.	Failure to comply with the enrollee records documentation requirements pursuant to the Contract.	One thousand dollars (\$1,000) per enrollee record that does not include all of the required elements.
125.	Failure to develop and document a treatment or service plan for an enrollee with complex dental issues, high service utilization, intensive health care needs, or who consistently accesses services at the highest level of care, that shall be documented in writing as described in the Contract.	Five hundred dollars (\$500) per deficient/missing treatment or service plan.
126.	Failure to comply with standards for the completion of oral health risk assessments.	Two thousand five hundred dollars (\$2,500) per occurrence
127.	Failure to pay physician payment rates equal to or in excess of Medicare rates for services provided as part of a physician incentive plan approved by the Agency in accordance with s. 409.967(2)(a), F.S.	One thousand dollars (\$1,000) per occurrence, plus one hundred dollars (\$100) per day for each day the physician has not received payment.

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TABLE 12		
LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	CORE PROGRAM ISSUES	DAMAGES
128.	Failure to submit the annual healthy behavior program evaluation as described in this Contract	Five hundred dollars (\$500) per occurrence, in addition to two hundred fifty dollars (\$250) for each day that the Agency determines that the Dental Plan is not in compliance
129.	Failure to submit an annual progress report on the Dental Plan Specific Commitments	Five thousand dollars (\$5,000) per occurrence
130.	Failure to execute each MMA plan agreement that is neither reviewed, approved, nor executed by one hundred twenty (120) days after contract initiation with the Agency	Five hundred dollars (\$5,000) per day for each day following the one hundred twentieth (120 th) day after contract execution that the MMA plan agreement is not executed as required
131.	Failure to notify eligible physicians of the Agency's DPIP qualifying criteria at least sixty (60) days prior to October 1 of each year.	Five thousand dollars (\$5,000) per occurrence
132.	Failure to meet VBP reporting requirements as described in the Contract.	Two thousand five hundred dollars (\$2,500) per occurrence
133.	Failure to meet VBP benchmarks as described in the Contract.	Fifty thousand dollars (\$50,000) per occurrence
134.	Failure to meet minimum requirements of the VBP arrangement as described in the Contract.	Five thousand dollars (\$5,000) per occurrence

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Section XIII. Liquidated Damages

C. Performance Measure Liquidated Damages

1. The Agency may impose liquidated damages for performance measures as described below in the event that the Dental Plan fails to perform at the level of the Agency's expected minimum standards, as specified below in the Performance Measure Liquidated Damages Issues and Amounts Table, **Table 13**, below.

TABLE 13		
PERFORMANCE MEASURE LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	CORE PROGRAM ISSUES	DAMAGES
1.	Failure to comply with the following preventive dental services rates requirements: FFY 2024-25: 40% FFY 2025-26: 42% FFY 2026-27: 44% FFY 2027-28: 46% FFY 2028-29: 48% FFY 2029-30: 50%	Fifty thousand dollars (\$50,000) per occurrence in addition to ten thousand dollars (\$10,000) for each percentage point less than the target.
2.	Failure to comply with the following Oral Evaluation, Dental Services rate requirements: CY 2025: 34% CY 2026: 35% CY 2027: 36% CY 2028: 37% CY 2029: 38% CY 2030: 39%	Twenty-five dollars (\$25) per eligible enrollee not receiving the service up to the performance target rate for that Contract year.
3.	Failure to comply with the following Sealant Receipt on Permanent First Molars – At Least One rates requirements: CY 2025: 48% CY 2026: 49% CY 2027: 50% CY 2028: 51% CY 2029: 52% CY 2030: 53%	Twenty-five dollars (\$25) per eligible enrollee not receiving the service up to the performance target rate for that Contract year.

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TABLE 13		
PERFORMANCE MEASURE LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	CORE PROGRAM ISSUES	DAMAGES
4.	Failure to comply with the following Follow-up after ED Visits for Dental Caries in Children –30 Day rate requirements: CY 2025: 44% CY 2026: 45% CY 2027: 46% CY 2028: 47% CY 2029: 48% CY 2030: 49%	Twenty-five dollars (\$25) per eligible enrollee not receiving the service up to the performance target rate for that Contract year.
5.	Failure to comply with the following Topical Fluoride for Children rates requirements: CY 2025: 13% CY 2026: 14% CY 2027: 15% CY 2028: 16% CY 2029: 17% CY 2030: 18%	Twenty-five dollars (\$25) per eligible enrollee not receiving the service up to the performance target rate for that Contract year.
6.	Failure to comply with the following Caries Risk Documentation rate requirements: CY 2025: 10% CY 2026: 12% CY 2027: 14% CY 2028: 16% CY 2029: 18% CY 2030: 20%	Twenty-five dollars (\$25) per eligible enrollee not receiving the service up to the performance target rate for that Contract year.
7.	Performance Measure: Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children	Two hundred fifty dollars (\$250) per occurrence (i.e., per case in the numerator of the measure).
8.	Performance Measure: Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults	One hundred dollars (\$100) per occurrence (i.e., per case in the numerator of the measure).

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A. Applicable Laws and Regulations

1. The Dental Plan shall comply with all applicable federal and State laws, rules and regulations including but not limited to:
 - a. Title IX of the Education Amendments of 1972;
 - b. Title IX of the Education Amendments of 1972 (regarding education programs and activities);
 - c. Title 42 CFR 422.208 and 422.210 on Physician Incentive Plans;
 - d. The Rehabilitation Act of 1973, as amended, 29 USC 794 (which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance);
 - e. Medicare - Medicaid Anti-Fraud and Abuse Amendments of 1977;
 - f. 42 CFR part 438;
 - g. Section 1557 of the ACA;
 - h. 2 CFR part 200; and 2 CFR 300.1; and 45 CFR part 75;
 - i. Section 508 of the Federal Water Pollution Control Act as amended (33 U.S.C. 1251, et seq.);
 - j. Executive Order 11738 as amended;
 - k. Environmental Protection Agency regulations 40 CFR 30, as applicable;
 - l. Title 2 CFR part 200 and Executive Order 11246, Equal Employment Opportunity, as amended by Executive Order 11375 and others, and as supplemented in Department of Labor regulation 41 CFR part 60, if applicable;
 - m. The Pro-Children Act of 1994 (20 U.S.C. 7183);
 - n. Title 2 CFR parts 180 and 376 and Executive Orders 12549 and 12689 “Debarment and Suspension;
 - o. Title 2 CFR part 175 relating to trafficking in persons;
 - p. Title 2 CFR part 170, relating to the Transparency Act, as applicable;
 - q. Section 501.171, F.S., the Florida Information Protection Act of 2014;
 - r. ss. 1903(i)(16)-(17) and 1903(i)(2)(A)-(C) of the Social Security Act;

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- s. Chapter 409, F.S.;
 - t. Section 403.7065, F.S.;
 - u. Rule 62-730.160, F.A.C. pertaining to standards applicable to generators of hazardous waste;
 - v. All applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 USC 7401 et seq.;
 - w. 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin;
 - x. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended;
 - y. 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation, or beliefs;
 - z. Other federal omnibus budget reconciliation acts; and
 - aa. All regulations, guidelines and standards as are now or shall be lawfully adopted under the above statutes.
2. The Dental Plan is subject to any changes in federal and State law, rules or regulations and federal CMS waivers applicable to this Contract and shall implement such changes in accordance with the required effective dates upon notice from the Agency without waiting for an amendment to this Contract. However, an amendment to this Contract shall be processed to incorporate the changes.

B. Coordination of Medical and Dental Services

- 1. The Dental Plan agrees to participate in meetings with the Agency and the SMMC Health Plans to foster enhanced communication, strategic planning, and collaboration in coordinating benefits provided through the SMMC and PDHP delivery system and to address any major organizational challenges and/or barriers during the implementation process.
- 2. Within one hundred twenty (120) days of contract execution, the Dental Plan shall enter into a coordination of benefits agreement with each SMMC Health Plan. The written agreements must include, at a minimum, sections addressing the following:
 - a. Quarterly, bidirectional data sharing between the Managed Care Plan and the Dental Plan that specifies the enrollee data to be shared, HIPAA protection of the data, and how the data will be used to improve dental quality performance measures;
 - b. Goals, measurable objectives, and actionable strategies to integrate dental and physical health care for enrollees;
 - c. Goals, measurable objectives, and actionable strategies to provide prevention, education, screening, and treatment services in schools and other community settings;
 - d. Goals, measurable objectives, and actionable strategies for reducing potentially preventable events (PPE), including but not limited to potentially preventable

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emergency department visits (PPV), potentially preventable hospital admissions (PPA), and potentially preventable hospital readmissions (PPR);

- e. Coordination protocols for the timely care of people with cleft lip, cleft palate, or other craniofacial deformities, including but not limited to timely data sharing, enhanced care coordination, case managers, regular care coordination meetings between the plans;
 - f. Coordination protocols for the timely dental care of people with intellectual or developmental disabilities (IDD), such as people covered by the iBudget waiver, including but not limited to timely data sharing, enhanced care coordination, case managers, regular care coordination meetings between the plans;
 - g. Coordination protocols for the timely dental care of pregnant people, including but not limited to timely data sharing, enhanced care coordination, case managers, regular care coordination meetings between the plans;
 - h. Coordination protocols for timely access and utilization of ambulatory surgical centers (ASC) for dental procedures, including but not limited to how to authorize urgent ASC care for enrollees undergoing dental procedures;
 - i. Training the Managed Care Plan's medical providers about dental benefits offered by the Dental Plan and how to refer enrollees for dental care; and
 - j. Plan to evaluate the effectiveness of the agreement on an annual basis.
3. Before dental plan agreement execution, the Dental Plan must provide the Agency and the SMMC Health Plans thirty (30) days to review and approve the agreements.
4. The Dental Plan shall be subject to liquidated damages for each dental plan agreement that is neither reviewed, approved, nor executed by one hundred twenty (120) days after contract initiation with the Agency.
5. The Dental Plan shall provide an annual report to the Agency about its effectiveness in coordinating dental care with the SMMC Health Plans. For each Dental Health Plan agreement, the annual report shall include, at a minimum, the following:
- a. Summary of data shared between the Managed Care Plan and the Dental Plan;
 - b. Trend data on the dental-related potentially preventable events, including PPV, PPA, PPR, and the impact of the agreement on those trends;
 - c. Trend data about enrollees with cleft lip and cleft palate (including age, sex, case characteristics, county of residence, and region of residence), proportion in various stages of repair, the timeliness of various stages of repair, the provider types paid to care for enrollees with cleft lip and cleft palate, and the facilities providing repair for enrollees with cleft lip and cleft palate;
 - d. Trend data about the use of ambulatory surgical centers for dental procedures, including the number of centers, the geographic distribution of the centers, procedures performed in the centers, and provider types, such as anesthetist, dentist, or surgeon;
 - e. Trend data on dental quality performance measures and the impact of the agreements on the trend;

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- f. Descriptions of revisions to coordinated efforts to improve dental quality performance measures that are below 50th percentile; and
 - g. Summary data on Managed Care Plan provider trainings about dental benefits.
6. If the Dental Plan fails to comply with the requirements of this Sub-Section, the Dental Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

C. Entire Agreement

This Contract, including all Attachments, represents the entire agreement between the Dental Plan and the Agency and supersedes all other contracts between the parties when it is executed by duly authorized signatures of the Dental Plan and the Agency. Correspondence and memoranda of understanding do not constitute part of this Contract. In the event of a conflict of language between this Contract and the Attachments (which includes the ITN), the provisions of this Contract shall govern, unless otherwise noted. The Agency reserves the right to clarify any contractual relationship in writing and such clarification shall govern. Pending final determination of any dispute over any Agency decision, the Dental Plan shall proceed diligently with the performance of its duties as specified under this Contract and in accordance with the direction of the Agency's Division of Medicaid. The Parties, notwithstanding any other term of this Contract, do not intend to create through this Contract, and hereby disclaim and reject, any rights enforceable by third-parties or non-parties to this Contract, through a third-party beneficiary cause of action or under any other contractual claim in equity or in law.

D. Ownership and Management Disclosure

- 1. The Dental Plan shall fully disclose any business relationships, ownership, management, and control of disclosing entities in accordance with State and federal law.
A Dental Plan providing Statewide Medicaid Prepaid Dental Program services shall not contract with the Agency to operate as a Dental Plan that has a business relationship with another Dental Plan providing Dental Plan services and operating in the State. (s. 409.966(3)(b), F.S.)
- 2. The Dental Plan shall be located in the United States (42 CFR 438.602(i)).
- 3. Liquidated Damages for Services Indirectly/Directly Covered by the Contract that are Provided External to the U.S.

The Dental Plan shall ensure all services, provided directly or indirectly under the Contract, shall be performed within the borders of the United States and its territories and protectorates. This includes but is not limited to dental laboratory services. Non-compliance with this section may be subject to liquidated damages and sanctions, as determined by the Agency.

- 4. If the Dental Plan fails to disclose a business relationship or is considering a business relationship with a Dental Plan that has a Contract with the Agency under the Statewide Medicaid Prepaid Dental Program, the Dental Plan shall immediately disclose such

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business relationship to the Agency pursuant to s. 409.966(3)(b), F.S., within five (5) days after discovery. The disclosure shall include but not be limited to the identifying information for each Dental Plan, the nature of the business relationship, and the signature of the authorized representative for each Dental Plan.

5. The Dental Plan shall submit the following for the areas of ownership and control interest information in compliance with 42 CFR 438.230, 42 CFR 438.604(a)(6), 42 CFR 438.308(c)(d), and 42 CFR 455.104(b)(2)-(4):

- a. The name and address of any person (individual or corporation) with an ownership or control interest in the Dental Plan and its subcontractors. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;
- b. The date of birth and SSN of any individual with an ownership or control interest in the Dental Plan and its subcontractors;
- c. Other tax identification number of any corporation with an ownership or control interest in the Dental Plan and any subcontractors in which the Dental Plan has a five (5) percent or more interest;
- d. Information on whether an individual or corporation with ownership or control interest in the Dental Plan as a spouse, parent, child, or sibling;
- e. Information on whether a person or corporation with an ownership or control interest in any subcontractor in which the Dental Plan has a five (5) percent or more interest is related to another person with ownership or control interest in the Dental Plan as a spouse, parent, child, or sibling;
- f. The name of any other disclosing entity in which an owner of the Dental Plan has an ownership or control interest; and
- g. The name, address, date of birth, and SSN or any managing employee of the Dental Plan.

(42 CFR 438.604(a)(6); 42 CFR 455.104(b)(1)(i)-(iii); 42 CFR 455.104(b)(2)-(4); 42 CFR 438.230; 42 CFR 438.608(c)(2))

6. Disclosure shall be made on forms prescribed by the Agency for business transactions (42 CFR 455.105); conviction of crimes (42 CFR 455.106); public entity crimes (s. 287.133(2)(a), F.S.); and disbarment and suspension (Executive Order No. 12549; 52 Fed. Reg., pages 20360-20369, and s. 4707 of the Balanced Budget Act of 1997). The forms are available through the Agency and are to be submitted to the Agency by September 1 of each Contract year. In addition, the Dental Plan shall submit to the Agency for review, full disclosure of ownership and control of the Dental Plan and any subcontractors as required in 42 CFR 438.608(c), and any changes in management within five (5) days of knowing the change shall occur and at least sixty (60) days before any change in the Dental Plan's ownership or control takes effect. (s. 1128(b)(8) of the Act. [42 CFR 438.808(a); 42 CFR 438.808(b)(1); 42 CFR 431.55(h); s. 1903(i)(2) of the Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09)

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7. The following definitions apply to ownership disclosure:
- a. A person with an ownership interest or control interest means a person or corporation that:
 - (1) Owns, indirectly or directly, five percent (5%) or more of the Dental Plan's capital or stock, or receives five percent (5%) or more of its profits;
 - (2) Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the Dental Plan or by its property or assets and that interest is equal to or exceeds five percent of the total property or assets;
 - (3) Is an officer or director of the Dental Plan, if organized as a corporation, or is a partner in the Dental Plan, if organized as a partnership; or
 - b. The percentage of direct ownership or control is calculated by multiplying the percentage of interest that a person owns by the percent of the Dental Plan's assets used to secure the obligation. Thus, if a person owns ten percent (10%) of a note secured by sixty percent (60%) of the Dental Plan's assets, the person owns six percent (6%) of the Dental Plan.
 - c. The percentage of indirect ownership or control is calculated by multiplying the percentage of ownership in each organization. Thus, if a person owns ten percent (10%) of the stock in a corporation, which owns eighty percent (80%) of the Dental Plan's stock, the person owns eight percent (8%) of the Dental Plan.
8. The following definitions apply to management disclosure:
- a. Changes in management are defined as any change in the management control of the Dental Plan. Examples of such changes are those listed below and in **Section IX.**, Administration and Management, or equivalent positions by another title;
 - b. Changes in the board of directors or officers of the Dental Plan, medical director, CEO, administrator, and CFO; and
 - (1) Changes in the management of the Dental Plan where the Dental Plan has decided to contract out the operation of the Dental Plan to a management corporation. The Dental Plan shall disclose such changes in management control and provide a copy of the contract to the Agency for approval at least sixty (60) days prior to the management contract start date.
9. The Dental Plan shall conduct criminal history record check on all principals of the Dental Plan, and all persons with five percent (5%) or more ownership interest in the Dental Plan, or who have executive management responsibility for the Dental Plan or have the ability to exercise effective control of the Dental Plan. (s. 435.04, F.S.)
- a. Principals of the Dental Plan shall be as defined in s. 409.907, F.S.
 - b. The Dental Plan shall initiate the criminal history check on newly hired principals (officers, directors, agents, and managing employees) within thirty (30) days of the hire date, if the individual's fingerprints are not already retained in the Care Provider Background Screening Clearinghouse (Clearinghouse, see s. 435.12, F.S.).

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- c. The Dental Plan shall conduct this verification as follows:
- (1) By requesting screening results through the Agency's background screening system. (See the Agency's background screening website.) If the person's fingerprints are not retained in the Clearinghouse and/or eligibility results are not found, the Dental Plan shall submit complete sets of the person's fingerprints electronically for Medicaid Level II screening following the process described on the Agency's Care Provider Background Screening Clearinghouse website.
 - (2) The Dental Plan shall complete and email a Background Screening (BGS) Managed Care User Registration Agreement to the Agency at BGSCREEN@ahca.myflorida.com.
 - (3) In accordance with s. 435.12(2)(c), F.S., the Dental Plan shall register with the Clearinghouse and maintain the employment status of all employees within the Clearinghouse. The Dental Plan shall report initial employment status and changes to the Clearinghouse within ten (10) business days after the initial employment or change.
 - (4) The Dental Plan shall comply with the employment screening regulations described in Chapter 435, F.S.
 - (5) By the five (5)-year expiration date of retained fingerprints for a Dental Plan principal, the Dental Plan shall initiate and complete a new background screening via the Agency's Care Provider Background Screening Clearinghouse website for that individual.
- 10.** The Dental Plan shall submit to the Agency, within five (5) business days, any information on any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the Dental Plan who has been found guilty of, regardless of adjudication, or who entered a plea of *nolo contendere* or guilty to, any of the offenses listed in s. 435.04, F.S. The Dental Plan shall submit information to the Agency for such persons who have a record of illegal conduct according to the background check. The Dental Plan shall keep a record of all background checks to be available for Agency review upon request.
- 11.** The Dental Plan that has an officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the Dental Plan, who has committed any of the above listed offenses shall not contract with the Agency. (42 CFR 455.434 and s. 435.04, F.S.) In order to avoid termination, pursuant to a timeline as determined by the Agency, the Dental Plan shall submit a CAP, acceptable to the Agency, which ensures that such person is divested of all interest and/or control and has no role in the operation and/or management of the Dental Plan.
- 12.** The Dental Plan shall submit to the Agency reports regarding current administrative subcontractors and affiliates as specified in **Section XV.**, Accountability, and the *Managed Care Plan Report Guide*.

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E. Conflict of Interest

This Contract is subject to the provisions of Chapter 112, F.S. Within ten (10) business days of discovery, the Dental Plan shall disclose to the Agency the name of any officer, director or agent who is an employee of the State of Florida, or any of its agencies. Further, within this same timeframe, the Dental Plan shall disclose the name of any State employee who owns, directly or indirectly, an interest of five percent (5%) or more in the Dental Plan or any of its affiliates. The Dental Plan shall disclose the name of any Agency or DOEA employee who owns, directly or indirectly, an interest of one percent (1%) or more in the Dental Plan or any of its affiliates. The Dental Plan covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of the services hereunder. The Dental Plan further covenants that in the performance of this Contract, no person having any such known interest shall be employed. No official or employee of the Agency and no other public official of the State of Florida or the federal government who exercises any functions or responsibilities in the review or approval of the undertaking of carrying out this Contract shall, prior to completion of this Contract, voluntarily acquire any personal interest, direct or indirect, in this Contract or proposed Contract.

F. Readiness

Prior to enrolling recipients in the Dental Plan, the Agency shall conduct a plan-specific readiness review to assess the Dental Plan's readiness and ability to provide services to recipients. The plan readiness review shall include, but is not limited to, desk and onsite review of plan procedures and corresponding documents, the Dental Plan's provider network and corresponding Contracts, a walk-through of the Dental Plan's processes, system demonstrations, and interviews with Plan staff. The scope of the plan readiness review shall include any and all Contract requirements, as determined by the Agency.

G. Withdrawing Services

1. If the Dental Plan intends to withdraw services, the Dental Plan shall provide the Agency with one hundred eighty (180) days' notice. Once the Agency receives the request for withdrawal, the Dental Plan shall not receive new voluntary enrollments, mandatory assignments, and reinstatements going forward.
2. The Dental Plan shall work with the Agency to develop a transition plan for enrollees, particularly those under care coordination/case management and those with complex medical needs. The Dental Plan withdrawing from the Contract shall perform as follows:
 - a. Notice its enrollees, providers and subcontractors of the change at least sixty (60) days before the last day of service; and
 - b. Provide the Agency with the data, including encounter data, needed by the Agency to maintain existing case relationships.
3. The notice to enrollees shall contain the same information as required for a notice of termination according to **Section XIV.**, Special Terms and Conditions, **Sub-Section H.**, Termination Procedures.
4. If the Dental Plan withdraws from the Contract before the end of the term of this Contract,

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the Dental Plan shall pay the costs and penalties specified in s. 409.967(2)(i)1, F.S., and **Section XII.**, Sanctions and Corrective Action Plans, and this Contract shall be terminated in accordance with the termination procedures in s. 409.967(2)(i)3, F.S., this **Section** and **Section XII.**, Sanctions and Corrective Action Plans.

5. As specified in s. 409.967(2)(i)1. F.S., if the Dental Plan intends to withdraw services, the Dental Plan shall provide the Agency with one hundred eighty (180) days' notice and work with the Agency to develop a transition plan for enrollees, particularly those under case management and those with complex medical needs, and provide data needed to maintain existing case relationships.
6. As specified in s. 409.967 (2)(i)1., F.S., Dental Plans that limit enrollment levels or leave the Contract before the end of this Contract term must continue to provide services to the enrollee for ninety (90) days or until the enrollee is enrolled in another Dental Plan, whichever occurs first.

H. Termination Procedures

In conjunction with the **Standard Contract, Section III.**, The Vendor and Agency Hereby Mutually Agree, **Item A.**, Termination, all provider agreements and subcontracts shall contain termination procedures. The Dental Plan shall extend the thirty (30)-day termination notice found in the **Standard Contract, Section III., Item A.1.**, Termination at Will, to one hundred eighty (180) days' notice. Depending on the volume of Dental Plan enrollees affected, the Agency shall require an extension of the termination date. Once the Agency receives the request for termination, the Dental Plan shall not receive new voluntary enrollments, mandatory assignments, and reinstatements going forward.

1. The Dental Plan shall work with the Agency to create a transition plan that shall ensure the orderly and reasonable transfer of enrollee care and progress whether or not the enrollees are under care coordination/case management and/or have complex medical needs. The Dental Plan shall perform as follows:
 - a. Notice its enrollees, providers, and subcontractors of the change in accordance with this Contract; and
 - b. Provide to the Agency the data needed by the Agency to maintain existing case/care relationships.
2. The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery, or by facsimile letter followed by certified mail, return receipt requested. The notice of termination shall specify the nature of termination, the extent to which performance of work under this Contract is terminated, and the date on which such termination shall become effective. In accordance with s. 1932(4), Social Security Act, the Dental Plan shall be provided with an opportunity for a hearing prior to termination for cause. This does not preclude the Agency from terminating the Dental Plan without cause.
3. Upon receipt of final notice of termination, on the date and to the extent specified in the notice of termination, the Dental Plan shall:
 - a. Continue work under this Contract until the termination date unless otherwise required by the Agency;

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- b. Cease enrollment of new enrollees under this Contract;
 - c. Terminate all marketing activities and subcontracts relating to marketing;
 - d. Assign to the State those subcontracts as directed by the Agency's contracting officer including all the rights, title, and interest of the Dental Plan for performance of those subcontracts;
 - e. Take such action as shall be necessary, or as the Agency's contracting officer shall direct, for the protection of property related to this Contract that is in the possession of the Dental Plan and in which the Agency has been granted or shall acquire an interest;
 - f. Not accept any payment after this Contract ends, unless the payment is for the time period covered under this Contract. Any payments due under the terms of this Contract shall be withheld until the Agency receives from the Dental Plan all written and properly executed documents as required by the written instructions of the Agency; and
 - g. At least sixty (60) days before the termination effective date, provide written notification to all enrollees of the following information: the date on which the Dental Plan shall no longer participate in the State's Medicaid program and instructions on contacting the Agency's enrollment broker help line to obtain information on enrollment options and to request a change in Dental Plans.
- 4. If the Dental Plan fails to disclose any business relationship, as defined in s. 409.966(3)(b), F.S., with another Dental Plan in the State during the procurement process, the Dental Plan's Contract shall be terminated.
 - 5. In the event the Agency terminates the Dental Plan's participation due to non-compliance with Contract requirements, the Dental Plan's entire Contract shall be terminated in accordance with s. 409.967(2)(i)3., F.S.
 - 6. If the Dental Plan fails to meet plan readiness criteria by the Agency's specified monthly enrollment calculation date prior to becoming operational in Statewide Medicaid Prepaid Dental Program, the Dental Plan shall be terminated from participation. In addition, the following requirements apply to the Dental Plan's entire Contract shall be terminated with thirty (30) days' notice, as specified in the **Standard Contract, Section III.**, The Vendor and Agency Hereby Mutually Agree, **Item A., Sub-Item 1.**, Termination at Will.
 - 7. If the Dental Plan Contract is terminated by either the Dental Plan or the Agency (with cause) prior to the end of this Contract period, the Dental Plan shall be assessed the performance bond required under this Contract to cover the costs of issuing a solicitation and selecting a new Dental Plan. The Agency's damages in the event of termination shall be considered the full amount of the bond. The Agency need not prove the damage amount in exercising its right of recourse against the bond.

I. Agency Contract Management

- 1. The Agency shall be responsible for management of this Contract. Contract management shall be conducted in good faith, with the best interest of the State and the Medicaid recipients it serves being the prime consideration. The Agency shall make all statewide

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policy decisions via issuance of a Policy Transmittal or Contract Interpretation, which shall be included in the next amendment.

2. The Dental Plan shall submit all procedures to the Agency as required by this Contract. Unless specified elsewhere in this Contract, procedures required by this Contract shall be submitted to the Agency at least seventy-five (75) days before the proposed effective date of the policy and procedure or change. Other procedures related to this Contract shall be submitted to the Agency upon request. If the Agency has requested procedures, the Dental Plan shall notify the Agency of any subsequent changes in such materials.
3. The Dental Plan shall seek an interpretation from the Agency of any Contract requirement or Medicaid policy. When an interpretation of this Contract is sought, the Dental Plan shall submit a written request to the Agency's Secretary or designee in a format prescribed by the Agency.
4. The terms of this Contract do not limit or waive the ability, authority or obligation of the OIG, MPI, its contractors, DOEA, or other duly constituted government units (State or federal) to audit or investigate matters related to, or arising out of this Contract.
 - a. This Contract shall be amended only as follows (unless specified elsewhere in this Contract):
 - b. The parties cannot amend or alter the terms of this Contract without a written amendment and/or change order to this Contract.
 - c. The Agency and the Dental Plan understand that any such written amendment to amend or alter the terms of this Contract shall be executed by an officer of each party, who is duly authorized to bind the Agency and the Dental Plan.
 - d. The Agency reserves the right to amend this Contract within the scope set forth in the procurement (to include original Contract and all Attachments) in order to clarify requirements or if it is determined by the Agency that modifications are necessary to better serve or provide covered services to the eligible population.

J. Disputes

1. To dispute an interpretation of this Contract, the Dental Plan shall request that the Agency's Secretary or designee hear and decide the dispute. The Dental Plan shall submit a written dispute of this Contract interpretation directly to the Secretary; by U.S. mail and/or commercial courier service (hand delivery shall not be accepted); this submission must be received by the Agency within twenty-one (21) days after the interpretation of this Contract and shall include all arguments, materials, data, and information necessary to resolve the dispute (to include all evidence, documentation, and exhibits). A Dental Plan submitting such written requests for appeal or dispute as allowed under this Contract by U.S. mail and/or commercial courier service, shall submit such appeal or dispute to the following mailing address:

Agency for Health Care Administration
Attn: Managed Care Appeals/Disputes, MS 70
2727 Mahan Drive
Tallahassee, FL 32308

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Regardless of whether delivered by U.S. mail or commercial courier service, appeals or disputes not delivered to the above address shall be denied.

The Dental Plan waives any dispute not raised within twenty-one (21) days of receiving a notice of this Contract interpretation. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving a Contract interpretation, and waives the right to use any materials, data, and/or information not contained in or accompanying the Dental Plan's submission submitted within the twenty-one (21) days following its receipt of the notice of this Contract interpretation in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).

2. The Secretary or his/her designee shall decide the dispute under the reasonableness standard, reduce the decision to writing and serve a copy to the Dental Plan. This written decision shall be final.

The exclusive venue of any legal or equitable action that arises out of or relating to this Contract, including an appeal of the final decision of the Secretary or his/her designee, shall be Circuit Court in Leon County, Florida; in any such action, the Dental Plan shall waive its rights to a jury trial, and that the Circuit Court can only review the final decision for reasonableness, and Florida law shall apply. In the event the Agency issues any action under Florida Statutes or Florida Administrative Code apart from this Contract, the Dental Plan shall receive notice of the appropriate administrative remedy.

K. Indemnification

1. The Dental Plan shall indemnify, defend, and hold harmless the Agency, as provided in this Clause.
2. Scope. The Duty to Indemnify and the Duty to Defend, as described herein (collectively known as the "Duty to Indemnify and Defend"), extend to any completed, actual, pending, or threatened action, suit, claim, or proceeding, whether civil, criminal, administrative, or investigative (including any action by or in the right of the Dental Plan), and whether formal or informal, in which the Agency is, was, or becomes involved and which in any way arises from, relates to, or concerns the Dental Plan's acts or omissions related to this Contract (inclusive of all Attachments, etc.) (collectively "Proceeding").
 - a. Duty to Indemnify. The Dental Plan shall hold harmless and indemnify the Agency to the full extent permitted by law against any and all liability, claims, actions, suits, judgments, damages, and costs of whatsoever name and description, including attorneys' fees, arising from or relating to any Proceeding.
 - b. Duty to Defend. With respect to any Proceeding, the Dental Plan shall fully defend the Agency and shall timely reimburse all of the Agency's legal fees and costs; provided, however, that the amount of such payment for attorneys' fees and costs is reasonable pursuant to Rule 4-1.5, Rules Regulating the Florida Bar. The Agency retains the exclusive right to select, retain, and direct its defense through defense counsel funded by the Dental Plan pursuant to the Duty to Indemnify and Defend the Agency.
3. Expense Advance. The presumptive right to indemnification of damages shall include the right to have the Dental Plan pay the Agency's expenses in any Proceeding as such expenses are incurred and in advance of the final disposition of such Proceeding.

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4. Enforcement Action. In the event that any claim for indemnity, whether an Expense Advance or otherwise, is made hereunder and is not paid in full within sixty (60) days after written notice of such claim is delivered to the Dental Plan, the Agency shall, but need not, at any time thereafter, bring suit against the Dental Plan to recover the unpaid amount of the claim (hereinafter "Enforcement Action"). In the event the Agency brings an Enforcement Action, the Dental Plan shall pay all of the Agency's attorneys' fees and expenses incurred in bringing and pursuing the Enforcement Action.
5. Contribution. In any Proceeding in which the Dental Plan is held to be jointly liable with the Agency for payment of any claim of any kind (whether for damages, attorneys' fees, costs, or otherwise), if the Duty to Indemnify provision is for any reason deemed to be inapplicable, the Dental Plan shall contribute toward satisfaction of the claim whatever portion is or would be payable by the Agency in addition to that portion which is or would be payable by the Dental Plan, including payment of damages, attorneys' fees, and costs, without recourse against the Agency. No provision of this part, or of any other section of this Contract (inclusive of all Attachments, etc.), whether read separately or in conjunction with any other provision, shall be construed to: (i) waive the State or the Agency's immunity to suit or limitations on liability; (ii) obligate the State or the Agency to indemnify the Dental Plan for the Dental Plan's own negligence, or otherwise assume any liability for the Dental Plan's own negligence; or (iii) create any rights enforceable by third parties, as third party beneficiaries or otherwise, in law or in equity.

L. Public Records Requests

In accordance with s. 119.0701, F.S., and notwithstanding the **Standard Contract, Section I., THE VENDOR HEREBY AGREES, Sub-Section I.,** Public Records Requests, in addition to other Contract requirements provided by law, the Dental Plan shall comply with public records laws, as follows:

1. The Dental Plan shall keep and maintain public records that ordinarily and necessarily would be required in order to perform services under this Contract;
2. The Dental Plan shall provide the public with access to public records on the same terms and conditions that the Agency would provide the records and at a cost that does not exceed the cost provided in s. 119.0701, F.S., or as otherwise provided by law;
3. The Dental Plan agrees that it is the custodian of any and all recordings for purposes of the Public Records Act, Chapter 119, F.S., and is solely responsible for responding to any public records requests for recordings. This responsibility includes gathering, redacting, duplication, and provision of the recordings, as well as defense of any actions for enforcement brought pursuant to s. 119.11, F.S.;
4. The Dental Plan shall ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law;
5. The Dental Plan shall meet all requirements for retaining public records and transfer, at no cost, to the Agency all public records in possession of the Dental Plan upon termination of this Contract and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. All records stored electronically must be provided to the Agency in a format that is compatible with the IT systems of the Agency; and

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6. If the Dental Plan does not comply with a public records request, the Dental Plan shall be subject to enforcement of these Contract provisions in accordance with this Contract.

M. Communications

1. Notwithstanding any term or condition of this Contract to the contrary, the Dental Plan bears sole responsibility for ensuring that its performance of this Contract (and that of its subcontractors related to this Contract) fully complies with all State and federal law governing the monitoring, interception, recording, use or disclosure of wire, oral or electronic communications, including but not limited to the Florida Security of Communications Act, Sections 934.01, et seq., F.S., and the Electronic Communications Privacy Act, 18 U.S.C. 2510 et seq. (hereafter, collectively, “Communication Privacy Laws”).
2. Prior to intercepting, recording, or monitoring any communications which are subject to Communication Privacy Laws, the Dental Plan shall:
 - a. Submit a plan which specifies in detail the manner in which the Dental Plan (and its subcontractors related to this Contract) shall ensure that such actions are in full compliance with Communication Privacy Laws (the “Privacy Compliance Plan”).
 - b. Obtain written approval, signed, and stamped by the Agency Contract Manager, of the Privacy Compliance Plan.
3. No modifications to an approved Privacy Compliance Plan shall be implemented by the Dental Plan unless an amended Privacy Compliance Plan is submitted to the Agency, and written approval of the amended Plan is signed and stamped by the Agency Contract Manager. Agency approval of the Dental Plan’s Privacy Compliance Plan in no way constitutes a representation by the Agency that the Privacy Compliance Plan is in full compliance with applicable Communication Privacy Laws, or otherwise shifts or diminishes the Dental Plan’s sole burden to ensure full compliance with applicable Communication Privacy Laws in all aspects of the Dental Plan’s performance of this Contract. Violation of this term shall result in sanctions to include termination of this Contract and/or liquidated damages.

N. Audits and Monitoring

1. The Agency shall conduct, or have conducted, performance and/or compliance reviews, reviews of specific records or other data as determined by the Agency. The Agency shall conduct a review of a sample of analyses performed by the Dental Plan to verify the quality of the Dental Plan’s analyses. Reasonable notice shall be provided for reviews conducted at the Dental Plan’s place of business.
2. Reviews shall include, but shall not be limited to, reviews of procedures, computer systems, recipient records, accounting records, and internal quality control reviews. The Dental Plan shall work with any reviewing entity selected by the Agency.
3. During this Contract period, these records shall be available at the Dental Plan’s office at all reasonable times. After this Contract period and for ten (10) full years following, the records shall be available at the Dental Plan’s chosen location subject to the approval of the Agency. If the records need to be sent to the Agency, the Dental Plan shall bear the expense of delivery. Prior approval of the disposition of the Dental Plan and subcontractor

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records must be requested and approved by the Agency. This obligation survives termination of this Contract.

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

O. Inspection of Records and Work Performed

1. The Agency and its authorized representatives shall have the right to enter the Dental Plan's premises, or other places where duties under this Contract are performed, at all reasonable times. All inspections and evaluations shall be performed in such a manner as not to unduly delay work.
2. The Dental Plan shall retain all financial records, Dental Plan enrollee records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to performance under this Contract for a period of ten (10) full years after termination of this Contract, or if an audit has been initiated and audit findings have not been resolved at the end of ten (10) full years, the records shall be retained until resolution of the audit findings.
3. Refusal by the Dental Plan to allow access to all records, documents, papers, letters, other materials, or on-site activities related to this Contract performance shall constitute a breach of this Contract.
4. The right of the Agency and its authorized representatives to perform inspections shall continue for as long as the Dental Plan is required to maintain records.
5. The Dental Plan shall be responsible for all storage fees associated with all records maintained under this Contract. The Dental Plan is also responsible for the destruction of all records that meet the retention schedule noted above.
6. Failure to retain all records as required shall result in cancellation of this Contract. The Agency shall give the Dental Plan advance notice of cancellation pursuant to this provision and shall pay the Dental Plan only those amounts that are earned prior to the date of cancellation in accordance with the terms and conditions of this Contract. Performance by the Agency of any of its obligations under this Contract shall be subject to the Dental Plan's compliance with this provision.
7. In accordance with Section 20.055, F.S., the Dental Plan and its subcontractors shall cooperate with the OIG in any investigation, audit, inspection, review, or hearing; and shall grant access to any records, data, or other information the OIG deems necessary to carry out its official duties.

P. Employment

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

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Q. Work Authorization Program

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

R. Equal Employment Opportunity (EEO) Compliance

The Dental Plan awarded a Contract shall not discriminate in its employment practices with respect to race, color, religion, age, sex, marital status, political affiliation, national origin, or handicap.

S. Discrimination

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

T. Patents, Royalties, Copyrights, Right to Data, and Sponsorship Statement

1. The Dental Plan, without exception, shall indemnify and hold harmless the Agency and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or unattended invention, process, or article manufactured or supplied by the Dental Plan. The Dental Plan has no liability when such claim is solely and exclusively due to the combination, operation or use of any article supplied hereunder with equipment or data not supplied by the Dental Plan or is based solely and exclusively upon the Agency's alteration of the article.
2. The Agency shall provide prompt written notification of a claim of copyright or patent infringement and shall afford the Dental Plan full opportunity to defend the action and control the defense. Further, if such a claim is made or is pending, the Dental Plan shall, at its option and expense procure for the Agency the right to continue the use of, replace, or modify the article to render it non-infringing (if none of the alternatives is reasonably available, the Agency shall return the article on request to the Dental Plan and receive reimbursement, if any, as shall be determined by a court of competent jurisdiction).
3. If the Dental Plan brings to the performance of this Contract a pre-existing patent, patent

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pending, and/or copyright, the Dental Plan shall retain all rights and entitlements to that pre-existing patent, patent pending and/or copyright, unless this Contract provides otherwise.

4. If the Dental Plan uses any design, device, or materials covered by letter, patent, or copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or cost arising from the use of such design, device, or materials in any way involved in the work. Prior to the initiation of services under this Contract, the Dental Plan shall disclose, in writing, all intellectual properties relevant to the performance of this Contract which the Dental Plan knows, or should know, could give rise to a patent or copyright. The Dental Plan shall retain all rights and entitlements to any pre-existing intellectual property that is so disclosed. Failure to disclose shall indicate that no such property exists. The Agency shall then have the right to all patents and copyrights that arise as a result of performance under this Contract as provided in this **Sub-Section**.
5. If any discovery or invention arises or is developed in the course of, or as a result of, work or services performed under this Contract, or in any way connected herewith, the Dental Plan shall refer the discovery or invention to the Agency for a determination whether patent protection shall be sought in the name of the State of Florida. Any and all patent rights accruing under or in connection with the performance of this Contract are hereby reserved to the State of Florida. All materials to which the Agency is to have patent rights or copyrights shall be marked and dated by the Dental Plan in such a manner as to preserve and protect the legal rights of the Agency.
6. Where activities supported by this Contract produce original writing, sound recordings, pictorial reproductions, drawings or other graphic representation, and works of any similar nature, the Agency has the right to use, duplicate, and disclose such materials in whole or in part, in any manner, for any purpose whatsoever and to have others acting on behalf of the Agency to do so. If the materials so developed are subject to copyright, trademark, or patent, legal title and every right, interest, claim, or demand of any kind in and to any patent, trademark or copyright, or application for the same, shall vest in the State of Florida, Department of State for the exclusive use and benefit of the State. Pursuant to s. 286.021, F.S., no person, firm, corporation, including parties to this Contract shall be entitled to use the copyright, patent, or trademark without the prior written consent of the Florida Department of State.
7. The Agency shall have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Dental Plan under any Contract.
8. Pursuant to s. 286.25, F.S., all non-governmental vendors must assure that all notices, information pamphlets, press releases, advertisements, descriptions of the sponsorship of the program, research reports, and similar public notices prepared and released by the Dental Plan shall include the statement: "Sponsored by (name of Dental Plan) and the State of Florida, Agency for Health Care Administration." If the sponsorship reference is in written material, the words, "State of Florida, Agency for Health Care Administration" shall appear in the same size letters or type as the name of the organization.
9. All rights and title to works for hire under this Contract, whether patentable or copyrightable or not, shall belong to the Agency and shall be subject to the terms and conditions of this Contract.

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10. The computer programs, data, materials, and other information furnished by the Agency to the Dental Plan hereunder shall be and remain the sole and exclusive property of the Agency, free from any claim or right of retention by or on behalf of the Dental Plan. The services and products listed in this Contract shall become the property of the Agency upon the Dental Plan's performance and delivery thereof. The Dental Plan hereby acknowledges that said computer programs, materials and other information provided by the Agency to the Dental Plan hereunder, together with the products delivered and services performed by the Dental Plan hereunder, shall be and remain confidential and proprietary in nature to the extent provided by Chapter 119, F.S., and that the Dental Plan shall not disclose, publish, or use same for any purpose other than the purposes provided in this Contract; however, upon the Dental Plan first demonstrating to the Agency's satisfaction that such information, in part or in whole, (1) was already known to the Dental Plan prior to its receipt from the Agency; (2) became known to the Dental Plan from a source other than the Agency; or (3) has been disclosed by the Agency to third parties without restriction, the Dental Plan shall be free to use and disclose same without restriction. Upon completion of the Dental Plan's performance or otherwise cancellation or termination of this Contract, the Dental Plan shall surrender and deliver to the Agency, freely and voluntarily, all of the above-described information remaining in the Dental Plan's possession.
11. The Dental Plan warrants that all materials produced hereunder shall be of original development by the Dental Plan and shall be specifically developed for the fulfillment of this Contract and shall not knowingly infringe upon or violate any patent, copyright, trade secret, or other property right of any third party, and the Dental Plan shall indemnify and hold the Agency harmless from and against any loss, cost, liability, or expense arising out of any breach or claimed breach of this warranty.
12. The terms and conditions specified in this **Sub-Section** shall also apply to any subcontract made under this Contract. The Dental Plan shall be responsible for informing the subcontractor of the provisions of this **Sub-Section** and obtaining disclosures.

U. Confidentiality of Information

1. The Dental Plan shall not use or disclose any information, that is confidential by State or federal law, including but not limited to Social Security numbers that shall be supplied under this Contract pursuant to law, and also including the identity or identifying information concerning a Dental Plan enrollee or services under this Contract for any purpose not in conformity with State and federal laws, except upon written consent of the enrollee or the enrollee's guardian.
2. Confidential information, including Medicaid information, shall be used only as authorized for purposes directly related to the administration of this Contract. The Dental Plan shall have a process that specifies that patient-specific information remains confidential, is used solely for the purposes of data analysis or other Dental Plan responsibilities under this Contract and is exchanged in a manner compliant with HIPAA/HITECH and only for the purpose of conducting a review or other duties outlined in this Contract.
3. Any patient-specific information and/or data constituting protected health care information received by the Dental Plan shall be shared only with those agencies that have legal authority to receive such information and cannot be otherwise transmitted for any purpose other than those for which the Dental Plan is retained by the Agency. The Dental Plan shall have in place written confidentiality procedures to ensure confidentiality and to

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comply with all federal and State laws (including the HIPAA and HITECH Acts) governing confidentiality, including electronic treatment records, facsimile mail, and electronic mail).

4. The Dental Plan's subcontracts must explicitly State expectations about the confidentiality of information, and the subcontractor is held to the same confidentiality requirements as the Dental Plan. If provider-specific data are released to the public, the Dental Plan shall have procedures for exercising due care in compiling and releasing such data that address statutory protections of quality assurance and confidentiality while assuring that open records requirements of Chapter 119, F.S., are met.
5. Any releases of information to the media, the public, or other entities require prior approval from the Agency.
6. The Dental Plan must submit to the Agency Contract Manager:
 - a. Notice, in a manner and format prescribed by the Agency, of the discovery of any new use or disclosure of PHI that is not in compliance with the Contract or state or federal law (See **Standard Contract, Attachment III**, Business Associate Agreement, **Item 11., Sub-Item a.**); and
 - b. Copies of all United States Department of Health and Human Services (HHS) breach notifications per 45 CFR 164.408(c), including breaches involving five hundred (500) or more individuals, no later than sixty (60) days after the end of each calendar year, concurrently with an attestation in accordance with 42 CFR 438.606(c). (See **Standard Contract, Attachment III**, Business Associate Agreement, **Item 11., Sub-Item d.**)

V. Legal Action Notification

The Dental Plan shall give the Agency, by certified mail, immediate written notification (no later than thirty (30) calendar days after service of process) of any action or suit filed or of any claim made against the Dental Plan by any subcontractor, vendor, or other party that results in litigation related to this Contract for disputes or damages exceeding the amount of fifty thousand dollars (**\$50,000**).

W. Venue

1. In the event of any legal challenges to this Contract, the Dental Plan shall agree and shall consent that hearings and depositions for any administrative or other litigation related to this procurement shall be held in Leon County, Florida. The Agency, in its sole discretion, shall waive this venue for depositions.
2. The Dental Plan (and their successors, including but not limited to their parent(s), affiliates, subsidiaries, subcontractors, assigns, heirs, administrators, representatives, and trustees) acknowledges that this Contract and its Attachments or amendments are not rules nor subject to rulemaking under Chapter 120 (or its successor) of the Florida Statutes and are not subject to challenge as a rule or non-rule policy under any provision of Chapter 120, F.S.
3. This Contract shall be delivered in the State of Florida and shall be construed in accordance with the laws of Florida. Wherever possible, each provision of this Contract shall be interpreted in such a manner as to be effective and valid under applicable law,

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but if any provision shall be found ineffective, then to the extent of such prohibition or invalidity, that provision shall be severed without invalidating the remainder of such provision or the remaining provisions of this Contract.

4. The exclusive venue and jurisdiction for any action in law or in equity to adjudicate rights or obligations arising pursuant to or out of this Contract for which there is no administrative remedy shall be the Second Judicial Circuit Court in and for Leon County, Florida, or, on appeal, the First District Court of Appeal (and, if applicable, the Florida Supreme Court). Any administrative hearings hereon or in connection herewith shall be held in Leon County, Florida.

X. Performance Bond

1. A performance bond in the amount of one million dollars (**\$1,000,000**) shall be furnished to the Agency for each contract awarded to a Dental Plan. The bond shall be furnished to the Procurement Officer identified in **Attachment A, Section A., Overview, Item 5.,** Procurement Officer, within thirty (30) calendar days after execution of the Contract and prior to commencement of any work under this Contract.
2. The bond must be furnished to the Issuing Officer identified in **Attachment A, Section A., Overview, Item 5.,** Procurement Officer, within thirty (30) calendar days after execution of the Contract and prior to commencement of any work under this Contract. Thereafter, the bond shall be furnished on an annual basis, thirty (30) calendar days prior to the new Contract year for the same amount as required for the initial performance bond. A copy of all performance bonds shall be submitted to the Agency's Contract Manager. The performance bond must not contain any provisions that shorten the time for bringing an action to a time less than that provided by the applicable Florida Statute of Limitations. See Section 95.03, F.S. No payments shall be made to the Dental Plan until an acceptable performance bond is furnished to the Agency.
3. The Dental Plan shall maintain an effective performance bond for the full term of this Contract, including any renewal period. The Dental Plan shall name the Agency as the beneficiary of the Dental Plan's bond. The bond shall provide that the insurer or bonding company(s) pay losses suffered by the Agency directly to the Agency.
4. The Dental Plan shall bear the cost of the performance bond.
5. Should the Dental Plan terminate this Contract prior to the end of the Contract period, an assessment against the bond shall be made by the Agency to cover the costs of issuing a new solicitation and selecting a new Dental Plan. The Dental Plan agrees that the Agency's damages in the event of termination by the Dental Plan shall be considered to be for the full amount of the bond. The Agency need not prove the damage amount in exercising its right of recourse against the bond.

Y. Fidelity Bond

The Dental Plan shall secure and maintain during the life of this Contract and any Contract extension(s), a blanket fidelity bond from a company doing business in the State of Florida on all personnel in its employment. The bond shall be issued in the amount of at least two hundred fifty thousand dollars (**\$250,000**) per occurrence. Said bond shall protect the Agency from any losses sustained through any fraudulent or dishonest act or acts committed by any employees

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of the Dental Plan and subcontractors, if any. Proof of coverage shall be submitted to the Agency within sixty (60) calendar days after execution of this Contract and prior to the delivery of health care. To be acceptable to the Agency for fidelity bonds, a surety company shall comply with the provisions of Chapter 624, F.S.

Z. Insurance

1. To the extent required by law, the Dental Plan shall be self-insured against, or shall secure and maintain during the life of this Contract, Worker's Compensation Insurance for all its employees connected with the work of the Contract and, in case any work is subcontracted, the Dental Plan shall require the subcontractor similarly to provide Worker's Compensation Insurance for all of the latter's employees unless such employees engaged in work under the resulting Contract are covered by the Dental Plan's self- insurance program. Such self-insurance or insurance coverage shall comply with the Florida Worker's Compensation law. In the event hazardous work is being performed by the Dental Plan under the Contract and any class of employees performing the hazardous work is not protected under Worker's Compensation statutes, the Dental Plan shall provide, and cause each subcontractor to provide, adequate insurance satisfactory to the Agency, for the protection of its employees not otherwise protected.
2. The Dental Plan shall secure and maintain Commercial General Liability insurance including bodily injury, property damage, personal and advertising injury, and products and completed operations. This insurance shall provide coverage for all claims that shall arise from the services and/or activities completed under this Contract, whether such services and/or activities are by the Dental Plan or anyone directly, or indirectly employed by it. Such insurance shall include a Hold Harmless Agreement in favor of the State of Florida and also include the State of Florida as an Additional Named Insured for the entire length of the Contract and hold the State of Florida harmless from subrogation. The Dental Plan shall set the limits of liability necessary to provide reasonable financial protections to the Dental Plan and the State of Florida under this Contract.
3. All insurance policies shall be with insurers licensed or eligible to transact business in the State of Florida. The Dental Plan's current insurance policy(ies) shall contain a provision that the insurance shall not be canceled for any reason except after thirty (30) calendar days' written notice. The Dental Plan shall provide thirty (30) calendar days' written notice of cancellation to the Agency's Contract Manager.

The Dental Plan shall submit insurance certificates evidencing such insurance coverage prior to execution of a Contract with the Agency.

AA. MyFloridaMarketPlace Vendor Registration and Transaction Fee

1. MyFloridaMarketPlace Vendor Registration. Each vendor doing business with the State of Florida for the sale of commodities or contractual services as defined in Section 287.012, F.S., shall register in MyFloridaMarketPlace, in compliance with Rule 60A-1.033, F.A.C., unless exempt under Rule 60A-1.033(3), F.A.C.
2. MyFloridaMarketPlace Transaction Fee. This Contract has been exempted by the Florida Department of Management Services from paying the transaction fee per Rule 60A-1.031(4)(a and b), F.A.C.

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BB. Agency Goals

1. The Dental Plan shall submit a written report and present to the Agency on progress towards the commitments contained within **Attachment I**, Scope of Services, of this Contract annually, on a schedule determined by the Agency. The Dental Plan shall notify the Agency prior to discontinuing any of the commitments contained within **Attachment I**, Scope of Services, of this Contract. Discontinuation of or non- performance on a commitment by the Dental Plan may result in monetary or non-monetary contract actions, as determined by the Agency.
2. The Dental Plan shall enter into a coordination of benefits agreement with the Managed Medical Assistance Plan that includes data sharing requirements and coordination protocols to support the provision of dental services and reduction of potentially preventable events. The Dental Plan shall ensure that the agreement complies with and includes the minimum requirements and guidelines established by the Agency.
3. The Dental Plan shall participate in meetings with the Agency and the MMA Plan to foster enhanced communication, strategic planning, and collaboration in coordinating benefits provided through the managed care delivery system and to address any major organizational challenges and/or barriers during the implementation process.
4. If the Dental Plan fails to comply with the requirements of this **Section**, the Dental Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

CC. Transition Enrollment Requirements

Upon implementation of the Contract and for the sole purpose of transitioning recipients into the Dental Plans authorized to provide services under the Statewide Medicaid Dental Plan Contract, the Agency shall enroll recipients into Dental Plans using the following:

1. The Agency shall provide Medicaid recipients with an enrollment packet electronically or in the mail, informing recipients of the available Dental Plan options in their region. The enrollment packet will inform recipients of the Dental Plan that they will be assigned to if they do not select a Dental Plan. Medicaid recipients who meet all of the eligibility criteria for enrollment shall have an opportunity to select the Dental Plan of their choice prior to the regional implementation date.
2. Assignment Criteria for Recipients Who Do Not Select a Dental Plan
 - a. For the purposes of this **Sub-Section**, existing Dental Plan means a Dental Plan that was contracted as a Dental Plan under the SMMC 2018-2024 contracts and was assigned by the Agency within sixty (60) days prior to the regional implementation date to provide dental services to the recipient.
 - b. The Agency shall automatically assign a recipient into a Dental Plan if he or she does not voluntarily choose a Dental Plan. The Agency shall utilize the following criteria when assigning such recipients to a Dental Plan:
 - (1) Whether the recipient's existing Dental Plan will operate as a Dental Plan under

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the Statewide Medicaid Dental Plan Contract. If so, the Agency will assign recipients into their existing Dental Plan;

- (2) Whether the Dental Plan has sufficient network capacity to meet the needs of the recipients;
 - (3) Whether the recipient has a family member enrolled in an existing plan; and
 - (4) A newborn of a mother enrolled in a Dental Plan at the time of the child's birth shall be enrolled in the mother's Dental Plan. Upon birth, such a newborn is deemed enrolled in the Dental Plan, regardless of the administrative enrollment procedures, and the Dental Plan is responsible for providing Medicaid covered dental services to the newborn. The mother may choose another Dental Plan for the newborn within ninety (90) days after the child's birth.
- c. All remaining recipients who do not meet the criteria above and who do not voluntarily select a Dental Plan will be assigned by DCF eligibility case among the Dental Plans serving the region successively (i.e., "round-robin").

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A. General Provisions

1. The Dental Plan shall comply with all reporting and submission requirements set forth in this Contract.
2. The Dental Plan shall be required to provide to the Agency or its agents any other information, documentation, or data relative to this Contract in accordance with 42 CFR 438.604(b). In such instances, and at the direction of the Agency, the Dental Plan shall fully cooperate with such requests and furnish all data or information in a timely manner, in the format in which it is requested. The Dental Plan shall have at least thirty (30) days to fulfill such ad hoc requests unless the Agency directs the Dental Plan to provide data or information in less than thirty (30) days. The Dental Plan shall certify that data and information it submits to the Agency is accurate, truthful, and complete in accordance with 42 CFR 438.606.
3. Deadlines for reports and submissions referred to in this Contract specify the actual time of receipt at the Agency bureau or location, not the date the file was postmarked or transmitted.
4. If a reporting due date falls on a weekend or State holiday, the report or submission shall be due to the Agency on the following business day.
5. All reports filed on a quarterly basis shall be filed on a calendar year quarter (i.e., January – March, April – June, July – September, October – December), unless otherwise specified in this Contract.
6. Unless otherwise specified, all reports and submissions shall be submitted electronically, as prescribed in the reporting guidelines or submissions summary. Materials including PHI shall be submitted to the Agency SFTP sites.
7. The Agency reserves the right to modify the reporting or submission requirements and to provide technical assistance to the Dental Plan for up to ninety (90) days , to allow the Dental Plan to complete implementation, unless otherwise required by law.
8. The Dental Plan shall be provided with written notification of any modifications to reporting or submission requirements.
9. If the Dental Plan fails to submit the required reports or submissions accurately or within the timeframes specified, the Dental Plan shall be subject to fines or otherwise sanctioned in accordance with **Section XII.**, Sanctions and Corrective Action Plans.

B. Dental Plan Reporting Requirements

1. General Provisions

- a. The Dental Plan shall comply with the *Managed Care Plan Report Guide* in submitting required reports, including the report formats, templates, instructions, data specifications, submission timetables and locations, and other materials contained in

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the guide. The *Managed Care Plan Report Guide* shall be posted on the Agency’s website. The Dental Plan shall be furnished with appropriate technical assistance in using the *Managed Care Plan Report Guide*.

- b. Unless otherwise specified, all reports shall be submitted electronically, as prescribed in the reporting guidelines. Materials including PHI shall be submitted to the Agency SFTP sites.

2. Submission Deadlines

- a. Deadlines for report submission referred to in this Contract specify the actual time of receipt at the Agency bureau or location, not the date the file was postmarked or transmitted.
- b. If a reporting due date falls on a weekend or State holiday, the report shall be due to the Agency on the following business day.
- c. All reports filed on a quarterly basis shall be filed on a calendar year quarter.

3. Required Reports

- a. The Dental Plan shall comply with reports required by the Agency as specified in the *Managed Care Plan Report Guide*. All reports shall be submitted to the Agency Contract Manager unless otherwise indicated in the *Managed Care Plan Report Guide*. A summary of the reporting requirements is provided in the Summary of Reporting Requirements Table, **Table 14**, below:

TABLE 14	
SUMMARY OF REPORTING REQUIREMENTS	
Report Name	Frequency
Actual Value of Enhanced Payment (VEP) Dental Provider Incentive Program (DPIP Report)	Semi-Annual
Administrative Subcontractors and Affiliates Report	Quarterly
Adverse Incident Summary Report	Monthly
Annual Fraud, Waste and Abuse Activity Report	Annually
ASR Financial Reports	Annually / Quarterly
Appointment Wait Times Report	Annually
Claims Aging Report and Supplemental Filing Report	Monthly
Denied/Suspended/Terminated Provider Report	Monthly
Denial, Reduction, Suspension, or Termination of Services Report	Monthly
DPIP Provider Metrix Report	Annually
Enrollee Complaints, Grievance, and Plan Appeals Report	Monthly
ER Visits for Enrollees without PDP Appointment Report	Annually
Estimated Value of Enhanced Reimbursement	Annually

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(EVER)/Quality Provider Dental Provider Incentive Program (DPIP) Report	
Healthy Behaviors	Quarterly
Inter-Rater Reliability Report (IRR)	Quarterly
Internal Training Report	Monthly
Marketing Agent Status Report	Quarterly
Marketing/Public/Educational Events Report	Monthly
Member Satisfaction Improvement Report	Quarterly
Oral Health Risk Assessment Report	Quarterly
PDP Appointment Report	Annually
Performance Measure Action Plan	Quarterly
Performance Measure Report	Annually
Plan-Specific Commitments Progress Report	Quarterly
Provider Complaint Report	Monthly
Provider Network File	Weekly
Quarterly Fraud and Abuse Activity Report	Quarterly
Service Authorization Performance Outcome Report	Monthly
Special Populations Care Coordination Report	Quarterly
Suspected/ Confirmed Fraud & Abuse Activity Report	Within fifteen (15) days of detection
Suspected/ Confirmed Recovered Fraud & Abuse Reporting	Within thirty (30) days of detection
Suspected/Confirmed Waste Reporting	Monthly
WellChild Health Check-up Visit (CMS-416) and FL 80% Screening	Annually

4. Modifications to Reporting Requirements

- a. The Agency reserves the right to modify the reporting requirements and to provide technical assistance to the Dental Plan for up to ninety (90) day notice, to allow the Dental Plan to complete implementation, unless otherwise required by law.
- b. The Dental Plan shall be provided with written notification of any modifications to the reporting requirements.

5. Certification of Timely, Complete and Accurate Submission

- a. The Dental Plan shall assure the accuracy, completeness, and timely submission of each report.
- b. The Dental Plan’s CEO, CFO or an individual who is an immediate report to the CEO or CFO and who has delegated authority to certify the Dental Plan’s reports, shall attest, under penalty of perjury based on his/her best knowledge, information, and belief, that all data submitted in conjunction with the reports and all documents requested by the Agency are accurate, truthful, and complete, under penalty of perjury. (42 CFR 438.606(a) and (b); 42 CFR 457.1201(o).)
- c. The Dental Plan shall submit its certification at the same time it submits the certified

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data reports. (42 CFR 438.606(c).) The certification page shall be scanned and submitted electronically.

- d. If the Dental Plan fails to submit the required reports accurately or within the timeframes specified, the Dental Plan shall be subject to fines or otherwise sanctioned in accordance with **Section XII.**, Sanctions and Corrective Action Plans.

C. Dental Plan Submission Requirements

1. General Submission Requirements

The Dental Plan shall comply with the Dental Plan Submissions Summary in submitting required reports, including the report formats, templates, instructions, data specifications, submission timetables and locations, and other materials contained in the guide. The Dental Plan Submissions Summary shall be posted on the Agency’s website. The Dental Plan shall be furnished with appropriate technical assistance in using the Dental Plan Submissions Summary.

2. Required Submissions

The Dental Plan shall comply with reports required by the Agency as specified in the Dental Plan Submissions Summary. All reports shall be submitted to the Agency Contract Manager unless otherwise indicated in the Dental Plan Submissions Summary on the Agency’s website. A summary of the submission requirements is provided in **Table 15**, Summary of Submission Requirements Table, below:

TABLE 15	
SUMMARY OF SUBMISSION REQUIREMENTS	
Submission Name	Due
Annual Audited Financial Statements	September 1
Annual Healthy Behavior Program Evaluation	October 1
Business Continuity-Disaster Recovery (BC-DR) Plan/Certification	May 1
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Vendor's Final Report and Action Plan to Address Results of CAHPS Survey	October 1
Care Coordination/Case Management Program Description	June 1
Compliance and Anti-fraud and Abuse Prevention Plan	September 1
Emergency Management Plan	May 1
Enrollee Record Review Strategy	June 1
Enrollee Satisfaction Survey, Proposal for Survey Administration and Reporting	December 1
Experience Implementing Anti-Fraud Plan & Investigating Possible Fraud or Abuse Report	September 1
Multiple Signature Verification Agreement	April 1
Multiple Signature Verification Agreement for Custody Arrangements	Within thirty (30) days of change

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TABLE 15 SUMMARY OF SUBMISSION REQUIREMENTS	
Submission Name	Due
National Association of Insurance Commissioners Health Statements	March 31
Network Development Plan	September 1
Ownership and Management Disclosure and Any Subcontractors	September 1
Performance Improvement Projects (PIP) – Ongoing	October 1
Provider Complaint Report Analysis	Upon request
Provider Satisfaction Survey and Dental Plan's Action Plan to Address Results of Provider Satisfaction Survey	September 1
Provider Satisfaction Survey Plan	January 1
Quality Improvement (QI) Plan Update and Annual QI Program Evaluation Findings	November 1
Subcontractor Monitoring Schedule	December 1

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Section XVI. Definitions and Acronyms

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A. Definitions

The Florida Medicaid Definitions Policy contains definitions of commonly used terms that are applicable to all sections of Rule Chapter 59G, Florida Administrative Code (F.A.C.), unless specifically stated otherwise in a service-specific coverage policy, rule, or this Contract. (Rule 59G-1.010, F.A.C.) The following terms as used in this Contract shall be used unless this Contract otherwise expressly requires a different construction and/or interpretation. Some defined terms do not appear in all Contracts.

Abandoned Call - A call or other type of contact initiated to a call center that ends before any conversation occurs.

Abuse, Neglect and Exploitation - As defined in Chapter 415, F.S., and Chapter 39, F.S.

Acclimation Visit – One or more shorter appointments by an enrollee with the dental office to build trust and become familiar with the dentist and dental practice environment prior to attending a treatment appointment. During an acclimation visit, dental providers create a supportive and accommodating atmosphere, with an emphasis on patience and empathy. The objectives of the acclimation visit are familiarization with facility and staff, establishing trust, sensory adaptation, dental chair familiarization including its reclining and positioning features, and behavioral assessment to help tailor future dental treatments.

Adjudicated Claim - A claim for which a determination has been made to pay, accept, deny, or reject the claim.

Adjudicated Date - The date the Dental Plan processed for determination of payment, acceptance, denial, or rejection.

Adverse Benefit Determination - As defined in 42 CFR Part 438.400(b).

Adverse Incident - An injury of an enrollee occurring during delivery of Dental Plan covered services that:

1. Is associated in whole or in part with service provision rather than the condition for which such service provision occurred; and,
2. Is not consistent with or expected to be a consequence of service provision; or
3. Occurs as a result of service provision to which the patient has not given his informed consent; or
4. Occurs as the result of any other action or lack thereof on the part of the staff of the provider.

After Hours - The hours between 5:00 p.m. and 8:00 a.m. in the enrollee's time zone, Monday through Friday inclusive, and all-day Saturday and Sunday. State holidays are included.

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Agency - State of Florida, Agency for Health Care Administration (Agency or AHCA), its employees acting in their official capacity, or its designee.

Agent - A term that refers to certain independent contractors with the State that perform administrative functions, including but not limited to fiscal agent activities; outreach, eligibility and enrollment activities; and systems and technical support. The term used herein does not create a principal-agent relationship.

Ambulatory Surgical Center Care – As described in Rule 59G-4.020, F.A.C.

Ancillary Dental Services - Secondary services in support of primary care dental services, such as dental hygiene and dental laboratory services.

Appeal – See Plan Appeal

Automated Phone Tree System - A telephone information system consisting of a fixed menu of options that registers information or routes calls based on a programmed response. A phone tree prompts the caller to respond to a menu of options by pressing phone keys on a touch-tone telephone. A phone tree also includes interactive voice response (IVR) technology that allows the telephone information system to interact with a caller speaking words or short phrases and responds with prerecorded or dynamically generated audio to direct the caller further on how to proceed to available options.

Automatic Call Distribution - A device or system that manages incoming calls, handles incoming calls based on the number called and associated automated handling instructions, and distributes incoming calls to a specific group of terminals that agents use, based on caller need, call type, or agent skill set.

Biometric Technology - The use of computer technology to identify people based on physical or behavioral characteristics such as fingerprints, retinal or voice scans.

Blog (Web Blog) - A type of website, usually maintained by an individual with regular entries of commentary, description of events, or other materials such as graphics or video. Entries are commonly displayed in reverse-chronological order.

Branding - Marketing through branding advertisements is typically used in television ads, and flash information quickly across a screen for the sole purpose of enticing an enrollee or potential enrollee to contact the Dental Plan to enroll or obtain more information. Branding also includes “banner-like” advertisements which are usually in some media other than television (e.g., outdoor advertising and internet banner ads). Branding advertisements are intended to be brief and to entice someone to call the Dental Plan or to alert someone that information is forthcoming.

Broadcast - Video, audio, text, or email messages transmitted through an internet, cellular, or wireless network for display on any device.

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Business Days - A day scheduled for regular State of Florida employees to work: Monday through Friday, except holidays observed by regular State of Florida employees. Timeframes requiring completion within a number of business days shall mean by 5:00 p.m. Eastern Time on the last workday.

Calendar Day - A period of twenty-four (24) hours from midnight to midnight.

Calendar Year - A twelve (12) month period of time beginning on January 1 and ending on December 31.

Call Center - A physical place equipped for receiving a large volume of requests by telephone and where telephone calls are handled, usually with some amount of computer automation, to respond to incoming inquiries from callers. Call centers shall function as a component of a broader contact center, or as a customer interaction center from which all customer contacts are managed via telephone, email, fax, online chat, or other means of communication.

Capitation Rate - The per-member, per-month amount, including any adjustments, that is paid by the Agency to a Dental Plan for each enrollee under a Contract for the provision of Medicaid services during the payment period.

Care Coordination - Case Management as defined in Rule 59G-1.010, F.A.C.

Cause - Special reasons that allow mandatory enrollees to change their Dental Plan choice outside their open enrollment period. Will also be referred to as “good cause.” (Rule 59G-8.600, F.A.C.)

Children/Adolescents - Enrollees under the age of twenty-one (21) years.

Claim - (1) A bill for services, (2) a line item of service, or (3) all services for one (1) recipient within a bill, pursuant to 42 CFR 447.45, in a format prescribed by the Agency through its Medicaid provider handbooks.

Clean Claim - A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 CFR 447.45.

Code on Dental Procedures and Nomenclature® - A systematic listing and coding of procedures and services published annually by the American Dental Association.

Cold-Call Marketing - Any unsolicited personal contact with a Medicaid recipient by the Dental Plan, its staff, its volunteers, or its vendors with the purpose of influencing the Medicaid recipient to enroll in the Dental Plan or either to not enroll in, or disenroll from, another Dental Plan.

Community Partner Network - A coalition of community-based organizations that provide services and supports for individuals’ health-related social needs, including referral(s), planning, program development, information sharing and management, community awareness, and individual education.

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Community Partnerships to Improve Outcomes (CPIO) - Certain health-related, community-based services that the Dental Plan must offer and coordinate access to its enrollees. Dental Plans are not reimbursed by the Agency/Medicaid for these types of services.

Complaint - Any oral or written expression of dissatisfaction by an enrollee submitted to the Dental Plan or to a State agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or Dental Plan employee, failure to respect the enrollee's rights, Dental Plan administration, claims practices or provision of services that relates to the quality of care rendered by a provider pursuant to the Dental Plan's Contract. A complaint is a subcomponent of the grievance and appeal system.

Continuous Quality Improvement - A management philosophy that mandates continually pursuing efforts to improve the quality of products and services produced by an organization.

Contract Manager - The Agency individual responsible for providing overall Contract direction, acting as liaison between the Dental Plan and other Agency staff and monitoring the Dental Plan's performance.

Contract Year – Each October 1 through September 30.

Contracting Officer - The Secretary of the Agency or designee.

Copayment - As described in Rule 59G-1.010, F.A.C.

Covered Services - Those services provided by the Dental Plan in accordance with this Contract, and as outlined in **Section V.**, Service Administration.

Date of Claim Receipt - The date the Dental Plan receives the claim at its designated claims receipt location, as indicated by its date stamp on the claim. (42 CFR 447.45(d)(5)-(6))

Date of Claim Payment - The date of the check or other form of payment. (42 CFR 447.46)

Day (or Days) - All seven (7) days of the week. Unless otherwise specified, the term "days" in this Contract refers to calendar days.

Dental Plan - As defined in s. 409.973(5)(b), F.S.

Department of Children and Families (DCF) - The State agency responsible for overseeing programs involving behavioral health, childcare, family safety, domestic violence, economic self-sufficiency, refugee services, homelessness, and programs that identify and protect abused and neglected children and adults.

Direct Ownership Interest - The possession of equity in the capital, the stock, or the profits of the disclosing entity. (42 CFR 455.101)

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Direct Secure Messaging (DSM) - Enables Managed Care Organizations and providers to securely send patient health information to many types of organizations.

Disclosing Entity - A Medicaid provider, other than an individual practitioner or group of practitioners, or a fiscal agent that furnishes services or arranges for funding of services under Medicaid, or health-related services under the social services program.

Disaster Recovery Plan - A plan to ensure continued business processing through adequate alternative facilities, equipment, backup files, documentation, and procedures in the event that the primary processing site is lost to the Dental Plan.

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) - As defined by 42 U.S.C. s. 1396d(r)(5) and 42 CFR 440.40(b) or its successive regulation.

Educational Event - An event designed to inform Dental Plan enrollees about Medicaid programs and does not include marketing.

Eligible Plan - In accordance with s. 409.973(5)(b), F.S., an entity that is licensed as a prepaid limited health service organization under part I of chapter 636, F.S., or as a health maintenance organization under Part I of Chapter 641, F.S.

Emergency Dental Services – In accordance with the Medicaid State Plan, medically necessary emergency procedures to relieve pain or infection, limited to emergency oral examinations, necessary radiographs, extractions, and the incision and drainage of an abscess.

Emergency Department Visit - Emergency services and care received in an emergency department or outpatient hospital.

Emergency Management Plan – As defined in Section 252.34, F.S.

Emergency Room Care – Emergency Care, Emergency Medical Services, or Emergency Services as defined in Rule 59G-1.010, F.A.C.

Emergency Services – Emergency Care, Emergency Medical Services, or Emergency Services as defined in Rule 59G-1.010, F.A.C.

Encounter Data - A record of diagnostic or dental treatment procedures or other allied services to the Dental Plan's Medicaid enrollees, excluding services paid by the Agency through the FFS delivery system.

Endorsement - A celebrity or influencer who gives a declaration of support in writing or speaking as to the quality or merit of a product or service.

Enrollee Incentive - Related to a Dental Plan Healthy Behaviors Program, something offered to an enrollee that encourages or motivates an enrollee to take action. For example, an incentive shall be offered for enrolling in a series of educational classes focused on the target behavior. Enrollee incentives should be linked to effective engagement strategies.

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Enrollee Record - As used in reference to provider, a medical record, as defined in Rule 59G-1.010, F.A.C. As used in reference to the Dental Plan, a comprehensive file containing information regarding the management of services for an enrollee including the plan of care and documentation of care coordination/case management activities.

Enrollee Reward - Related to a Dental Plan Healthy Behaviors Program, if used in the program, something that shall be offered to an enrollee after successful completion of a milestone (meaningful step towards meeting the goal) or goal attainment. An enrollee reward should be linked to positive behavior change. For example, a reward shall be offered after successful completion of a series of educational classes focused on a target behavior.

Enrollment - The process by which an eligible Medicaid recipient signs up to participate in a Dental Plan.

Enrollment Broker - The State's contracted or designated entity that performs functions related to outreach, education, enrollment, and disenrollment of potential enrollees into a Dental Plan.

Enrollment Files - X-12 834 files sent by the Agency's Medicaid designee to the Dental Plans to provide the Dental Plans with their official Medicaid recipient enrollment.

Enrollment Specialists - Individuals, authorized through an Agency-approved process, who provide one-on-one information to Medicaid recipients to help them choose the Dental Plan that best meets their dental health care needs.

Encounter Notification Service (ENS) - An automated alerting service that provides timely alert messages to subscribing Dental Plans and accountable care organizations when patients are discharged from a hospital or emergency department.

Excluded Services - As described in **Section V.**, Service Administration, **Sub-Section D.**, Excluded Services, of this Contract.

Excluded Parties List System (EPLS) - The EPLS, or its equivalent is a federal database containing information regarding entities debarred, suspended, proposed for debarment, excluded, or disqualified under the non-procurement common rule, or otherwise declared ineligible from receiving federal contracts, certain subcontracts, and certain federal assistance and benefits.

Expanded Benefit - A benefit covered by the Dental Plan for which the Dental Plan receives no direct payment from the Agency.

Expedited Plan Appeal Process - The process by which the appeal of a Dental Plan's adverse benefit determination is accelerated because the standard timeframe for resolution of the plan appeal could seriously jeopardize the enrollee's life, health, or ability to obtain, maintain or regain maximum function.

External Quality Review (EQR) - The analysis and evaluation by an external quality review organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that are furnished to Medicaid recipients by a Dental Plan.

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External Quality Review Organization (EQRO) - An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, other related activities as set forth in federal regulations, or both.

Federal Fiscal Year - The United States government's fiscal year, which starts October 1 and ends on September 30.

Federally Qualified Health Center (FQHC) - An entity that is receiving a grant under Section 330 of the Public Health Service Act, as amended. (Also see s. 1905(l)(2)(B) of the Social Security Act.)

Fee Schedule - A list of health services or products covered by the Florida Medicaid program in the FFS delivery system, which provide the associated reimbursement rates for each covered service or product and are promulgated into rule.

For Cause --- See Cause.

Full-Time Equivalent (FTE) Position/Employee - The equivalent of one (1) full-time employee who works forty (40) hours per week.

Fully Enrolled Provider - An enrollment type that is furnished to a provider that meets the full eligibility credentialing for participation in Florida Medicaid. Enrolled providers are eligible to provide services to recipients enrolled in either the FFS delivery system or the managed care delivery system.

Functional Status - The ability of an individual to perform self-care, self-maintenance, and physical activities in order to carry out typical daily activities.

General Anesthesia - As defined in Rule 64B-5-14.001, Florida Administrative Code.

Grievance and Appeal System - As defined by 42 CFR 438.400(b).

Healthcare Effectiveness Data and Information Set (HEDIS) - The data and information set developed and published by the National Committee for Quality Assurance. HEDIS includes technical specifications for the calculation of performance measures.

Health Care Professional - A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, dental hygienist, orthodontist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), a licensed clinical social worker, registered respiratory therapist, certified respiratory therapy technician, and licensed pharmacist.

Health Information Exchange (HIE) - The secure, electronic exchange of health information among authorized stakeholders in the health care community – such as care providers, patients, and public health agencies – to drive timely, efficient, high-quality, preventive, and patient-centered care.

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Health Insurance - As defined in s. 627.603, F.S.

Health Insurance Premium Payment (HIPP) Program - A program that reimburses part or all of a Medicaid recipient's share of employer-sponsored health care coverage, if available and cost-effective.

Health Maintenance Organization (HMO) - An organization or entity licensed in accordance with Chapter 641, F.S.

Healthy Behaviors - A program offered by Dental Plans that encourages and rewards behaviors designed to improve the enrollee's overall health.

Health Information Technology for Economic and Clinical Health (HITECH) Act - The Health Information Technology Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) - A federal law that includes requirements to protect patient privacy, to protect security of electronic medical records, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers.

Hospital Outpatient Care - As described in 59G-4.160, F.A.C.

iBudget Waiver and Waitlist Enrollee - An enrollee receiving services or determined eligible to receive services through the Home and Community Based (HCBS) Developmental Disabilities Individual Budgeting (iBudget) Waiver, including individuals receiving services through the Consumer Directed Care Plus (CDC+) Program.

Indirect Ownership - An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. (42 CFR 455.101) See also as calculated in 42 CFR 455.102.

Individual Marketing Appointments - Marketing appointments are individual appointments designed to steer or attempt to steer enrollees or potential enrollees toward a Dental Plan. All individual appointments between an agent and an enrollee or potential enrollee are considered marketing appointments regardless of the content discussed.

Information - As the term relates to Information Management and Systems, (a) Structured Data: Data that adheres to specific properties and validation criteria that are stored as fields in database records. Structured queries can be created and run against structured data, where specific data can be used as criteria for querying a larger data set; (b) Document: Information that does not meet the definition of structured data includes text files, spreadsheets, electronic messages and images of forms and pictures.

Information System(s) - A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data (which includes digitized

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audio and video) and documents as well as non-digitalized audio and video; and/or (b) the processing and/or calculating of information and non-digitalized audio and video for the purposes of enabling and/or facilitating a business process or related transaction.

Injury - Any of the following outcomes when caused by an adverse incident:

1. Death
2. Brain damage
3. Spinal damage
4. Permanent disfigurement
5. Fracture or dislocation of bones or joints
6. Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition.
7. Any condition requiring surgical intervention to correct or control.
8. Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care.

Insolvency - A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets.

Insurer - Pursuant to s. 624.03, F.S., every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity.

Interactions - Conversational exchange of messages.

Intervention - Any measure or action intended to improve or restore health or alter the course of a disease or behavior.

Licensed - A facility, equipment, or an individual that has formally met State, county, and local requirements, and has been granted a license by a local, State, or federal government entity.

Limited Enrolled Provider - An enrollment type that is furnished to a provider that meets the basic eligibility credentialing for participation in Florida Medicaid. Limited Enrollment providers are only eligible to provide services to recipients enrolled in managed care.

List of Excluded Individuals and Entities (LEIE) - A database maintained by the Department of Health & Human Services, Office of the Inspector General. The LEIE provides information to the public, health care providers, patients and others relating to parties excluded from participation in Medicare, Medicaid, and all other federal health care programs.

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Mandatory Assignment - The process the Agency uses to assign enrollees to a Dental Plan. The Agency automatically assigns those enrollees required to be in a Dental Plan who did not voluntarily choose one.

Mandatory Enrollee - The categories of eligible Medicaid recipients who must be enrolled in a Dental Plan.

Mandatory Potential Enrollee - A Medicaid recipient who is required to enroll in a Dental Plan but has not yet made a choice.

Managed Care Plan Report Guide - A companion guide to the SMMC and Dental Plan Contracts that provides detailed information about standard reports required by this Contract to be submitted by the Dental Plans to the Agency. Detailed information includes report-specific format and submission requirements, instructions for completion, and report templates and supplemental tables.

Marketing - Marketing includes activities and use of materials by the Dental Plan with the intent to draw an enrollee or potential enrollee's attention to a plan or to influence a potential enrollee or enrollee's decision-making process when selecting a plan for enrollment or deciding to remain enrolled in a plan. (That is, retention-based marketing).

Marketing Agent - In accordance with s. 626.015, F.S., a Florida licensed health insurance agent who acts on behalf of the Dental Plan to provide marketing activities to enrollees and potential enrollees.

Marketing Events - Marketing events are events designed to steer, or attempt to steer, enrollees or potential enrollees toward a plan. Licensed and appointed marketing agent(s), in accordance with s. 626.829, F.S., from the Dental Plan is present distributing marketing materials, nominal gifts and/or engaging in verbal discussion regarding Plan-specific, enrollment, and/or benefit information.

Marketing Materials - Materials used with the intent to draw a potential enrollee's attention to a plan or to influence a potential enrollee or enrollee's decision-making process when selecting a plan for enrollment or deciding to remain enrolled in a plan. (That is, retention-based marketing).

Medicaid Fair Hearing - An administrative hearing conducted by the Agency to review an action taken by a Dental Plan that limits, denies, or stops a requested service.

Medicaid Program Integrity (MPI) - The unit of the Agency responsible for preventing and identifying fraud and abuse in the Medicaid program.

Medicaid Recipient - Any individual whom DCF, or the Social Security Administration on behalf of DCF, determines is eligible, pursuant to federal and State law, to receive medical or allied care, goods, or services for which the Agency shall make payments under the Medicaid program, and who is enrolled in the Medicaid program.

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Medicaid State Plan - A written plan between a State and the federal government that outlines the State's Medicaid eligibility standards, provider requirements, payment methods, and health benefit packages. A Medicaid State Plan is submitted by each State and approved by the Centers for Medicare & Medicaid Services (CMS).

Medically Necessary or Medical Necessity - As defined in Rule 59G-1.010, F.A.C.

Month - Also called calendar month, any of the twelve parts, such as January or February, into which the calendar year is divided. Unless otherwise specified, the term "month" in this Contract refers to calendar month.

Moderate Sedation - As defined in Rule 64B-5-14.001, Florida Administrative Code.

National Correct Coding Initiative (NCCI) - A Centers for Medicare & Medicaid Services edit system that promotes national correct coding methodologies pursuant to applicable provisions of the Social Security Act, s. 1903(r)(1)(B)(iv).

Network - As defined in **Section VII.**, Provider Network and Services, of this Contract.

Nominal Gift - An individual item or service worth fifteen dollars (**\$15**) or less (based on the retail value of the item), with a maximum aggregate of seventy-five dollars (**\$75**) per person, per year.

Non-Covered Service - A service that is not a benefit under either the Medicaid State Plan, or the Dental Plan.

Non-Participating Provider - A person or entity eligible to provide Medicaid services that does not have a contractual agreement with the Dental Plan to provide services.

Normal Business Hours - The hours between 8:00 a.m. and 5:00 p.m. in the enrollee's or provider's time zone, Monday through Friday inclusive. State holidays are excluded.

Office of Fair Hearing (Office) - The hearing authority within the Agency for Health Care Administration designated to conduct Medicaid fair hearings per s. 409.285(2), F.S.

Ongoing Course of Treatment - Services that were previously authorized or prescheduled prior to the enrollee's enrollment in the Dental Plan.

Open Enrollment - The sixty (60)-day period before the end of certain enrollees' enrollment year, during which the enrollee may choose to change Dental Plans, without good cause, for the following enrollment year.

Oral Health Risk Assessment - An assessment of an enrollee's oral health history and oral health status, including results of the enrollee's current oral evaluation and/or released dental records, used to determine the enrollee's risk for development of specific diseases or conditions.

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Other Benefits - Services, excluding expanded benefits, covered by Dental Plans for all or some enrollees (based upon criteria established by the Dental Plan) that exceed coverage and limitations specified under the Medicaid State Plan, including services provided in accordance with **Section V.**, Service Administration, of this Contract.

Other Provider-Preventable Condition - A condition occurring in any health care setting that meets the following criteria:

1. Is identified in the Florida Medicaid State Plan.
2. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
3. Has a negative consequence for the beneficiary.
4. Is auditable.
5. 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; surgical or other invasive procedure performed on the wrong patient.

Participating Provider - A health care practitioner or entity authorized to do business in Florida and contracted with the Dental Plan to provide services to the Dental Plan's enrollees.

Pediatric Moderate Sedation - As defined in Rule 64B-5-14.001, Florida Administrative Code.

Peer Review - An evaluation of the professional practices of a provider by his or her peers. The evaluator assesses the necessity, appropriateness and quality of care furnished by comparing the care to that customarily furnished by the provider's peers and to recognized health care standards.

Physicians' Current Procedural Terminology (CPT®) - A systematic listing and coding of procedures and services published annually by the American Medical Association.

Plan – See Dental Plan.

Plan Appeal - A formal request from an enrollee to seek a review of an adverse benefit determination made by the Dental Plan pursuant to 42 CFR 438.400(b).

Post-Stabilization Dental Care Services - Covered dental services provided under this Contract that are related to an emergency medical condition after an enrollee is stabilized in order to maintain, improve, or resolve the enrollee's condition pursuant to 42 CFR 422.113.

Potential Enrollee - Pursuant to 42 CFR 438.2, an eligible Medicaid recipient who is subject to mandatory assignment in a given Dental Plan but is not yet an enrollee of a specific Dental Plan.

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Potentially Preventable Emergency Room Visit (PPV) - Emergency room visits that shall result from a lack of adequate access to care or ambulatory care coordination.

Prepaid Limited Health Service Organization - An organization or entity licensed in accordance with part I of Chapter 636, F.S.

Preventive Dental Services - Services as described in rule 59G-4.060, F.A.C. and including CDT codes 1000-1999.

Primary Dental Care – Comprehensive, coordinated, and readily accessible dental care, including dental health promotion and maintenance, treatment of illness and injury, early detection of disease, and referral to specialists when appropriate.

Primary Dental Provider (PDP) - A general dentist or pediatric dentist who furnishes primary dental care and patient management services to an enrollee.

Prior Authorization - The act of authorizing specific services before they are rendered.

Protected Health Information (PHI) - For purposes of this Contract, PHI shall have the same meaning and effect as defined in 45 CFR 160 and 164, limited to the information created, received, maintained, or transmitted by the Dental Plan from, or on behalf of, the Agency.

Protocols - Written guidelines or documentation outlining steps to be followed for handling a particular situation, resolving a problem, or implementing a plan of dental, medical, nursing, psychosocial, developmental, and educational services.

Provider - A person or entity eligible for a Medicaid provider agreement.

Provider Agreement - A contract between the Dental Plan and a dental provider to serve Dental Plan enrollees.

Provider Claim Complaint Resolution - A claim complaint is considered resolved after a claim is reviewed and either processed, or reprocessed accurately, and thereafter, the correct payment is issued, funds are recouped, or a determination is made to uphold a previous decision.

Public Event - An event planned or sponsored to benefit, educate, and/or assist the community with information concerning health-related matters or public awareness. Dental Plans cannot market at Public Events.

Public Event Materials - Materials used by the Dental Plan to educate or assist the community by providing information concerning health-related topics or topics which require public awareness.

Publication Ready - The final edition of marketing material ready for dissemination which includes all written content and graphics. Materials which include placeholders are not considered publication ready.

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Quality Enhancements - Certain health-related, community-based services to which the Dental Plan must offer and coordinate access to its enrollees. Dental Plans are not reimbursed by the Agency/Medicaid for these types of services.

Quality Improvement (QI) - The process of monitoring that the delivery of health care services is available, accessible, timely, and medically necessary.

Readily Accessible - As defined in 42 CFR 438.10(a) in the context of information requirements.

Region - As described in s. 409.966(2), F.S.

Remediation - The act or process of correcting a fault or deficiency.

Residential Commitment Facilities - As applied to the Department of Juvenile Justice, refers to the out-of-home placement of adjudicated youth who are assessed and deemed by the court to be a low or moderate risk to their own safety and to the safety of the public; for use in a level 4, 6, 8, or 10 facility as a result of a delinquency disposition order. Also referred to as a residential commitment program.

Retrospective Review – A review that is conducted after services are provided to a patient. The review is focused on determining the appropriateness, necessity, quality, and reasonableness of health care services provided.

Routine Dental Care – A well care (non-acute) dental visit for preventive services (e.g., screening, cleaning, check-up, evaluation) or follow up to a previously treated condition and any other routine visit for other than the treatment of a dental illness/condition (e.g., sick care).

Rural - An area with a population density of less than one hundred (100) individuals per square mile, or an area defined by the most recent United States Census as rural, i.e., lacking a metropolitan statistical area (MSA).

Sanctions - In relation to **Section XII.**, Sanctions and Corrective Action Plans; Any monetary or non-monetary penalty imposed upon a provider, entity, or person (e.g., a provider entity, or person being suspended from the Medicaid program).

Scripts - Scripts are standardized text intended to draw a potential enrollee's attention to a plan or to influence a potential enrollee or enrollee's decision-making process when selecting a plan for enrollment or deciding to remain enrolled in a plan. Scripts that respond to enrollee or potential enrollees' questions or requests and provide Plan specific, enrollment or benefit information also must be submitted to Agency prior to use. Broadcast scripts (T.V., radio, social media), marketing scripts (presentations), and telephonic scripts will be subject to review by the Agency.

Securities - United States Treasury Securities that are backed by the full faith and credit of the United States government. For purposes of this Contract, the term shall be limited to those securities approved by the Agency as specified in **Section XI.**, Financial Requirements.

Service Authorization - The Dental Plan's approval for services to be rendered.

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Service Delivery Systems - Mechanisms that enable provision of certain health care benefits and related services for Medicaid recipients as provided in s. 409.973, F.S.

Sick Care - Non-urgent problems that do not substantially restrict normal activity, but could develop complications if left untreated (e.g., chronic disease such as diabetes, cancer, or HIV).

Significant Change - As defined in s. 409.962(17), F.S.

Social Networking - Web-based applications and services (excluding the Dental Plan's State-mandated website content, enrollee portal, and provider portal) that provide a variety of ways for users to interact, such as email, comment posting, image sharing, invitation, and instant messaging services.

Span of Control - Information systems and telecommunications capabilities that the Dental Plan itself operates or for which it is otherwise legally responsible according to the terms and conditions of this Contract. The span of control also includes systems and telecommunications capabilities outsourced by the Dental Plan.

Special Health Care Needs - Enrollees who face physical, behavioral, or environmental challenges daily that place at risk their health and ability to function fully in society. This includes individuals with intellectual and developmental disabilities or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; and children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.

Sponsorship Only Events - Events where the Dental Plan serves as a financial sponsor, provides nominal gift items for distribution through event organizer or permits the use of Dental Plan name and logo on event materials provided by event organizer, but there is no Dental Plan representative present distributing Plan materials or nominal gifts. Sponsorship only events do not require Agency approval and are not reported on the Marketing, Public, Educational Events Report.

State - State of Florida.

State Fiscal Year - The State of Florida fiscal year is the twelve (12) month period beginning July 1 and ending June 30.

Statutory Accounting Principles - A set of accounting regulations as defined by the 2002 National Association of Insurance Commissioners Accounting Practices and Procedures Manual and as specified in s. 641.19, F.S.

Subcontract - An agreement entered into for provision of services on behalf of the Dental Plan as related to this Contract.

Subcontractor - Any entity contracting with the Dental Plan to perform services or to fulfill any of the requirements requested in this Contract or any entity that is a subsidiary of the Dental Plan that performs services or fulfills the requirements requested in this Contract.

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Surface Mail - Mail delivery via land, sea, or air, rather than via electronic transmission.

Surplus - Net worth (i.e., total assets minus total liabilities).

System Unavailability - As measured within the Dental Plan's information systems' span of control, when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "enter" or other function key.

Systems - See Information Systems.

Tags/Tagging - Placing personal identification information within a picture or video.

Teledentistry - The practice of oral health care delivery by a dental provider who is located at a site other than the site where an enrollee is located for the purposes of evaluation, diagnosis, or treatment, as defined in Rule 59G-1.057, F.A.C.

Temporary Assistance to Needy Families (TANF) - As described in 45 CFR 260.20.

Temporary Loss Period - Period in which an enrollee loses eligibility and regains it, allowing the recipient to be re-enrolled in the Dental Plan in which the recipient was enrolled prior to the eligibility loss.

Temporary Management - State-imposed oversight of the operation of the Dental Plan, upon a finding by the State that there is continued egregious behavior by the Dental Plan or a substantial risk to the health of the Dental Plan's enrollees, or to assure the health of the Dental Plan's enrollees, in accordance with s. 1932(e)(2)(B) of the Social Security Act.

Testimonial - A written or spoken statement testifying to the quality or the merit of a product or service.

Timely Files - When an enrollee files for continuation of benefits on or before the later of the following:

- a. Within ten (10) days of the Dental Plan sending the notice of adverse benefit determination; or
- b. The intended effective date of the Dental Plan's proposed adverse benefit determination.

Urban - An area with a population density of greater than one hundred (100) individuals per square mile or an area defined by the most recent United States Census as urban, i.e., as having a metropolitan statistical area (MSA).

Urgent Care - Services for conditions, which, though not life threatening, could result in serious injury or disability unless medical attention is received or substantially restrict an enrollee's activity.

Urgent Medical - Any sudden or unforeseen situation that requires immediate action to prevent hospitalization or nursing facility placement.

Username - An identifying pseudonym associated with the author to messages or content

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generated.

Validation - The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Value-Added – As described in 42 CFR 438.3(e)(i).

Value-Based Purchasing (VBP) - A reimbursement strategy that links provider payments to improved performance by health care providers. VBP arrangements include contractual agreements between payers and health care providers that hold the health care providers accountable for both the quality and cost of care that they provide.

Vendor – When capitalized, an entity submitting a proposal to become a Dental Plan.

Violation - A determination by the Agency that a Dental Plan failed to act as specified in this Contract or applicable statutes, rules or regulations governing Dental Plans. For the purposes of this Contract, each day that an ongoing violation continues shall be considered a separate violation. In addition, each instance of failing to furnish necessary and/or required medical services or items to each enrollee shall be considered a separate violation. Also, each day that the Dental Plan fails to furnish necessary and/or required medical services or items to enrollees shall be considered a separate violation.

Waste - Overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.

Written Marketing Materials - Printed informational material targeted to enrollees and potential enrollees, which promotes the Dental Plan, including but not limited to brochures, flyers, leaflets, or other printed information about the Dental Plan. Written marketing material includes materials for circulation by dentists, other dental care providers, or third parties.

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B. Acronyms

ACA - Patient Protection and Affordable Care Act

ADA - Americans with Disabilities Act of 1990

AHCA – Agency for Health Care Administration

ANSI - American National Standards Institute

APD - Agency for Persons with Disabilities

ASR - Achieved Savings Rebate

BC - Business Continuity

BAA - Business Associate Agreement

CAHPS - Consumer Assessment of Healthcare Providers and Systems

CARC - Claim Adjustment Reason Code

CAP - Corrective Action Plan

CBO - Community-Based Organization

CCP - Cultural Competency Plan

CDC - Centers for Disease Control and Prevention

CEO - Chief Executive Officer

CFO - Chief Financial Officer

CFR - Code of Federal Regulations (citations may be searched online at: <http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR>)

CHD - County Health Department

CMS - Centers for Medicare & Medicaid Services

CDT® - Code on Dental Procedures and Nomenclature

CPIO - Community Partnerships to Improve Outcomes

CPT® - Physicians' Current Procedural Terminology

DCA - District Court of Appeal

DCF - Department of Children and Families

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DFS - Department of Financial Services

DHHS - United States Department of Health & Human Services

DOH - Department of Health

DR - Disaster Recovery

DRG - Diagnostic Related Group

DSM - Direct Secure Messaging

EDI - Electronic Data Interchange

ENS - Encounter Notification Service

EPLS - Excluded Parties List System

EPSDT - Early and Periodic Screening, Diagnosis and Treatment Program

EQR - External Quality Review

EQRO - External Quality Review Organization

EDT - Eastern Daylight Time

EST - Eastern Standard Time

F.A.C. - Florida Administrative Code

FAR - Florida Administrative Register

FFS - Fee-for-Service

FFY – Federal Fiscal Year

FIPS - Federal Information Processing Standards Publication

FMMIS - Florida Medicaid Management Information System

FQHC - Federally Qualified Health Center

F.S. - Florida Statutes

FSFN - Florida Safe Families Network (formerly HomeSafeNet), also known as SACWIS, (Statewide Automated Child Welfare Information System)

FTE - Full-Time Equivalent Position

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FX - Florida Health Care Connections

HCPCS - Healthcare Common Procedure Coding System

HEDIS - Healthcare Effectiveness Data and Information Set

HIE - Health Information Exchange

HIPAA - Health Insurance Portability and Accountability Act

HIPP - Health Insurance Premium Payment

HIT - Health Information Technology

HITECH Act - Health Information Technology for Economic and Clinical Health Act

HIV - Human Immunodeficiency Virus

HMO - Health Maintenance Organization

ICD - International Classification of Diseases

IHCP - Indian Health Care Provider

IDD – Individuals with Intellectual and Developmental Disabilities

ISM - Information Security Manager

IT - Information Technology

ITN - Invitation to Negotiate

LEIE - List of Excluded Individuals & Entities

LOINC - Logical Observation Identifiers Names and Codes

MEDS - Medicaid Encounter Data System

MFCU - Medicaid Fraud Control Unit, Office of the Attorney General

MLR - Medical Loss Ratio

MMA - Managed Medical Assistance

MPI - Medicaid Program Integrity Bureau, AHCA Health Quality Assurance

NAIC - National Association of Insurance Commissioners

NCCI - National Correct Coding Initiative

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NCQA - National Committee for Quality Assurance

NIST - National Institute of Standards and Technology

NPI - National Provider Identifier

ODBC - Open Database Connectivity

OIG - Office of the Inspector General

OIR - Office of Insurance Regulation

PCP - Primary Care Provider

PDP – Primary Dental Care Provider

PDO - Participant Direction Option

PDP - Primary Dental Provider

PHI - Protected Health Information

PIP - Performance Improvement Project

PM - Performance Measure

PMPM – Per member per month

PNV - Provider Network Verification

PPV - Potentially Preventable Emergency Room Visit

QI - Quality Improvement

RARC - Remittance Advice Reason Code

SACWIS - Statewide Automated Child Welfare Information System, also known as Florida Safe Families Network (FSFN, formerly HomeSafeNet)

SAM - System for Award Management

SFTP - Secure File Transfer Protocol

SFY – State Fiscal Year

SIU - Special Investigations Unit

SMMC - Statewide Medicaid Managed Care Program

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SOBRA - Sixth Omnibus Budget Reconciliation Act

SQL - Structured Query Language

SSI - Supplemental Security Income

SSN - Social Security Number

TANF - Temporary Assistance for Needy Families

TLS - Transport Layer Security

TPA - Third Party Administrator

UM - Utilization Management

U.S. - United States

U.S.C. - United States Code

VBP - Value-Based Purchasing

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