



# CONTRACT

(fee-for-goods or services contract with an individual, business, non-profit, or governmental entity of another state)

<b>Begin Date</b> January 2, 2015	<b>End Date</b> June 30, 2020	<b>Agency Tracking #</b> 31865-00377	<b>Edison Record ID</b> 44466
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<b>Contractor Legal Entity Name</b> DentaQuest USA Insurance Company, Inc.	<b>Edison Vendor ID</b> 8993
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**Goods or Services Caption (one line only)**  
Fully Insured Dental Benefits Manager Services for CoverKids

<b>Subrecipient or Contractor</b> <input type="checkbox"/> Subrecipient <input checked="" type="checkbox"/> Contractor	<b>CFDA #</b> 93.767
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Funding —					
FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2016	\$4,346,678.00	\$13,040,035.00			\$17,386,713.00
2017	\$4,996,111.00	\$14,988,335.00			\$19,984,446.00
2018	\$5,740,363.00	\$17,221,090.00			\$22,961,453.00
2019	\$6,599,684.00	\$19,799,051.00			\$26,398,735.00
2020	\$7,584,645.00	\$22,753,936.00			\$30,338,581.00
<b>TOTAL:</b>	<b>\$29,267,481.00</b>	<b>\$87,802,447.00</b>			<b>\$117,069,928.00</b>

**Contractor Ownership Characteristics:**

Minority Business Enterprise (MBE): African American, Asian American, Hispanic American, Native American

Woman Business Enterprise (WBE)

Tennessee Service Disabled Veteran Enterprise (SDVBE)

Tennessee Small Business Enterprise (SBE): \$10,000,000.00 averaged over a three (3) year period or employs no more than ninety-nine (99) employees.

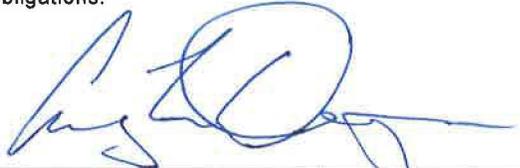
Other: For-Profit Corporation

**Selection Method & Process Summary (mark the correct response to confirm the associated summary)**

Competitive Selection | RFP

Other

**Budget Officer Confirmation:** There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.



<b>Speed Chart (optional)</b> TN00000266	<b>Account Code (optional)</b>
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**CONTRACT  
BETWEEN THE STATE OF TENNESSEE,  
DEPARTMENT OF FINANCE AND ADMINISTRATION  
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION  
AND  
DENTAQUEST USA INSURANCE COMPANY, INC.**

This Contract, by and between the State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration (HCFA), hereinafter referred to as the "State" or "HCFA" and DentaQuest USA Insurance Company, Inc., hereinafter referred to as the "Contractor," or "Dental Benefits Manager (DBM)", is for the provision of provision of fully insured dental coverage for eligible individuals participating in CoverKids, Tennessee's Children's Health Insurance Plan, as further defined in the "SCOPE OF SERVICES."

The Contractor is For-Profit Corporation  
Contractor Place of Incorporation or Organization: Texas  
Contractor Edison Registration ID # 8993

**A. SCOPE OF SERVICES:**

- A.1. The Contractor shall provide all service and deliverables as required, described, and detailed herein and shall meet all service and delivery timelines as specified by this Contract. Refer to Attachment A for applicable terms and definitions located within this Contract.

**POTENTIAL ENROLLEES**

- A.2. The Contractor shall act as the Dental Benefits Manager (DBM) to provide a fully insured dental plan coverage, based upon the benefits provided for in this Contract to enrollees of CoverKids. Enrollees include children under age 19 enrolled in CoverKids medical coverage, hereafter to be collectively referred to as "CoverKids". Those enrollees who are participating in HealthyTNBabies due to their pregnancy are not eligible for dental benefits. The Contractor shall comply with all applicable administrative rules and HCFA CoverKids written policies and procedures, as may be amended from time to time. HCFA shall provide the Contractor with copies of such rules and policies. The Contractor shall adhere to its standard administrative policies and procedures, including without limitation dental policies, claims administration procedures, provider reimbursement practices and grievance procedures, in administering its fully insured coverage. The State shall be the Contract holder, and the persons covered through the CoverKids program shall be enrollees, who receive descriptions of the coverage in a Member Handbook (MH). When used in this Contract, the term "Member" shall have the same meaning as the term "Enrollee." Enrollees are defined as:

- A.2.1. Group One Child: Enrollees who are a member of a family with an income between 150 percent and 250 percent of the Federal Poverty Level (FPL) as reported by the State to the Contractor for the coverage period.
- A.2.2. Group Two Child: Enrollees who are a member of a family with an income below 150 percent of FPL as reported by the State to the Contractor for the coverage period.
- A.2.3. American Indian and Alaskan Native Child (AI/AN): American Indian and Alaska Native individuals (individually or collectively, "AI/AN"), as defined by the Indian Health Care Improvement Act of 1976 and certified by the State, will be exempt from all cost sharing to the extent that such children are covered by Children's Health Insurance Plan (CHIP) as required by Federal law. This group includes enrollees who are (a) certified AI/AN, and (b) members of families with incomes less than or equal to 250 percent of the FPL, as reported by the State to the Contractor for the coverage period.



## EVIDENCE OF MEMBER COVERAGE AND MEMBER MATERIAL

- A.3. The Contractor shall distribute various types of member materials within its entire service area as required by this Contract. These materials include, but may not be limited to member handbooks, provider directories, member newsletters, dental reminder notices, fact sheets, notices, or any other material necessary to provide information to members as described herein. The Contractor may distribute additional materials and information, other than those required by this Section, to members in order to promote dental health and/or educate members. All materials sent to members and member communications including form letters, mass mailings and system generated letters, whether required or otherwise, shall require written approval by HCFA prior to dissemination as described herein and shall be designed and distributed in accordance with the minimum requirements as described in this Contract. The required member materials include the following:
- A.3.1. The Contractor shall develop and update the member handbook when major changes occur within the CoverKids program, the DBM or upon request by HCFA. The member handbooks shall contain the actual date it was printed either on the handbook or on the first page within the handbook. Member handbooks must be distributed to member within ten (10) days of receipt of notice of enrollment in the DBM plan. In situations where there is more than one (1) member enrolled under a Parent ID, it shall be acceptable for the Contractor to mail one (1) member handbook. Should a single individual be enrolled and be added under a Parent ID, a member handbook new or updated must be mailed to that individual regardless of whether or not a member handbook has been previously mailed to member in the existing Parent ID.
  - A.3.2. The Contractor shall update enrollment and shall mail enrollee I.D. cards and member handbooks to a minimum of ninety-eight percent (98%) of enrollees within ten (10) calendar days from receipt of the new enrollment information or change in enrollment data. Failure to comply may result in monetary assessment as listed in Attachment C.
  - A.3.3. Upon notice by HCFA of CoverKids benefit changes, the Contractor shall make the appropriate revisions to the member handbook, including two (2) separate versions of the Contractor's CoverKids Member Handbook if necessary for the specific population being serviced for the purpose of describing Dental Benefits. All revisions must be approved by HCFA prior to dissemination.
  - A.3.4. Once materials are approved by HCFA, the Contractor shall submit an electronic version (pdf) of the final product, unless otherwise specified by HCFA, within thirty (30) calendar days from the print date. If the print date exceeds thirty (30) calendar days from the date of approval, the Contractor shall submit a written notification to the HCFA Member Materials Coordinator to specify a print date. Should HCFA request original prints be submitted in hard copy, photo copies may not be submitted as a final product. Upon request, the Contractor shall provide additional original prints of the final product to HCFA. When large distributions of the member handbook occur, the Contractor must submit to HCFA the date the information was mailed to the enrollees along with an invoice or a specific document to indicate the date and volume of handbooks mailed. Each member handbook shall, at a minimum, be in accordance with the following guidelines:
    - a. Must be in accordance with all applicable requirements as described in this contract.
    - b. Shall include a table of contents;
    - c. Shall include an explanation on how members will be notified of member specific information such as effective date of enrollment;



- d. Shall include a description of services provided including limitations, exclusions and out-of-plan use;
- e. Shall include a description of cost share responsibilities;
- f. Shall include information about preventive services for children;
- g. Shall include an explanation of emergency services and procedures on how to obtain emergency services both in and out of the Contractor's service area;
- h. Shall include appeal procedures as described in this Contract;
- i. Shall include notice to the member that it is the member's right to file an appeal for adverse actions taken by the Contractor;
- j. Shall include written policies on member rights and responsibilities;
- k. Shall include notice to the member that it is the member's responsibility to notify the Contractor every time the member moves to a new address and that failure to notify could result in the member not receiving important eligibility and/or benefit information;
- l. Shall include the toll free telephone number for Contractor with a statement that the member may contact the Contractor regarding questions about dental benefits;
- m. Shall include information on how to obtain language assistance services, such as, auxiliary aids or services and how to access interpretation and translation services as well as a statement that these services are free. Effective communication services, such as, auxiliary aids or services and language assistance are required to be provided to individuals under the applicable federal and state civil right laws, which include 42 C.F.R. § 438.10, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and Titles II and III of the Americans with Disabilities Act of 1990 and the written material requirements of this Contract, including, section A.16.7;
- n. Shall include information educating members about the privacy and confidentiality of their information, and the rights and necessary steps to amend their data in accordance with HIPAA regulations;
- o. Shall include information for individuals with disabilities to use in order to request assistance with access services or other program benefits that these individuals are entitled to under the applicable federal and state civil rights laws including, but not limited to, Section 504 of the Rehabilitation Act of 1973 and Titles II and III of the Americans with Disabilities Act of 1990, and
- p. Shall include notice to the members of the protections given to them under the applicable federal and state civil right laws, which includes the right to file a complaint under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 and 42 U.S.C.A. § 18116 and a complaint form on which to do so. These materials shall be provided in accordance with the written material requirements of this Contract, including, section A.16.7.



- A.3.5. The Contractor shall, at a minimum, distribute on a quarterly basis a newsletter to all members which is intended to educate the member, proper utilization of services, etc., and encourage utilization of preventive care services.
- a. The Contractor shall include the following information, in each newsletter:
    - (1) Specific articles or other specific information as described when requested by HCFA. Such requests shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included;
    - (2) The procedures on how to obtain auxiliary aids or services in order to achieve effective communication and how to access language interpretation and translation services which will include a statement that these services are free. This information shall comply with the Contract requirements set forth in A.16.7 and at a minimum be available in the English and Spanish languages; and
    - (3) Information on how individuals with disabilities can request assistance with accessing services or other program benefits. This information shall comply with the Contract requirements set forth in A.16.7 and at a minimum be available in the English and Spanish languages.
  - b. The quarterly member newsletters shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to members associated with the same Parent ID. In addition to the prior authorization requirement regarding dissemination of materials to members, the Contractor shall also submit to HCFA, five (5) final printed originals, unless otherwise specified, of the newsletters and documentation from the Contractor's mail room or outside vendor indicating the quantity and date mailed to CoverKids as proof of compliance by the 30th of the month following each quarter, in accordance with the reporting schedules as described in this Contract.
  - c. The Contractor shall also include in the newsletter notice to the member the right to file a complaint as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972, and 42 U.S.C.A. § 18116 and a Contractor contact phone number for doing so. The notice shall comply with the Contract requirements set forth in A.16.7 and at a minimum be available in the English and Spanish languages.
- A.3.6. The Contractor shall be responsible for providing information on how to access the provider directory, including the right to request a hard copy, how to contact member services, and how to access the searchable version of the provider directory on the Contractor's website to new members within thirty (30) calendar days of receipt of notification of enrollment in the plan. The Contractor shall also be responsible for redistribution of updated provider information on a regular basis and shall make available a complete and updated provider directory at least on an annual basis.
- a. The provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network providers, and identification of providers accepting new patients.
  - b. Member provider directories, and any revisions thereto, shall be submitted to HCFA for approval prior to distribution to members. The text of the directory shall be in Microsoft Word or Adobe (pdf) format. In addition, the provider information



used to populate the member provider directory shall be submitted as a TXT file or such format as otherwise approved by HCFA and be produced using the same extract process as the actual member provider directory.

- c. In situations where there is more than one (1) member enrolled under a Parent ID, it shall be acceptable for the Contractor to mail one (1) provider directory. Should a single individual be enrolled and be added under an existing Parent ID, a provider directory must be mailed to that individual regardless of whether or not a provider directory has been previously mailed to members under the existing Parent ID.
- A.4. All materials shall be worded at a 6<sup>th</sup> grade reading level, unless HCFA approves otherwise.
- A.4.1. All written materials shall be clearly legible with a minimum font size of 12pt. with the exception of member I.D. cards, unless otherwise approved by HCFA.
  - A.4.2. All written materials shall be printed with an assurance of non-discrimination that has been preapproved by HCFA.
  - A.4.3. The following shall not be used on communication material without the written approval of HCFA:
    - a. The Seal of the State of Tennessee;
    - b. The word "free" can only be used if the service is no cost to all members;
  - A.4.4. All vital documents, including but not limited to, the member handbook must be translated and available as set forth in Contract section A.16.7. Within ninety (90) days of notification from HCFA, all vital documents must be translated and available to each Limited English Proficiency group identified.
  - A.4.5. All written member materials shall notify members that auxiliary aids or services and language interpretation and translation services are available at no expense to the member and how to access those services. This information shall comply with the Contract requirements set forth in A.16.7 and at a minimum be available in the English and Spanish languages. All written member material shall include information on how individuals with disabilities can request assistance with accessing services or other program benefits. This information shall comply with the Contract requirements set forth in A.16.7 and at a minimum be available in the English and Spanish languages.
  - A.4.6. All written member materials shall ensure effective communication with individuals with disabilities at no expense to the member. Effective Communication may be achieved by providing auxiliary aids or services, including, but may not be limited to: Braille, large print, and audio and shall be based on the needs of the individual member. The Contractor and its providers and direct service subcontractors shall be required to comply with Title III of the Americans with Disabilities Act of 1990 in the provision of auxiliary aids and services to members to achieve effective communication. In the event that the provision of auxiliary aids and services to a member is not readily achievable by the Contractor's providers or direct service subcontractors, the Contractor shall provide the member with the auxiliary aid or service that would result in effective communication with the member.
  - A.4.7. The Contractor shall provide written notice of any changes in policies or procedures described in written materials previously sent to members at least thirty (30) days before the effective date of the change to provide CoverKids an opportunity to review prior to the changes taking effect.
  - A.4.8. The Contractor shall be responsible for postage on all mailings sent out by the Contractor.



- A.5. All member materials must be provided as described and the materials must adhere to the requirements as described and must not mislead, confuse, or defraud the members or the State. Failure to comply with the communication limitations contained in this Contract, including but not limited to the use of unapproved and/or disapproved communication material, may result in the imposition by HCFA of one or more monetary assessments as provided in Attachment C of this Contract.

## **MEMBER SERVICES**

- A.6 The Contractor shall provide a Member Services Line and Provider Services Line, providing statewide, toll-free phone lines manned by qualified benefit specialists and for the exclusive purpose of handling inquiries from enrollees and providers. This line shall be available on regular business days Monday through Friday. Since Tennessee spans two time zones, this service shall be operated from 7:00 a.m. Central Standard Time to 5:00 p.m. Central Standard Time and corresponding hours during periods of Daylight Savings Time. The member service lines shall be adequately staffed and individuals trained to accurately respond to questions regarding covered services, to assist members in locating a participating dental provider, and other issues. The Average Speed of Answer (ASA) is defined as the amount of time elapsing between the time a call is received into the phone system and when a live member services representative answers the phone. During operational hours, the Contractor's Member Services Line and Provider Services Line shall provide free real time, third-party telephonic oral interpreter services to callers who are Individuals with Limited English Proficiency. The Contractor's Member Services Line and Provider Services Line shall be equipped with a Telecommunications Relay Service ("TRS") in order to service the hearing and speech impaired populations.
- A.6.1. Member Services Line - The ASA by a live member services representative of incoming enrollee services calls shall be thirty (30) seconds or less. The abandonment rate of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period. Less than 5% of telephone calls are to be abandoned by the Member Services line. Failure to comply may result in monetary assessment as listed in Attachment C.
- A.6.2. Provider Services Line – Eighty-five percent (85%) of incoming Provider Services calls shall be answered by a Provider Services representative within thirty (30) seconds or the prevailing benchmark stabled by NCQA. Telephone Response time is defined as the number of calls answered by a live voice within thirty (30) seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period. Less than 5% of telephone calls are to be abandoned by the Provider Services Line. Failure to comply may result in monetary assessment as listed in Attachment C.
- A. 7. Interpreter and Translation Services
- A.7.1. The Contractor shall develop written policies and procedures for the provision of language assistance services, including providing language interpreter and translation services and auxiliary aids and services to any member who needs such services, including but not limited to, members with Limited English Proficiency and members who are hearing and speech impaired.



- A.7.2. The Contractor shall provide language assistance services, including interpreter and translation services and auxiliary aids and services free of charge to members.
- A.7.3. Language assistance services shall ensure effective communication with members. This effective communication assistance should be available in the form of auxiliary aids or services, which include, but are not limited to in-person interpreters, sign language or access to telephonic assistance, such as the ATT TRS universal line.
- A.8. The Contractor shall make free of charge TRS/TDD/TDY services available to members.
- A.9. The Contractor shall distribute information on how to access the provider directory, including the right to request a hard copy, to all members (or heads of households), within thirty (30) days of initial enrollment, and upon request, such list shall include current provider address(es), telephone numbers, office hours, languages spoken, specialty and whether or not the provider is accepting new patients. The Contractor shall also be responsible for making available updated provider information on a regular basis and shall redistribute a complete and updated provider directory at least on an annual basis. All provider directories shall be approved by HCFA prior to the Contractor's distribution.
- A.10. The Contractor shall be required to provide identification cards to CoverKids members; however, the Contractor shall provide HCFA with a written process detailing how members and providers will access information, including but not limited to, pertinent phone numbers for member services, provider identification of eligible individuals and access to prior authorization procedures, etc.

**BENEFITS**

- A.11. The Contractor shall be responsible for ensuring that the benefits itemized below in CoverKids Dental Service Category are provided for enrollees under age 19 enrolled in CoverKids.

**CoverKids Dental Service Category**

DENTAL BENEFITS	GROUP ONE CHILD	GROUP TWO CHILD	AMERICAN INDIAN/ ALASKAN NATIVE (AI/AN) CHILD
<b>Preventive</b> -- Fluoride treatments (1 year of age and older) or fluoride varnish not to exceed twice a calendar year up to age 14 -- Dental sealants for permanent molars, no limit -- 2 cleanings per calendar year	No copayment	No copayment	No copayment
<b>Diagnostic Services</b> -- 2 oral exams per calendar year	No copayment	No copayment	No copayment
<b>Emergency Services</b> -- 2 visits per calendar year during office hours -- 2 visits per calendar year after office hours	\$15 copayment	\$5 copayment	No copayment
<b>Restorative Services</b> -- Stainless steel crowns -- Routine fillings (silver or tooth colored)	\$15 copayment	\$5 copayment	No copayment
<b>Extractions</b>	\$15 copayment	\$5 copayment	No copayment



<b>Radiographs</b> -- Bitewing x-rays no more frequently than once per calendar year (2 years of age and older) -- Full mouth x-rays no more frequently than once every three calendar years	No copayment	No copayment	No copayment
<b>Therapeutic Pulpotomy</b>	\$15 copayment	\$5 copayment	No copayment
<b>Anesthesia</b>	\$15 copayment	\$5 copayment	No copayment
<b>Other Dental Services</b>	\$15 copayment	\$5 copayment	No copayment
<b>Orthodontics Services</b> • 12-month waiting period*	\$15 copayment	\$5 copayment	No copayment
<b>Deductibles</b>	None	None	None
<b>Annual Benefit Maximum per child</b>	\$1,000	\$1,000	\$1,000
<b>Lifetime Orthodontics Maximum amount person**</b>	\$1250	\$1250	\$1250
<b>Annual Out of Pocket Maximum as a Percentage (%) of Family Income per calendar year</b>	5%	5%	Not applicable

Note: The copayments indicated are the maximum amounts allowable per visit. No more than one copayment can be charged for a single visit.

\* Children enrolled in CoverKids must wait 12 months of continuous coverage before they can obtain orthodontic benefits.

\*\* The Lifetime Orthodontics Maximum limit is not applicable to the family's five percent (5%) cost sharing.

A.11.1. The benefit shall not exceed \$1,000 per child per calendar year. For the purpose of the annual maximum, the time period will be the twelve months of the calendar year initiated by the child's original effective date of coverage (beginning of a month). Calendar year 2015 will begin no later than January 1, 2015 and extend to December 31, 2015.

A.11.2. Notwithstanding the benefit cap of \$1,000 per child, the Contractor shall, at a minimum, provide to each enrollee the services required by the basic dental package detailed below.

<b>DENTAL SERVICE CATEGORY</b>		
<b>Provided during a calendar year without consideration of the benefit cap of \$1,000</b>		
<b>Type of Dental Service</b>	<b>Frequency during a calendar year</b>	<b>Service by Dental Code</b>
<b>Preventive</b>	No less than one service	D1120
<b>Diagnostic Services</b>	No less than one service	D0120 D0150
<b>Emergency Services</b>	No less than two services	D9110 D9440
<b>Restorative Services</b>	No less than two services	D2140 D2150



		D2160 D2330 D2331
<b>Extractions</b>	No less than two services	D7140 D7210 D7250
<b>Radiographs</b>	No less than one service	D0210 D0220 D0230 D0270 D0272
<b>Anesthesia</b>	Whenever medically indicated	D9230 D9248
<b>Orthodontics</b>	12 month waiting period	D8020 D8050 D8060 D8070 D8080 D8090 D8210 D8220 D8660 D8670 D8680 D8690 D8692 D8999

- A.11.3. The list of complete dental service categories by CDT Codes, subject to medical necessity determination by the Contractor, is located in Attachment D, Dental Service Categories by Dental CDT Codes.
- A.11.4. The Contractor shall maintain a year to date calculation of all copayments required by Enrollees. The Contractor shall also maintain, in its enrollment database, an indicator which identifies Enrollees that are subject to the application of the five percent (5%) out of pocket cap during any specific calendar year. This five percent (5%) out of pocket maximum is accumulated across all benefits (medical, vision, and dental).
- A.11.5. In instances where an enrollee is no longer required to pay a copayment for a service (the enrollee has met the five percent (5%) out of pocket cap through medical, dental or a combination of these) the Contractor shall pay the provider the full allowable amount. In these cases, the Contractor shall apply the allowable amount less the applicable copayment to the \$1,000 payment cap.

## **COST SHARING**

- A.12. The Contractor shall report cost sharing requirements, based upon claims filed by providers, to the Medical Plan Administrator on a daily basis. The Medical Plan Administrator provides



comprehensive health coverage to CoverKids members. The information, which shall include patient name, date of service and patient copayment/coinsurance, shall be transmitted to the Medical Plan Administrator in an encrypted, secure electronic file via that data transfer method specified in advance by HCFA. The Medical Plan Administrator shall report to the Contractor on a daily basis the information on enrollees who have met or exceeded the five percent (5%) out of pocket maximum. The Medical Plan Administrator and the Contractor are expected to enter into a business trading agreement, as required by the Health Insurance Portability and Accountability Act.

- A.13. When advised by the Medical Plan Administrator that the plan enrollee has reached or exceeded the out of pocket maximum, the Contractor shall provide information through written correspondence to the plan enrollee advising them that for the balance of the plan year that they will no longer be required to pay copayments/coinsurance for covered dental expenses. The Contractor shall not have responsibility for the reimbursement to the family when the 5% out of pocket maximum has been met. In situations where the family has exceeded the 5% out of pocket maximum, the Medical Plan Administrator and the and Contractor will be responsible for notifying the providers of the provider's responsibility to reimburse the family.
- A.14. The Contractor shall maintain a process, through a service center, that would enable providers to verify that the plan enrollee has reached or exceeded their annual out of pocket maximum.
- A.15. Network providers or collection agencies acting on the provider's behalf may not bill enrollees for amounts other than applicable cost sharing responsibilities for CoverKids. Providers may seek payment from an enrollee in the following situation: If the service(s) is not covered by CoverKids, the provider shall inform the enrollee the service(s) is not covered prior to providing the service. The provider is required to inform the enrollee of the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service. The provider may bill the enrollee the total amount specified in the provider participation agreement. Non-covered services will not apply to any service or benefit maximum accumulators.

## **MEMBER RIGHTS AND RESPONSIBILITIES**

- A.16. The Contractor shall demonstrate a commitment to treating members in a manner that acknowledges their rights and responsibilities.
  - A.16.1. Written Policy and Procedure on Member Rights - The Contractor shall have a written policy and procedure that recognizes the following rights of members including but not limited to the following:
    - a. to be treated with respect, and recognition of their dignity and need for privacy;
    - b. to be provided with information about the Contractor, its services, the practitioners providing care, and members' rights and responsibilities;
    - c. to be able to choose dentists within the limits of the plan network, including the right to refuse care from specific practitioners;
    - d. to participate in decision making regarding their dental care;
    - e. to voice complaints or appeals about the Contractor or care provided;
    - f. to be guaranteed the right to request and receive a copy of his or her dental records, and to request that they be amended or corrected as specified in 45 CFR part 164;
    - g. to be guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
    - h. to be free to exercise his or her rights, and that that exercise of those rights does not adversely affect the way the DBM and its providers or the State agency treat the member, and



- i. to be guaranteed the right to receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand.
- A.16.2. Written Policy and Procedure on Member Responsibilities - The Contractor shall have a written policy and procedure that addresses members' responsibility for cooperating with those providing dental care services. This written policy addresses member's responsibility for:
- a. providing, to the extent possible, information needed by professional staff in caring for the member, and
  - b. following instructions and guidelines given by those providing dental care services.
- A.16.3. Communication of Policies to Providers - A copy of the Contractor's policies and procedures on member's rights and responsibilities shall be provided to all participating providers.
- A.16.4. Communication of Policies and Procedures to Members - Upon enrollment, members shall be provided with a written statement that includes information on the following:
- a. rights and responsibilities of members
  - b. benefits and services included and excluded as a condition of membership, and how to obtain them, including a description of:
    - (1) any special benefit provisions (for example, co payment, higher deductibles, rejection of claim) that may apply to services obtained outside the system; and
    - (2) the procedures for obtaining out of area coverage;
  - c. provisions for emergency coverage;
  - d. the Contractor's policy on referrals for specialty care;
  - e. charges to members, if applicable, including:
    - (1) policy on payment of charges; and
    - (2) co payment and fees for which the member is responsible;
  - f. procedures for notifying those members affected by the termination or change in any benefits, services, or service delivery office/site;
  - g. procedures for appealing decisions adversely affecting the member's coverage, benefits, or relationship to the organization;
  - h. procedures for changing practitioners;
  - i. procedures for voicing complaints and/or appeals and for recommending changes in policies and services.
- A.16.5. Member Complaint and Appeal Procedures - The Contractor shall have a system(s), linked to the Quality Monitoring Program (QMP), for resolving member's complaints and appeals. This system shall include:
- a. procedures for registering and responding to complaints and appeals in a timely fashion (Contractor shall establish and monitor standards for timeliness);
  - b. documentation of the substance of complaints or appeals, and actions taken;
  - c. procedures to ensure a resolution of the complaint or appeal;
  - d. aggregation and analysis of complaint and appeal data and use of the data for quality improvement, and
  - e. an appeal process for adverse actions.
- A.16.6. Steps to Assure Accessibility of Services - The Contractor shall take steps to promote accessibility of services offered to members. These steps include:



- a. the points of access to dental services, specialty care, and hospital or ambulatory surgical center services are identified for members; and
  - b. at a minimum, members are given information about:
    - (1) how to obtain services during regular hours of operations;
    - (2) how to obtain emergency care, and
    - (3) how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care.
- A.16.7. Written Information for Members shall comply with the requirements of this Contract, which includes, but is not limited to, Section A.39, set forth below, and the following:
- a. Member information (for example, subscriber brochures, announcements, handbooks) is written on a 6th grade reading level that is easily understood, and
  - b. Written information is available, as needed, in the languages of the major population groups served. A "major" population group is one which represents at least 10 percent (10%) of a plan's population or three thousand (3,000) members, whichever is less. All vital documents and the member handbook must be available at the minimum in the English and Spanish languages. All vital documents shall be available to Limited English Proficiency groups identified by CoverKids that constitutes five percent (5%) of the CoverKids population or one thousand (1,000) members, whichever is less.
- A.16.8. Confidentiality of Member Information - The Contractor shall ensure that the confidentiality of specified patient information and records is protected.
- a. The Contractor shall establish in writing, and enforced policies and procedures on privacy and confidentiality, including confidentiality of medical records.
  - b. The Contractor shall require that patient care offices/sites have implemented mechanisms that guard protected information in all forms, including but not limited to electronic and physical, against the unauthorized or inadvertent disclosure of confidential information to persons outside of the dental care organization.
  - c. The Contractor shall hold confidential all information obtained by its personnel about members related to their examination, care and treatment and shall not divulge it without the member's authorization, unless:
    - (1) it is required by law;
    - (2) it is necessary to coordinate the member's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment, or
    - (3) it is necessary in compelling circumstances to protect the health or safety of an individual.
  - d. Any release of information in response to a court order is reported to the member in a timely manner.
  - e. In accordance with the requirements set forth at 45 C.F.R 164.501, member records may be disclosed, whether or not authorized by the member, to qualified personnel for the purpose of conducting scientific research, but these personnel may not identify, directly or indirectly, any individual member in any report of the research or otherwise disclose participant identity in any manner.
- A.16.9. Assessment of Member Satisfaction - The Contractor shall conduct quarterly surveys of member satisfaction with its services.
- a. The surveys shall include content on perceived problems in the quality, availability, and accessibility of care.
  - b. As a result of the surveys, the Contractor shall:



- (1) identify and investigate sources of dissatisfaction;
  - (2) outline action steps to follow up on the findings, and
  - (3) inform providers of assessment results.
- c. The Contractor shall reevaluate the effects of the above member satisfaction survey and notify HCFA within ten (10) business days regarding any ongoing problems determined by the survey.
- d. In accordance with the requirements set forth in 42 U.S.C. § 300kk, the Contractor shall develop and maintain the ability to collect and report data on race, ethnicity, sex, primary language, and disability status for applicants and members and from applicants' and members' parents or legal guardians if applicants or members are minors or legally incapacitated individuals. In collecting this data the Contractor shall use the Office of Management and Budget (OMB) standards, at a minimum, for race and ethnicity measures. Data collection standards for Race, Ethnicity, Sex, Primary Language, and Disability Status are available from the Office of Minority Health and on its website located at:  
<http://www.minorityhealth.hhs.gov/templates/content.aspx?ID=9227&lvl=2&lvlID=208>.

## COMPLAINTS AND APPEALS

- A.17. The Contractor shall maintain a formal grievance procedure by which enrollees and providers may appeal decisions regarding benefits administration, medical necessity determinations, and disputes arising from the utilization management program. At Contract implementation, the Contractor shall provide to the State two (2) written copies describing in detail the Contractor's grievance procedures. The State reserves the right to review the procedure and make recommendations.
- A.18. The State appeals process is available to enrollees after the Contractor's appeal process has been exhausted. The Contractor shall have the appropriate qualified professionals available to participate in the State appeal process and to be available to personally attend the State appeals meetings when requested by the State. The Contractor shall have a qualified individual available to provide support to the State Appeals Coordinator in the research and development of appeals. Should the State override the Contractor's decision in an appeal, and mandate benefits that are not covered in the Member Handbook (MH), the State shall directly fund the costs of those benefits and reimburse the Contractor for the costs.
- A.19. The Contractor shall respond to all inquiries in writing from the state within one (1) week after receipt of said inquiry. In cases where additional information to answer the State's inquiry is required, the Contractor shall notify the State immediately as to when the response can be furnished to the State.
- A.20. Members shall have the right to file appeals regarding adverse actions taken by the Contractor. For purposes of this requirement, an appeal shall mean a member's right to contest verbally or in writing, any adverse action taken by the Contractor to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the Contractor that impair the quality, timeliness, or availability of such benefits. An appeal may be filed by the member or by a person authorized by the member to do so, including but not limited to, a provider with the member's consent. Complaint shall mean a member's right to contest an action taken by the Contractor or service provider that does not meet the definition of an adverse action. The Contractor shall inform members of their complaint and appeal rights in the member handbook in compliance with Contract Section A.39 requirements.
- A.21. The Contractor shall have internal complaint and appeal procedures for members in accordance with CoverKids rules and regulations governing the appeals process. The Contractor shall devote



a portion of its regularly scheduled QMP committee meetings to the review of received member complaints and appeals.

- A.22. The Contractor shall ensure that punitive action is not taken against a provider that files an appeal on behalf of a member with the member's consent, supports a member's appeal, or certifies that a member's appeal is an emergency appeal and requires an expedited resolution in accordance with CoverKids policies and procedures.
- A.23. The Contractor's appeal process shall provide for a contact person who is knowledgeable of appeal procedures and directs all appeals, whether the appeal is verbal or the member chooses to file in writing to CoverKids. Should a member choose to appeal in writing, the member will be instructed to file by mail or by facsimile to the designated CoverKids P.O. Box or fax number for medical appeals.
- A.24. The Contractor shall educate its staff concerning the importance of the appeals procedure, the rights of the member, and the time frames that action must be taken by the Contractor for the handling and disposition of an appeal. As part of the appeal procedure, the Contractor shall identify the appropriate individual or body within the plan having the decision-making authority.
- A.25. The Contractor shall ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, HCFA CoverKids rules and regulations, and appeal procedures, as they become effective. HCFA may develop additional appeal process guidelines or rules, including requirements for the content and timing of notices to members that shall be followed by the Contractor.
- A.26. The Contractor shall provide general and targeted education to providers regarding expedited appeals (described in HCFA CoverKids rules and regulations), including when an expedited appeal is appropriate and procedures for providing written certification and shall require providers to give written certification concerning whether an member's appeal is an emergency when requested by an member prior to filing such appeal, or upon reconsideration of such appeal by the Contractor when requested by HCFA.
- A.27. The Contractor shall provide notice to contracted providers regarding provider responsibility in the appeal process, including, but not limited to, the provision of medical records and/or documentation.
- A.28. Member eligibility and eligibility-related grievances and appeals, including termination of eligibility, effective dates of coverage, and the determination of premium and co-payment responsibilities shall be directed to the Tennessee Health Connection P, O. Box 305240, Nashville, TN 37230-5240.
- A.29. If determined by HCFA that the Contractor violated the appeal guidelines, HCFA shall require that the Contractor submit and follow through with a corrective action plan. Failure to comply with the appeal guidelines issued by HCFA, including an acceptable corrective action plan, may result in the Contractor being subject to possible monetary assessments as specified in Attachment C.

## **CLAIMS PROCESSING**

- A.30. The Contractor shall process all dental claims in strict accordance with the CoverKids Member Handbook, and its clarifications and revisions. The Contractor may not modify these benefits during the term of this Contract without the approval of the State. Upon agreement of the State and the Contractor, the Contractor shall modify its benefits administration system to reflect approved Plan benefit amendments (new, changed, or cancelled) within thirty (30) days of the parties' mutual agreement of the amendments. Should said benefit amendment(s) not be effective within thirty (30) days, the Contractor shall have until the effective date of the amendment to modify its benefits administration system.



- A.31. The Contractor shall ensure that the majority of all claims will be paperless for the enrollees. Providers will have the responsibility through their contract with the Contractor to submit claims directly to the Contractor.
- A.32. The Contractor shall ensure the electronic data processing (EDP) environment (hardware and software), data security, and internal controls meet all present standards, and will meet all future standards, required by the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 and the Health Information Technology for Economic and Clinical Health (HITECH) Act, as part of the American Recovery and Reinvestment Act of 2009. Said standards shall include the requirements specified under each of the following HIPAA subsections:
- Electronic Transactions and Code Sets
  - Privacy
  - Security
  - National Provider Identifier
  - National Employer Identifier
  - National Individual Identifier
  - Claims attachments
  - National Health Plan Identifier
  - Enforcement
- A.32.1. The Contractor shall maintain an EDP and electronic data interface (EDI) environment that meets the requirements of this Contract and meets the privacy and security requirements of HIPAA and HITECH. The Contractor must maintain its disaster recovery plan for restoring the application software and current master files and for hardware backup if the production systems are destroyed.
- A.32.2. To maintain the privacy of personal health information, the Contractor agrees to accept and use a method of secure email for daily communications between the Contractor and the State that is approved by the State.
- A.33. The Contractor shall confirm eligibility of each enrollee as claims are submitted on the basis of the enrollment information provided by the State, which applies to the period during which the charges were incurred. The Contractor shall process said claims, in an accurate manner, either filed directly by enrollees and/or the provider(s). Failure to comply may result in monetary assessment as listed in Attachment C.
- A.33.1. Claims Payment Dollar Accuracy - The average quarterly financial accuracy for claims payments shall be ninety-nine percent (99%) or higher. Claims Payment Dollar Accuracy is defined as the absolute value of financial errors, inclusive of both human and system generated, divided by the total paid value of Contractor audited dollars paid.
- A.33.2. Claims Processing Accuracy - The average quarterly processing accuracy shall be ninety-seven percent (97%) or higher. Claims Processing Accuracy is defined as the absolute number of claims with no in processing or procedural errors, divided by the total number of claims within the audit sample. This excludes financial errors.
- A.33.3. Claims Turnaround Time - The average quarterly claims payment turnaround time will not be greater than: thirty (30) business days for ninety-seven percent (97%) of all claims. Claims Turnaround Time is measured from the date the claim is received in the office to the date processed, including weekends and holidays.
- A.34. The State shall establish all Plan benefits, and have the authority to approve the Member Handbooks. Said approval shall not unreasonably be withheld.
- A.34.1. The State shall have responsibility for and authority to clarify and/or revise the benefits available through CoverKids, but these must be agreed to by Contractor, since the coverage is fully insured coverage.



- A.34.2. The Contractor shall, when processing/adjudicating claims, employ its medical necessity guidelines to the extent that those guidelines do not conflict with or limit the provisions as outlined in the CoverKids Member Handbook.
- A.35. To ensure the efficient and timely processing of claims and the adequate capture of data, the Contractor shall provide enrollees with identification cards. Identification cards shall contain unique identifiers for each enrollee, however, such identifier shall NOT be the member's federal Social Security Number. The cost of these items shall be borne by the Contractor. The State reserves the authority to review any claim forms and identification cards prior to issuance for use.

## CUSTOMER AND ADMINISTRATIVE SERVICES

- A.36. The Contractor shall maintain a full service staff to respond to inquiries, correspondence, complaints and problems. The Contractor shall designate an individual with overall responsibility for administration of this Contract. The Contractor shall answer, in writing, within ten (10) business days ninety percent (90%) of all written inquiries from Enrollees concerning requested information, including the status of claims submitted and benefits available through the CoverKids plan, its clarifications and revisions.
- A.37. The State shall consult with Contractor on proposed revisions to the CoverKids benefits. When so requested, the Contractor shall provide information regarding:
- Industry practices;
  - The overall cost impact to the program;
  - Any cost impact to the Contractor's fee;
  - Impact upon utilization management performance standards;
  - Necessary changes in the Contractor's reporting requirements, and
  - System changes.
- A.38. Both parties of this Contract shall meet periodically, but no less than quarterly, to discuss any problems and/or progress on matters outlined by either party.
- A.38.1. The Contractor shall have in attendance, the representatives from its organizational units required to respond to topics indicated by the State's agenda. The Contractor shall provide advice, assistance and information to the State regarding applicable existing and proposed Federal and State laws and regulations affecting managed care entities.
- A.38.2. The State shall have in attendance, when requested by the Contractor, the representatives from its organizational units required to respond to topics indicated by the State's agenda.
- A.39. The Contractor shall, in consultation with and following approval by the State, print and distribute all Member Handbooks, identification cards, provider directories, letters, administrative forms and manuals pertaining to or sent to enrollees. Additionally, the Contractor shall develop and print Member Handbooks detailing the benefits, procedures for accessing services, and other information helpful to enrollees. Member Handbooks and Provider Network Directories shall be distributed to enrollees within ten (10) calendar days of the effective date of enrollment or to individuals requesting information within five (5) business days of the request. The handbook and provider directory may be a single document. Failure to comply may result in monetary assessment as listed in Attachment C.
- A.40. The Contractor shall have available an up-to-date web-site dedicated to CoverKids that shall aid providers and enrollees in all aspects of the dental program. The web-site shall be available for HCFA approval at least one (1) month prior to the commencement of claims processing and be available on the internet two (2) weeks prior to the commencement of claims processing. The web-site shall contain a home page with general dental information with links to dedicated areas for CoverKids providers and enrollees. Each of these sections shall contain information that shall



answer, in an interactive format, the majority of questions that each group would ask. This shall include, but is not limited to:

A.40.1. Home Page, which includes:

- (1) General information related to dental benefit, and recent changes occurring within the CoverKids Dental Program, including pertinent fact sheets, and
- (2) Navigation tool bar that links to enrollee information, provider information, finding a dentist, policy and guidelines.

A.40.2. Provider Page, which includes:

- (1) Applying to become a participating provider;
- (2) Provider credentialing and recredentialing;
- (3) Provider Office Reference Manual;
- (4) Current Dental Fee Schedule;
- (5) Program policies and procedures;
- (6) Procedures for obtaining Prior Authorizations (PA's);
- (7) Printable provider education material;
- (8) Provider newsletters;
- (9) Procedures for electronic billing;
- (10) Fluoride varnish program;
- (11) Information about Peer Review Committee, and
- (12) Call Center hours of operation and contact numbers.

A.40.3. Enrollee Page, which includes:

- (1) A description of CoverKids services provided including limitations, exclusions and out-of-network use;
- (2) Member Handbook including provider directory;
- (3) Call Center hours of operation and contact numbers;
- (4) Copay information;
- (5) Language assistance services;
- (6) Printable education material specific to enrollees;
- (7) On-line search, by address or zip code, to locate the network dentists nearest to the enrollee;
- (8) Privacy and Security information regarding enrollee records;
- (9) Privacy Assistance for individuals with disabilities, and
- (10) Discrimination complaint forms and Notice of Fair treatment.

A.41. The Contractor shall perform, following review and approval by the State, Participant customer satisfaction surveys. The survey shall be conducted no more frequently than once during each calendar year at a time mutually agreed upon by the State and the Contractor but no later than the month of October. The survey shall involve a statistically valid random sample of parents and/or guardians of enrollees. The State reserves the right to review and mandate changes in the survey it feels are necessary to obtain valid, reliable, unbiased results. Those changes may include, but are not limited to, changes in the research design, units of analysis or observation, study dimension, sample size, sample frame, sample method, coding, or evaluation method. Based upon the results of the survey, the Contractor and the State shall jointly develop an action plan to correct problems or deficiencies identified through this activity.

A.41.1. The Participant Satisfaction shall be measured utilizing the most current National Committee on Quality Assurance (NCQA) Adult Participant Satisfaction Survey question that measures overall satisfaction.

A.41.2. The level of overall customer satisfaction, as measured annually by a State approved enrollee satisfaction survey(s), will be equal to or greater than eighty-five percent (85%) in the first year of the Contract, and ninety percent (90%) in all subsequent year(s) within the Contract term. Failure to comply may result in monetary assessment as



listed in Attachment C.

- A.42. The Contractor shall conduct a provider satisfaction survey of the participating network dentists and dental specialists, following approval by the State of the form, content and proposed administration of the survey, each October or November and report the results to the State by January 30 of the following year.
- A.43. The Contractor shall meet and confer at least twice each calendar year with representatives of a dental services provider organization designated by the State to discuss plan operations and network participation issues. The State shall be provided an opportunity to attend and observe the Contractor's sessions.

## ENROLLMENT AND DISENROLLMENT

- A.44. CoverKids is responsible for the enrollment of members in the Contractor's plan. The Contractor shall accept daily eligibility data from the State
  - A.44.1. The Contractor shall accept the member in the health condition the member is in at the time of enrollment.
  - A.44.2. Enrollment shall begin at 12:01 a.m. on the effective date that the member is enrolled in the Contractor's plan and shall end at 12:00 midnight on the date that the member is disenrolled pursuant to the criteria in HCFA CoverKids policy and/or rules and regulations.
- A.45. HCFA is responsible for the disenrollment of members from the Contractor's plan. The Contractor shall not disenroll members. The Contractor, may, however, provide HCFA with any information it deems appropriate for HCFA's use in making a decision regarding loss of eligibility or disenrollment of a particular Member.
  - A.45.1. No member shall be disenrolled from a health plan for any of the following reasons: Adverse changes in the member's health; Pre-existing medical conditions; High cost medical bills, a change in the member's health status, or because of the member's utilization of dental services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the plan seriously impairs the entity's ability to furnish services to either this particular member or other members); or failure or refusal to pay applicable cost-sharing fees, except when HCFA has approved such disenrollment.
  - A.45.2. The Contractor's responsibility for disenrollment shall be to inform HCFA promptly when the Contractor knows or has reason to believe that a member may satisfy any of the conditions for disenrollment described in CoverKids policy and/or rules and regulations. Actions taken by HCFA and/or HCFA decisions regarding loss of eligibility or disenrollment of a particular Member cannot be appealed by the Contractor.

## STAFFING

- A.46. The Contractor shall have total responsibility for hiring and management of any and all Contractor staff as determined necessary to perform the services in accordance with the terms of this Contract and shall provide a proposed staffing plan for review and approval by HCFA. The Plan shall include at a minimum, key staff identified below and corresponding job descriptions.
- A.47. Staff Requirements
  - A.47.1. The Contractor shall be responsible for assuring that all persons, whether they be employees, agents, subcontractors, providers or anyone acting for or on behalf of the Contractor, are legally authorized to render services under applicable state law and/or



regulations. Failure to adhere to this provision may result in one (1) or more of the following sanctions that shall remain in effect until the deficiency is corrected:

- a. CoverKids may refuse to approve or may rescind the approval of subcontracts with unlicensed persons;
  - b. CoverKids may refer the matter to the appropriate licensing authority for action;
  - c. CoverKids may assess monetary assessments provided by Attachment C of this Contract; and
  - d. CoverKids may terminate this Contract for cause defined by Section D.4. of this Contract.
- A.47.2. The Contractor shall provide to HCFA documentation verifying that all staff employed by the Contractor or employed as a sub-contractor are licensed to practice in his or her area of specialty. This documentation shall be supplied at the execution of this Contract and annually thereafter, due on September 15 of each year of the Contract.
- A.47.3. The Contractor shall provide HCFA with copies of resumes and job descriptions for all persons employed under this Contract. HCFA reserves the right, at its sole discretion, to request dismissal of Contractor staff and sub-contracted staff based on performance deficiencies and/or lack of knowledge, skills or demonstrated expertise necessary to perform contracted activities.
- A.47.4. The Contractor shall ensure that all Contractor staff and sub-contracted staff are trained and knowledgeable regarding all applicable aspects of the CoverKids Dental Program.
- A.47.5. A training plan shall be submitted and approved by HCFA within ten (10) business days of the execution of this Contract. Contractor shall be responsible for providing training to any newly hired Contractor staff and sub-contracted staff prior to those individuals performing any reviews. Training for newly hired Contracted staff and sub- contracted staff shall be approved by HCFA in advance.
- A.47.6. The Contractor shall employ competent staff in all key positions listed below. If any key position becomes vacant, the Contractor shall employ an adequate replacement within sixty (60) days of the vacancy unless HCFA grants an exception in writing to this requirement.
- A.47.8. The Contractor shall provide staff that is current and knowledgeable in their respective areas of expertise. This staff shall provide quality consultation and technical assistance services regarding all matters pertaining to dental benefits.
- A.47.9. The Contractor shall, at a minimum, have at least fifty percent (50%) of its staff in the core disciplines available during the hours of 8:00 a.m. to 4:30 p.m. Central Standard Time, Monday through Friday, as required to fulfill the scope of services specified in this Contract.
- A.48. Staff Dedicated to CoverKids Program - The Contractor shall maintain sufficient levels of staff, including supervisory and support staff, with appropriate training, work experience, and expertise to perform all contract requirements on an ongoing basis and be available to attend meetings as requested by HCFA. The Contractor staff shall include but is not limited to the following personnel:
- A.48.1. DBM Project Director - The Contractor shall designate and maintain, subject to HCFA approval, a full-time Project Director dedicated to this Contract who has day-to-day



authority to manage the total project. The Project Director shall be readily available to HCFA staff during regular working hours.

- A.48.2. DBM Dental Director - The Contractor shall designate and maintain, subject to HCFA approval, a Dental Director dedicated to this Contract who has authority to manage the clinical aspects of the project. A dentist who is licensed by the Tennessee Board of Dentistry, in good standing, and physically located in the State of Tennessee shall serve as DBM Dental Director to oversee and be responsible for the proper provision of medically covered services for members. The DBM Dental Director shall be closely involved in the monitoring of program integrity, quality, utilization management and utilization review, provider corrective action, site visits, credentialing processes, and Performance Improvement Projects (PIPs).
- A.48.3. Regulatory Compliance Manager – The Contractor shall designate and maintain, subject to HCFA approval, a Regulatory Compliance Manager. The Regulatory Compliance Manager shall possess a thorough knowledge regarding investigations related to provider fraud and abuse in the CoverKids program and will be the key staff handling day-to-day provider investigation related to inquiries from HCFA and TBI MFCU.
- A.48.4. Provider Network Director – The Contractor shall designate and maintain, subject to HCFA approval, a Provider Network Director, responsible for network development and management to ensure that there is a statewide dental network adequate to make services, service locations and service sites available and accessible in accordance with the terms and conditions for access and availability outlined in the contract. The Provider Network Director shall coordinate with other areas of the Contractor's organization that may impact provider recruitment, retention or termination. The Provider Network Director will also ensure that the provider enrollment file and the Insure Kids Now (IKN) files are accurate and delivered to HCFA timely. The Provider Network Director shall have a provider service line staffed adequately to respond to providers' questions during normal business hours, including appropriate and timely responses regarding prior authorization requests as described in this Contract. The provider service lines shall be adequately staffed and trained to accurately respond to questions regarding the CoverKids program. The Contractor shall adequately staff the provider service line to assure that the average wait time for assistance does not exceed ten (10) minutes. Difficult provider network questions and or complaints should be referred and fielded by the Provider Network Director. Supervision of provider representatives as described below, is also the responsibility of the Provider Network Director.
- A.48.5. Provider Representatives – The Contractor shall designate and maintain, subject to HCFA approval, a minimum of two (2) Provider Representatives to educate and assist participating dental providers in working with utilization management programs including, but not limited to, prior authorization requests, electronic billing, compliance initiatives, or other program requirements.
- A.48.6. Complaint and Appeals Coordinator – The Contractor shall designate and maintain, subject to HCFA approval, one (1) Complaint and Appeals Coordinator to process member complaints and appeals within specified time frames and in accordance with CoverKids requirements. The Complaint and Appeals Coordinator shall ensure compliance with all member notice requirements and notice content requirements specified in applicable state and federal law.
- A.48.7. Data Research Analyst – The Contractor shall designate and maintain, subject to HCFA approval, one (1) Data Research Analyst responsible for generating daily, weekly, monthly, quarterly and yearly reports required by the Contract, in addition to all ad hoc requests made by HCFA, in formats as requested. The Data Research Analyst shall be expert in data that is warehoused by the Contractor on behalf of the



CoverKids program and shall be available to assist HCFA staff with Contractor's decision support systems. The Data Research Analyst shall provide expertise and assistance in provider post utilization review, establishing benchmarks for procedures prone to provider fraud and abuse that don't require prior authorization, evaluation of provider's treatment patterns, identification of provider outliers, and drawing statistically valid random sample (SVRS) of dental records, utilizing a ninety five percent (95%) confidence interval, specific to the procedure(s) where the provider is an outlier;

- A.48.8. System Liaison- The Contractor shall designate and maintain, subject to HCFA approval, one (1) system liaison responsible for, but not limited to the planning and timely coding of edits to the Contractor's system when requested by HCFA, the quality control of such edits to ensure proper functioning within the system, and to ensure that newly entered system changes and edits do not affect existing edits within Contractor's system causing unanticipated adverse system events affecting CoverKids' claims, members and providers. The System Liaison shall be responsible for all testing of new programs or modules to be used by Contractor to manage CoverKids' business. The System Liaison shall also be responsible for the maintenance and management of Contractor's website, including updating.
- A.48.9. Member Materials and Marketing Coordinator – The Contractor shall designate and maintain, subject to HCFA approval, one (1) Member Materials and Marketing Coordinator responsible for ensuring that all member materials including, but not limited to, member handbooks, provider directories, member newsletters, dental reminder notices, fact sheets, notices or any other materials necessary to provide information to members as developed by the Contractor, is approved by HCFA and disseminated timely.
- A.48.10. Support Staff - Sufficient support staff to conduct daily business in an orderly manner, including such functions as administration, accounting and finance, prior authorizations, appeal system resolution, and claims processing and reporting, as determined through management and medical reviews;
- a. Appeals Support Staff (clerical and professional) to process member appeals related to adverse actions effecting members.
  - b. Dentist Consultants including at a minimum, general dentist(s), pediatric dentist(s), oral surgeon(s), and orthodontist(s), whose primary duties are medical necessity determinations for authorization of dental services;
  - c. Non-discrimination Compliance Coordinator to be responsible for Contractor compliance with all applicable Federal and State civil rights laws and regulations, which include, but are 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 Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and Title IX of the Education Amendments of 1972, 42 U.S.C.A § 18116, the Church Amendments (42 U.S.C. 300 a-7), Section 245 of the Public Health Service Act (42 U.S.C. 238n.) and the Weldon Amendment (Consolidated Appropriations Act 2010, Public Law 111-117, Div. G., Section 508(d), 123 Stat. 3034, 3279-80). The Contractor does not have to require that compliance with the aforementioned federal and state laws and regulations be the sole function of the designated staff member. However, the Contractor shall identify the designated compliance staff member to HCFA by name. The Contractor shall report to HCFA in writing, to the attention of the Director of Non-Discrimination Compliance/Health Care Disparities, within ten (10) calendar days of the commencement of any period of time that the Contractor does not have a designated staff person for non-discrimination compliance. At such time that this function is redirected, the name of the staff member who



assumed the duties shall be reported in writing to HCFA within ten (10) calendar days of the change.

- d. The Contractor shall provide a toll-free telephone line accessible to members that provides information to members about how to access needed services.

A.48.11. The Contractor shall identify in writing the name and contact information for the Key contact persons within thirty (30) days of Contract award. Any changes in staff persons listed in this section during the term of this Contract must be made in writing within ten (10) business days after receipt of any required approvals from HCFA. The identity of each of the persons listed above shall be disclosed on the Contractor's web site.

## PROVIDER NETWORK

A.49. The Contractor shall maintain and administer a Plan dental provider network covering the entire State of Tennessee service area for eligible enrollees, in accordance with this Contract with coverage effective July 1, 2015. The Contractor shall maintain under contract, participation by General and Pediatric Dentists and Dental Specialists (i.e. Oral Surgeons, Endodontists, Orthodontists, Periodontist and Pedodontists) as needed and necessary to continuously provide high quality, cost effective services. Each enrollee shall be required to obtain covered services from any general or pediatric dentist in the Contractor's network accepting new patients. The Contractor shall maintain a network of dental providers with a sufficient number of providers who accept CoverKids enrollees within each geographical location in the state so that appointment waiting times do not exceed three (3) weeks for regular appointments, forty-eight (48) hours for urgent care, and that office waiting time does not exceed forty-five (45) minutes. In so doing, the Contractor shall consider the following:

A.49.1. The anticipated CoverKids enrollment;

A.49.2. The expected utilization of services, taking into consideration the characteristics and health care needs of the CoverKids population;

A.49.3. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted CoverKids services;

A.49.4. The number of network providers who are not accepting CoverKids enrollees;

A.49.5. The geographic location of providers and CoverKids enrollees, considering distance, travel time, and whether the location provides physical access for CoverKids enrollees with disabilities; and

A.49.6. Mobile dental clinics will not be considered in determining sufficient network access.

A.50. The Contractor 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.

A.51. The Contractor shall prepare monthly, a provider enrollment file by the 5<sup>th</sup> business day of each month to be submitted to the State and be analyzed utilizing GeoAccess analysis of provider accessibility using the standards outlined below and specified in Attachment C. The State shall then review the network accessibility analysis and shall inform the Contractor, in writing, of any deficiencies it identifies which deny reasonable access to dental care. The Contractor shall respond to the State, within thirty (30) calendar days and in writing, as to the action it intends to take to correct said deficiencies.

A.51.1. The Contractor shall maintain under contract a statewide network of dental providers to provide the covered services. The Contractor shall make services, service locations



and service sites available and accessible so that transport distance to general dental providers will be the usual and customary, not to exceed an average of thirty (30) miles for 100% of enrollees, as measured by GeoAccess Software, except in rural areas where community standards, as defined by CoverKids, will be applied. Exceptions must be justified and documented to the State on the basis of community standards. Failure to comply may result in monetary assessment as listed in Attachment C.

- A.51.2 If the Contractor's network is unable to provide necessary, medical services covered under the contract to a particular enrollee, the Contractor must adequately and timely cover these services out of network for the enrollee, for as long as the Contractor is unable to provide them. Out of network providers must coordinate with the Contractor with respect to payment. The Contractor must ensure that cost to the enrollee is no greater than it would be if the services were furnished within the network.
- A.51.3. If the Contractor revises the provider reimbursement methodology or payment amounts, the State shall then review the network accessibility analysis and shall inform the Contractor, in writing, of any deficiencies it identifies which deny reasonable access to dental care. The Contractor shall respond to the State, within thirty (30) calendar days and in writing, as to the action it intends to take to correct said deficiencies.
- A.51.4. The Contractor shall maintain the capability to respond to inquiries from enrollees concerning participation by dentists in the network, by specialty by county. Such capabilities shall be by toll-free telephone and web based provider search capability. The Contractor shall provide toll-free telephone line accessible to enrollees that provides information to enrollees about how to access needed services.
- A.51.5. The Contractor shall contract only with dentists who are duly licensed to provide such dental services. In addition, the Contractor shall require that all providers maintain all licenses and accreditations in existence at the time of selection as a network provider and in order to continue their status as a network provider. The Contractor shall perform on a continuous basis appropriate provider credentialing that assures the quality of network providers. Re-credentialing of network providers must be performed at least every three (3) years. The Contractor is responsible for assuring that all persons, whether they are employees, agents, subcontractors, providers or anyone acting for or on behalf of the Contractor, are legally authorized to render service under applicable state law and/or regulations.
- A.51.6. The Contractor shall maintain communication with providers to ensure a high degree of continuity in the provider base and ensure that the providers are familiar with the CoverKids benefits and procedural requirements. There must be provisions for face-to-face contact in addition to telephone and written contact for the purpose of monitoring through statistical analysis, surveys and other techniques, provider conformance with plan standards and quality requirements.
- A.52. The Contractor shall notify all network providers of and enforce compliance with all provisions relating to utilization management procedures. The Contractor shall require all network providers to file claims, associated with their services, directly with the Contractor on behalf of enrollees. Claims payment dispute or request for authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate services to an eligible CoverKids member ages 0 through 18 years of age. In the event there is a claim for emergency dental services, the party receiving a request for authorization to treat any member shall insure that the member is treated immediately and payment for the claim must be approved or disapproved based on the definition of emergency dental services. Prior authorization shall not be required for emergency services.
- A.53. The Contractor shall cooperate fully with federal and state audits the State may conduct of management to include clinical processes and outcomes, internal audits, provider networks, and any other aspect of the program the State deems appropriate. The State may select any qualified persons, or organization to conduct the audits. To the extent allowed by applicable law, the State



agrees that persons or organizations conducting audits of the Contractor shall be prohibited from disclosing confidential patient records or proprietary or confidential information reasonably designated as such by the Contractor.

- A.54. The Contractor shall maintain an internal quality assurance plan and shall provide the State with a summary of the plan indicating areas addressed, established criteria and standards, and those methods employed to evaluate results.
- A.55. If the Contractor's network is unable to provide necessary dental services covered under the contract to a particular enrollee, the Contractor must adequately and timely cover these services out of network for the enrollee, for as long as the Contractor is unable to provide them.

## **PROBLEM CHANGE AND MANAGEMENT PROTOCOL**

- A.56. Problem Change and Management Protocol - The Control Memorandum Process shall be utilized by the State and Contractor to clarify or enforce Contract requirements, to issue instruction to the Contractor or request instruction from the State, to document submission of Contract deliverables, to document required action, approval or disposition, including, but not limited to, disputes or appeals regarding actual or monetary assessments by the State. This process is intended to be a mechanism that allows for the orderly investigation, escalation, and resolution of all matters or questions occurring during the term of the Contract that do not otherwise require a contract amendment as described in Section D.2.

Each party shall designate the individual(s) authorized to initiate Control Memoranda. All Control Memoranda submitted to or by the State shall be reviewed and prioritized by the State's Project Director (or his/her designee). All Control Memoranda submitted to the Contractor shall be signed and approved by the State's Project Director (or his/her designee). All Control Memoranda submitted by the Contractor shall be signed and approved by the Contractor's authorized representative.

Each Control Memorandum issued by either the State or Contractor shall be in writing and contain a unique identification number. All Control Memoranda shall contain the history, background, and any other pertinent information regarding the issue(s) being addressed in the Control Memoranda.

The Contractor shall comply with all Control Memoranda. The Contractor's failure to complete or comply with Control Memoranda as required may result in sanctions including Monetary Assessments listed in Attachment C and possible termination of the Contract.

The various components of the Control Memorandum Process are described below. When issued by the State, the Control Memorandum may include one (1) or more of the following six (6) notices or instructions, as applicable, and shall designate a reasonable due date for Contractor's reply or other action. When the Control Memorandum pertains to monetary assessments, the State may issue consecutive Control Memoranda incorporating the applicable notices or instructions as described below.

- A.56.1. On Request Report (ORR) – a request included in the Control Memorandum issued by the State directing the Contractor to provide information by close of business on a designated due date. The State shall treat an ORR as a request for information only, and shall not use it to direct that a given task be completed. Failure to complete or comply with an ORR by the due date may result in monetary assessment of actual damages as listed in Attachment C.
- A.56.2. Control Directive - an instruction included in the Control Memorandum issued by the State that requires the Contractor to complete a certain deliverable or perform any other request from the State within the scope of the Contract, by a designated due date. Once a Control Directive has been issued with the Control Memorandum, it shall be considered to be incorporated into this Contract. The Contractor's failure to complete or comply with the Control Directive by the due date may result in the



monetary assessment of actual damages listed in Attachment C for each day the Control Directive is not completed or complied with as required.

The Control Directive may include a request for a corrective action plan (CAP) which is a plan to correct the Contractor's noncompliance with the Contract that the Contractor prepares at HCFA's request and submits to HCFA for review and approval. A CAP can be requested by HCFA at any time and it is a requirement of this Contract that Contractor responds timely within seventy-two (72) hours to the CAP request and take all CAP actions that have been approved by HCFA. The various components of a CAP are as follows:

- a. **Notice of Deficiency:** If HCFA determines that the Contractor or Contractor's subcontractor or provider is not in compliance with a requirement of this Contract, HCFA will issue Control Memorandum with a Control Directive identifying the deficiency and requesting a CAP detailing how the Contractor intends to correct the deficiency. This notice of deficiency will also contain the deadline for the proposed CAP to be forwarded to HCFA for approval and may also contain recommendations or requirements the Contractor must include or address in the CAP.
  - b. **Proposed CAP:** Upon receipt of a Control Memorandum with a Control Directive containing a notice of deficiency, the Contractor shall prepare a proposed CAP and submit it to HCFA for approval within the time frame specified by HCFA. The proposed CAP shall comply with all recommendations and requirements of the notice of deficiency and contain a proposed time by which the noncompliance will be corrected.
  - c. **Approved CAP Implementation:** HCFA will review the proposed CAP and work with the Contractor to revise it as needed. Once approved, the Contractor shall be responsible for ensuring that all actions and documentation required by the CAP are completed in compliance with the Contract and CAP, to HCFA's satisfaction.
  - d. **Notice of Completed CAP:** Upon satisfactory completion of the implemented CAP, HCFA shall provide written notice to the Contractor. Until written approval is received by the Contractor, the approved CAP will be deemed to not have been satisfactorily completed.
- A.56.3. **Potential Monetary Assessment Notice** – a notice included in the Control Memorandum issued by the State to the Contractor where the State has determined that a potential contract performance or compliance issue exists and the State is contemplating assessing monetary assessments as listed in Attachment C. The State shall notify the Contractor of any potential contract performance or compliance issue within ninety (90) days of the Contractor's written notice of the issue to the State through a Control Memorandum or the State's discovery of the issue. The potential monetary assessment shall identify the Contract provision(s) on which the State bases any potential contract performance or compliance issue and, if available, a projection of the potential actual damages and/or assessments. The parties acknowledge that the total amount of monetary assessments may not be the final amount assessed. The Contractor may, in an attempt to settle this matter informally, within ten (10) business days of receipt of the notification of monetary assessments, elect to respond to the notification through the Control Memorandum process. If the State, after review of any information provided by Contractor, continues to assert that potential damages are warranted, the State shall so notify the Contractor through a Control Memorandum. The timely issuance of a response satisfies the State's requirement to provide notice of potential assessments and preserves the State's rights under the Contract to assess damages. This is the first step in the assessment of monetary assessments.
- A.56.4. **Calculation of Potential Monetary Assessment Notice** - a notice included in the Control



Memorandum issued by the State to Contractor that calculates the amount of potential actual damages or potential monetary assessments. If the Contractor elects to formally appeal either the basis for or calculation of potential actual or potential monetary assessments, the Contractor must file an appeal by written response to the Control Memorandum within ten (10) business days of receipt of the State's Calculation of Potential Monetary Assessment Notice. The State's Project Director (or his/her designee) shall review the appeal and provide notice of determination through a Control Memorandum. If the Contractor disagrees with the State's initial appeal determination or the Project Director (or his/her designee) is unable to resolve the appeal, the Contractor may request, through a Control Memorandum to the State, escalation of the appeal to the State's Project Director (or his/her designee) for reconsideration and final determination. Contractor shall send such notice within ten (10) business days of receipt of the State's initial appeal determination. The notice of the final determination made by the State's Project Director (or his/her designee) will be provided to the Contractor through a Control Memorandum. If the Contractor loses this formal appeal, the State in its sole discretion, may assess actual or monetary assessments. This is the second step in the monetary assessment. The State may not issue a Calculation of Potential Monetary Assessment before also issuing a Potential Monetary Assessment Notice.

- A.56.5. Intent to Assess Final Monetary Assessments— a notice included in the Control Memorandum issued by the State to Contractor that the State is assessing monetary assessments. This notice shall identify the Contract provision(s) on which the State bases the damages and specify the total amount of actual damages and/or monetary assessments the State intends to assess. At this point, the State may elect to withhold damages from payments due to Contractor. This is the third step in the monetary assessment process. The State may not issue an Intent to Assess Final Monetary Assessments without first issuing a Calculation of Potential Monetary Assessment.
- A.56.6. Assessment of Actual Monetary Assessment - a notice included in the Control Memorandum issued by the State containing a final demand for payment of actual and/or monetary assessments. This is the fourth step in the monetary assessment process. The State may not issue an Assessment of Actual Monetary Assessment before also issuing an Intent to Assess Final Monetary Assessment.

## **ACCESS AND AVAILABILITY TO CARE**

- A.57. The Contractor shall arrange for the provision of all services described as covered in this Contract. The Contractor shall maintain under contract, a state-wide provider network, including General Dentists and Dental Specialists, adequate to make services, service locations, and service sites available and accessible in accordance with the terms and conditions for access and availability outlined below. Nothing in this Contract shall be construed to preclude the Contractor from closing portions of the network to new providers when all conditions of access and availability are met.
- A.58. The Contractor shall maintain under contract a statewide network of dental providers to provide the covered services specified in Section A.11. The Contractor shall make services, service locations and service sites available and accessible so that transport distance to general dental providers will be the usual and customary, not to exceed an average of thirty (30) miles, as measured by GeoAccess Software, except in rural areas where community standards, as defined by HCFA, will be applied. Exceptions must be justified and documented to the State on the basis of community standards.
- A.59. The Contractor shall ensure that the office waiting time shall not exceed forty-five (45) minutes.
- A.60. Each member shall be permitted to obtain covered services from any general, pediatric dentist or specialist in the Contractor's network accepting new patients.
- A.61. If the Contractor's network is unable to provide necessary, medical services covered under the contract to a particular member, the Contractor must adequately and timely cover these services



out of network for the member, for as long as the Contractor is unable to provide them. Out of network providers must coordinate with the Contractor with respect to payment. The Contractor must ensure that cost to the member is no greater than it would be if the services were furnished within the network.

- A.62. The Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

## **CREDENTIALING AND RE-CREDENTIALING**

- A.63. The Contractor is responsible for ensuring that the Dental Specialists and other oral health professionals, who are under contract to the organization, are qualified to perform their duties. The Contractor is responsible for provider selection policies and procedures that cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. Since the Board of Dentistry requires that dental professionals renew licensure every two (2) years, it is the responsibility of the Contractor to ensure that a copy of the current, valid license is maintained on file at the Contractor's location for every dental professional in the network.

The Contractor is responsible for primary credentialing of providers in accordance with specifications outlined below:

- A.63.1 It is the Contractor's responsibility to completely process a credentialing/recredentialing application within thirty (30) calendar days of receipt of a completed application, including all necessary documentation and attachments, and signed provider agreement/contract.
- A.63.2. Written Policies and Procedures - The Contractor shall have written policies and procedures for the credentialing process, which includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, re-certifying and/or reappointment of practitioners.
- A.63.3. Oversight by Governing Body - The Governing Body, or the group or individual, to which the Governing Body has formally delegated the credentialing function, and HCFA shall review and approve the credentialing policies and procedures.
- A.63.4. Credentialing Entity - The Contractor's credentialing policies and procedures shall designate a Credentialing Committee or other peer review body which makes recommendations regarding credentialing decisions.
- A.63.5. Process - The Contractor's initial credentialing process shall obtain and review verification of the following information, at a minimum:
- a. Primary Verification:
- (1) the practitioner shall hold a current valid license to practice within the State;
  - (2) valid DEA certificate, as applicable;
  - (3) confirmation of highest level of education and training received;
  - (4) professional liability claims history (past five (5) years) from the National Practitioner Data Bank and the State Board of Dentistry;
  - (5) any sanctions imposed by Medicare, Medicaid, HCFA and/or the Tennessee Board of Dentistry;



- (6) good standing of clinical privileges at the hospital designated by the practitioner as the primary admitting facility; (This requirement may be waived for practices which do not have or do not need access to hospitals.); and
- (7) any revocation or suspension of a state license or DEA number.

b. Secondary Verification (self-reported by practitioner)

- (1) work history – past five (5) years. Verbal explanation for gaps greater than six (6) months, written explanation for gaps greater than one (1) year;
- (2) the practitioner shall hold current, adequate malpractice insurance according to the plan's policy;
- (3) any curtailment or suspension of medical staff privileges (other than for incomplete medical records);
- (4) the application process includes a statement by the applicant and an investigation of said statement regarding:
  - i. any physical or mental health problems that may affect current ability to provide dental care;
  - ii. any history of chemical dependency/substance abuse;
  - iii. history of loss of license and/or felony convictions;
  - iv. history of loss or limitation of privileges or disciplinary activity;
  - v. current malpractice coverage and limits; and
  - vi. an attestation to correctness/completeness of the application.

- c. The Contractor must verify licensure and valid DEA certificate, as applicable, within one hundred eighty (180) calendar days prior to the credentialing date.
- d. Any information obtained will be evaluated to determine whether any or all of said information would impact a practitioner's ability to conform to the standards established by the Contractor in accordance with the requirements placed on the Contractor by this Contract. The Contractor may decide, based on information obtained in the credentialing process, not to contract with a provider. If credentialing is denied the provider must be notified in writing and the reasons for the denial must be specified.
- e. A site review will be required for a dentist's office for which the Contractor receives a complaint from an enrollee.

A.63.6. Recredentialing - A process for the periodic reverification of clinical credentials (recredentialing, reappointment, or recertification) is described in the organization's policies and procedures.

- a. There is evidence that the procedure is implemented at least every three (3) years.
- b. There is verification of State licensure at least every three (3) years.
- c. The Contractor conducts periodic review of information from the National Practitioner Data Bank, along with performance data, on all dentists to decide



whether to renew the participating dentist agreement. At a minimum, the recredentialing, recertification or reappointment process is organized to verify current standing on items listed in subsections A.63.1 through A.63.2 above.

- d. The recredentialing, recertification or reappointment process also includes review of data from:
- (1) enrollee complaints;
  - (2) results of quality reviews;
  - (3) utilization management;
  - (4) member satisfaction surveys; and
  - (5) reverification of hospital privileges and current licensure.

A.63.7. Reporting Requirement – The Contractor shall have a mechanism for, and evidence of implementation of, the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.

A.63.8. Appeals Process – The Contractor shall have a provider appellate process for instances where the Contractor chooses to reduce, suspend or terminate a practitioner's privileges with the organization.

A.63.9. If credentialing is denied, the provider must be notified in writing by the Contractor and the reason for the denial must be specified.

#### **DATA AND SPECIFIC REPORTING REQUIREMENTS**

A.64. The Contractor shall maintain a secure electronic data interface with the State for the purpose of accessing enrollment information. The Contractor is responsible for equipping itself with the hardware and software necessary, as required by the state, for achieving and maintaining access. The Contractor shall engage in a monthly reconciliation process with the State to ensure enrollment files are up to date and accurate. Notwithstanding the requirement to maintain enrollment data, the Contractor is not authorized to initiate data changes to the system without the State's approval. This prohibition shall include, but not be limited to, initiation, termination, and/or changes of coverage. The Contractor shall:

A.64.1. Maintain in its computer system in-force enrollment records of all enrollees;

A.64.2. Maintain a duplicate set of all records relating to the benefit payments in electronic medium, usable by the State and Contractor for the purpose of disaster recovery. Such duplicate records are to be stored at a secure fire, flood, and theft- protected facility located away from the storage location of the originals. The duplicate data processing records shall be updated, at a minimum, on a daily basis and retained for a period of sixty (60) days from the date of creation. Upon notice of termination or cancellation of this Contract, the original and the duplicate data processing records medium, and the information they contain, shall be conveyed to the State on or before the effective date of termination or cancellation.

A.64.3. The Contractor shall reconcile, within ten (10) working days of receipt, payment information provided by the State. Upon identification of any discrepancies, the Contractor shall immediately advise the State.

A.65. The Contractor shall annually provide the State with a GeoNetworks® report showing service and geographic access (refer to Section A.51). The State shall review the network structure and shall



inform the Contractor in writing of any deficiencies the State considers to deny reasonable access to health care. The State and Contractor shall then mutually develop a plan of action to correct said deficiencies within sixty (60) days.

- A.66. The Contractor shall transmit required plan enrollment data monthly and dental claims monthly to the Division of Health Care Finance and Administration, Office of Healthcare Informatics (HCI), until all claims incurred during the term of this Contract have been paid. Data shall be submitted in the format approved by the state. The Contractor shall ensure that all claims processed for payment have valid provider identifications and complete ADA codes (and when applicable, updated versions).
- A.67. Claims Data Quality is measured by HCI for each quarter of the Contract term, and any extensions hereof. The Contractor's quarterly data submission to HCI shall meet the following Data Quality measures. Failure to meet these measures shall be subject to monetary assessments listed in Attachment C.

<i>Measure</i>	<i>Benchmark</i>
Gender	Data missing for <= (less than or equal to) 3% of claims
Date of birth	Data missing for <= 3% of claims
Outpatient diagnosis coding	Data invalid or missing for <= 5% of outpatient claims
Outpatient provider type missing	Data missing for <= 1.5% of outpatient claims

- A.68. The Contractor will work with HCI to identify a mutually-agreeable data format approved by the state for these transmissions, and is responsible for the cost incurred by the state to develop, test and implement conversion programs for the Contractor's claims data. Furthermore, the Contractor will pay during the full term of this Contract all applicable fees as assessed by the State's related to any data format changes, which are Contractor-initiated or are due to meeting compliance with new regulations. The Contractor shall also pay all applicable fees related to any state efforts to correct Contractor data quality errors that occur during the term of this Contract. Claims data are to be submitted to HCI no later than the 5th business day of the month following the end of each calendar month. Failure to comply may result in monetary assessment as listed in Attachment C.
- A.69. The Contractor shall maintain an electronic interface with the Medical Plan Administrator for the purpose of reconciling and aggregating family out of pocket costs. The Contractor's computer system shall be compatible or have the capability to utilize the enrollment information provided by the State in the format of HIPAA 834 or 837 or other mutually agreed upon format by the State and the Medical Plan Administrator.

**MANAGEMENT REPORTS**

- A.70. The Contractor shall submit Management Reports by which the State can assess the CoverKids Dental program costs and usage, in a mutually agreeable electronic format (MSWord, MSEXcel, etc.), of the type, at the frequency, and containing the detail in Attachment E. Reporting shall continue for the twelve (12) month period following termination of the Contract. The Contractor shall also generate and submit to the State, within five (5) working days of the end of each Contract quarter a Quarterly Network Changes Report, also in electronic format.

**MANAGEMENT INFORMATION SYSTEMS REQUIREMENTS**

- A.71. The Contractor shall complete all data mapping necessary to submit information to HCFA and respond to information provided by HCFA.



A.72. The Contractor must have a procedure to maintain and update member profiles that is capable of processing daily updates.

A.73. Requirements Prior To Operations:

A.73.1. Licensure

- a. Before the start date of operations and prior to accepting CoverKids members, the Contractor must hold all necessary, applicable business and professional licenses, including appropriate licensure from the Tennessee Department of Commerce and Insurance (TDCI). The Contractor must hold a license to act as an Administrator pursuant to Tennessee Code Annotated § 56-6-410, unless otherwise licensed pursuant to Tennessee Code Annotated § 56-6-401(3). The contract must include evidence that the Contractor either holds a current license to act as an Administrator in Tennessee or has submitted an application to TDCI to obtain such licensure.
- b. Prior to the start date of operations, the Contractor shall ensure that its staff, all subcontractors and providers, and their staff are appropriately licensed.
- c. The Contractor shall ensure that the Contractor and its staff, all subcontractors and staff, and all providers and staff retain at all times during the period of this Contract a valid license, as appropriate, and comply with all applicable licensure requirements.

A.73.2. Readiness Review

- a. Prior to the start date of operations, as determined by HCFA, the Contractor shall demonstrate to HCFA's satisfaction that it is able to meet the requirements of this Contract.
- b. The Contractor shall cooperate in a readiness review conducted by HCFA to review the Contractor's readiness to begin operations. This review may include, but is not limited to, desk and on-site review of documents provided by the Contractor, a walk-through of the Contractor's operations, system demonstrations (including systems connectivity testing), and interviews with Contractor's staff. The scope of the review may include any and all requirements of this Contract as determined by HCFA.
- c. The Contractor shall work in cooperation with HCFA to ensure that their information system, claims processing system, encounter files, eligibility files and all other systems, files and/or processes satisfy all functional and informational requirements of the CoverKids' dental program. The Contractor will assist HCFA in the analysis and testing of these systems prior to the delivery of services. The Contractor shall provide system access to allow HCFA to test the Contractor's system through the HCFA CoverKids network. Any software or additional communications network required for access shall be provided by the Contractor.
- d. Based on the results of the review activities, HCFA will issue a letter of findings and, if needed, will request a corrective action plan from the Contractor. CoverKids members may not be enrolled with the Contractor until HCFA has determined that the Contractor is able to meet the requirements of this Contract.
- e. If the Contractor is unable to demonstrate its ability to meet the requirements of this Contract, as determined by HCFA, within the time frames specified by HCFA, HCFA may terminate this Contract in accordance with Section D.4 of this Contract and shall have no liability for payment to the Contractor.



- A.74. Provider Assistance. The Contractor shall be available Monday thru Friday, 7:00 am – 5:00 pm Central Time and corresponding hours during periods of Daylight Savings Time to respond to provider inquiries related to prior approval and claims status.
- A.75. Help Desk for Prior Approval Operations. The Contractor shall maintain a toll-free telephone access to support the prior approval process, available between the hours of 7:00 a.m. and 5:00 pm, Central Time, Monday through Friday to respond to questions about Prior Approval Requests.
- A.76. Data Validation Edits and Audits. The Contractor's claims processing system must perform the following validation edits and audits:
- A.76.1. Prior Approval - The system shall determine whether a covered service requires prior approval, and if so, whether approval was granted by the Contractor;
  - A.76.2. Valid Dates of Service - The system shall assure that dates of services are valid dates, are no older than one hundred eighty (180) days from the date of prior approval, if such prior approval was required, and are not in the future. For orthodontics, the system must assure that dates of service are valid dates meeting HCFA CoverKids Rules 1200-13-13.04 and 1200-13-14.04;
  - A.76.3. Duplicate Claims - The system shall automatically inform the provider that the current claim is an exact or possible duplicate and deny that claim as appropriate;
  - A.76.4. Covered Service - The system shall verify that a service is a valid covered service and is eligible for payment under the CoverKids dental benefit for that eligibility group;
  - A.76.5. Provider Validation - The system shall approve for payment only those claims received from providers eligible to provide dental services and have a National Provider Identifier (NPI) per HIPAA Legislation requirements;
  - A.76.6. Member Validation - The system shall approve for payment only those claims for members eligible to receive dental services at the time the service was rendered;
  - A.76.7. Eligibility Validation – The system shall confirm the member for whom a service was provided was eligible on the date the service was incurred;
  - A.76.8. Quantity of Service - The system shall validate claims to assure that the quantity of services is consistent with HCFA CoverKids rules and policy;
  - A.76.9. Rejected Claims - The system shall determine whether a claim is HIPAA compliant and therefore acceptable for adjudication and reject claims that are not, prior to reaching the adjudication system, and,
  - A.76.10. Plan Administrator - The system shall reject or deny claims that should rightly be processed and paid by a member's Plan Administrator for any and all physical health treatments.
- A.77. Prior Approval Request Tracking. Each prior approval request processed by the Contractor shall be assigned a unique number and be maintained in a database designed by the Contractor that will contain all pertinent information about the request and be available to Help Desk staff. This information shall include, but not be limited to: provider, member, begin and end dates, covered service, request disposition (i.e., approved or denied).
- A.78. System Security. The Contractor shall apply recognized industry standards governing security of State and Federal Automated Data Processing systems and information processing. At a minimum, the State requires the Contractor to conduct a security risk analysis and to communicate the results in an Information Security Plan provided prior to the delivery of services.



The risk analysis shall also be made available to appropriate Federal agencies as needed. The following specific security measures shall be included in the system design documentation and operating procedures:

- A.78.1. Computer hardware controls that ensure acceptance of data from authorized networks and providers only;
- A.78.2. At the Contractor's central facility, placement of software controls that establish separate files for lists of authorized user access and identification codes;
- A.78.3. Manual procedures that provide secure access to the system with minimal risk;
- A.78.4. Multilevel passwords, identification codes or other security procedures that shall be used by State agency or Contractor personnel;
- A.78.5 All Contractor MIS software changes are subject to HCFA approval prior to implementation, and
- A.78.5 System operation functions shall be segregated from systems development duties.

#### **DENTAL AND CARE MANAGEMENT SERVICES**

- A.79. The Contractor shall provide a dental and care management system designed to help individual Members secure the most appropriate level of care consistent with their dental health status. In carrying out this function, the Contractor shall provide a system for reviewing the appropriateness of hospital inpatient care and other levels of care as necessary. The Contractor shall have in place an effective process that identifies and manages those Members in need of inpatient dental care. The Contractor shall meet one (1) of the following licensure requirements:
  - A.79.1. Dental Service Plan – licensed pursuant to TCA Title 56, Chapter 30;
  - A.79.2. Prepaid Limited Health Service Organization – licensed pursuant to TCA Title 56, Chapter 51;
  - A.79.3. Insurance Company – licensed pursuant to TCA Title 56, Chapter 2;
  - A.79.4. Hospital and Medical Service Corporation – licensed pursuant to TCA Title 56, Chapter 29, or
  - A.79.5. Health Maintenance Organization – licensed pursuant to TCA Title 56, Chapter 32.
- A.80. The Contractor shall maintain an internal quality assurance program. The Contractor's dental and case management services must be accredited by either the National Committee for Quality Assurance (NCQA) or the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or Utilization Review Accreditation Commission (URAC). If such accreditation is through NCQA, the Contractor shall annually submit to the State its Health Plan Employer Data and Information Set (HEDIS) report card.
- A.81. The State may retain an independent External Quality Review Organization (EQRO) contractor ("EQRO Contractor") to review compliance with CHIPRA. If the Contractor is accredited by the National Committee for Quality Assurance ("NCQA"), satisfaction of those standards shall be deemed satisfaction of the EQRO Contractor's standards to the extent that those measures are reflective of quality assurance measures set forth in Children's Health Insurance Program Reauthorization Act (CHIPRA).
  - A.81.1 The EQRO Contractor may schedule appointments and visits with the Contractor during regular business hours, provided that the Contractor is given at least thirty (30) days' notice in advance of any such appointment or visit. The State shall be promptly notified by the Contractor of any changes to an agreed upon appointment schedule. The EQRO Contractor shall draft a report of its review findings, including recommendations for improvement, and shall provide a draft to the State and the



Contractor within thirty (30) calendar days of completion of the EQRO Contractor's review. The Contractor shall be given an opportunity to provide additional information or comments to this draft report for a period of ten (10) business days following receipt of the draft report. A final report shall be submitted to the State within sixty (60) calendar days following the completion of the review by the EQRO Contractor.

- A.81.2. The EQRO Contractor must communicate to the Contractor any criteria by which it will assess the Contractor's compliance with current industry, federal, and State requirements for CHIPRA. Criteria may include review of enrollee rights and protections, quality assessment and performance improvement, structure and operation standards, measurement and improvement standards and compliance with the appeal process. The EQRO Contractor's review process may include document review, interviews with key Contractor personnel, and an assessment of the adequacy of information management systems. The EQRO may not impose greater requirements on the Contractor than are set forth in this Contract, except as required by law.
- A.82. As validated by the State's EQRO vendor quarterly, the Contractor shall meet a benchmark for accuracy of the provider data information submitted to the State at ninety percent (90%) or above accuracy. Failure to comply may result in monetary assessment as listed in Attachment C.
- A.83. As validated by the State's EQRO vendor annually, the Contractor shall meet a benchmark for the overall compliance with Quality Process Standards, Performance Activity File Review, and Credentialing/re-credentialing activities as submitted to the state at a one hundred percent (100%) overall compliance. Failure to comply may result in monetary assessment as listed in Attachment C.

#### **FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) AND RURAL HEALTH CLINICS (RHCs) PROSPECTIVE PAYMENTS**

- A.84. At the end of thirty (30) days following the end of each calendar quarter during the term of this Contract, commencing with the third quarter of calendar year 2015, the Contractor shall provide a report to the State, in a format approved by the state, to assist the State in identifying and confirming dental claims incurred at an FQHC or RHC and adjudicated within the calendar quarter, for services covered under the CoverKids program for members covered by CHIP. The State shall be responsible for identifying each FQHC and RHC and providing the Contractor with a current and up-to-date list of FQHCs and RHCs from which to pull the report.
- A.85. The State shall be responsible for determining the amount of any payment due to each FQHC or RHC pursuant to the prospective payment system ("PPS") as directed by Section 503 of CHIPRA (each, a "Prospective Payment"). The State shall be responsible for any and all remittances of Prospective Payments to an FQHC or RHC. The State and Contractor expressly acknowledge and agree that the State has sole responsibility for determining and issuing the Prospective Payment owed to the FQHC and RHC under the PPS.
- A.86. The State shall be responsible for resolving any FQHC or RHC inquiries regarding Prospective Payments, including but not limited to, the resolution of any adjustment inquiries and payments or payments returned to the State after remittance to the FQHC or RHC. The State shall have sole responsibility for resolving any overpayment or underpayment of the Prospective Payment to any FQHC or RHC as well as the recovery of any potential third party liability that may or may not be available to offset against the amount of the Prospective Payment. In addition, the State shall be responsible for providing FQHCs and RHCs any notice, report or other form or filing required by federal or state law for tax, regulatory or other purposes, including without limitation the provision of Form 1099s, related to the Prospective Payment.
- A.86.1. Upon request by the State, the Contractor shall provide assistance with claims incurred at an FQHC or RHC to resolve any Prospective Payment inquiries, at the time the



inquiry is presented to the State. The State will not wait until the end of the quarter to reconcile or the end of the year to resolve FQHC and RHC inquiries.

- A.86.2. For purposes of this Contract section, the parties expressly acknowledge and agree that the Contractor is acting at the State's direction to provide a quarterly report to the State for the sole purposes of facilitating Prospective Payments to FQHCs and RHCs. The Contractor is not acting as an insurer under the laws of the State of Tennessee. The State is solely responsible for determining the accuracy and appropriateness of any Prospective Payment made to a FQHC or RHC. Any obligations required of the Contractor regarding this Contract Section shall survive beyond the termination of this Contract and all such obligations hereunder shall not be deemed complete and fulfilled upon the termination of this Contract.

## PLAN IMPLEMENTATION

- A.87. Implementation of this CoverKids Dental Benefits Contract shall be conducted as series of defined phases described below. The benefit shall become fully effective and operable on July 1, 2015. The Contractor shall be required to complete all the tasks, obligations and responsibilities listed under each phase by the dates identified in the project plan. The project plan shall include a detailed timeline description of all work to be performed both by the Contractor and HCFA. The plan shall also include a description of the participants on the transition team and their roles and schedules of meetings between the transition team and HCFA, and approved by HCFA.
- A.88. Project Initiation and Requirements Definition Phase – HCFA shall conduct a project kick-off meeting. All key Contractor project staff shall attend and HCFA project staff shall provide access and orientation to the HCFA Dental Program and system documentation.
- A.88.1. Functional and Informational Requirements (FIR) Document. This document shall include detailed requirements for both internal and external interfaces and all CoverKids functionalities required by this contract and/or contained in the Contractor's proposal in the RFP. Eligibility interfaces with HCFA are critical at all times.
- a. The initial eligibility interface will occur with CoverKids and the Contractor must be in sync with the CoverKids Eligibility Contractor Children's Health Administration System (CHAS). All outbound 834 files from the Eligibility Contractor must be loaded to the Contractors database within twenty-four (24) hours of receipt from the Eligibility Contractor. This requirement includes any 834 transactions that must be handled manually by the Contractor. Failure to meet this performance guarantee may result in monetary assessment as set forth in Attachment C.
  - b. Also, upon implementation of the new state Eligibility and Determination System, the eligibility interface with HCFA must continue and the Contractor must be in sync with the state's Tennessee Eligibility and Determination System (TEDS). All outbound 834 files from the state will need to be loaded to the Contractors database within twenty-four (24) hours of receipt from the state. This requirement includes any 834 transactions that must be handled manually by the Contractor. Failure to meet this performance guarantee may result in monetary assessment as set forth in Attachment C.
- A.88.2. Data Dictionary. For each data field this shall indicate content, size, values, structure, edit criteria and purpose.
- A.88.3. Data Mapping. This shall consist of a cross-reference map of required data and CoverKids data elements and data structures. A separate data structure map shall be required for each transaction and interface. A data conversion plan, that includes both automated and manual activities, shall be provided for each data structure map. HCFA shall make any necessary data formats available to the Contractor.



- A.88.4. The Contractor shall recommend design modifications to the CoverKids and Tennessee system. Performing any maintenance and design enhancements shall be the decision and responsibility of HCFA.
- A.89. System Analysis/General Design Phase - After approval of the documentation by HCFA required in the Project Initiation and Requirements Definition Phase, the Contractor shall develop the General System Design Document. The General System Design Document shall include the following information:
- A.89.1. An Operational Impact Analysis that details the procedures and infrastructure required to enable TCMIS and the Contractor's system used by dental providers to work effectively together.
  - A.89.2. A Detailed Conversion Plan that specifies plans for conversion of fifteen (15) months of TCMIS and the previous DBM contractor/processor's claims history, prior authorization and reference data.
  - A.89.3. A Software Release Plan that sets forth the project's implementation into production. This document shall explain procedures for coordinating system changes that shall have an operational or information impact on CoverKids operations. It shall detail how CoverKids and/or TCMIS software releases are tested and coordinated.
- A.90. Technical Design Phase - During this phase, detailed specifications shall be developed for conversion and for the interface(s) between the TCMIS and the Contractor's system. The Contractor shall develop detailed plans that address back-up and recovery, information security and system testing. The Contractor shall develop the System Interface Design Overview Document (this document shall be completed after the Contractor has conducted a review of all previous design documents). In addition to the System Interface Design Overview, the Contractor shall provide the following system plan documents:
- A.90.1. Unit Test Plan that includes test data, testing process, and expected results;
  - A.90.2. Back-up and Recovery Plan that includes processes for daily backup and recovery of system information;
  - A.90.3. Final Disaster Recovery Plan;
  - A.90.4. Information Security Plan that includes how the Contractor shall maintain confidentiality of CoverKids data. This document shall include a comprehensive Risk Analysis; and
  - A.90.5. System, Integration, and Load and Test Plan.
- A.91. Development Phase - This phase includes activities that shall lead to the implementation. The Contractor shall develop interface and conversion programs, develop system documentation, and develop Unit Test Plans. Where manual data entry screens are required, the Contractor shall develop these screens. Testing shall be performed on all phases and programs shall be documented. System testing shall require reports to substantiate and document the testing. These reports shall include number of tests run, number of requirements tested, number of tests passed, number of tests failed, and number of tests retested after initial failure. The Contractor must maintain an issues log which details any testing failures and includes the resolution for those issues. During final User Acceptance Testing (UAT) with HCFA, only HCFA can approve the Contractor's issue resolutions. The Contractor shall perform testing activities that shall include the following:
- A.91.1. System test to validate the appropriate adjudication of a claim which shall include a description of the test procedure, expected results, and actual results;
  - A.91.2. Integration testing shall test external system impacts, downstream TCMIS applications, and all interfaces. It shall include a description of the test procedure, expected results, and actual results; and



- A.91.3. Load and Stress testing shall include volume and efficiency to ensure that the system is able to process the volume of CoverKids dental claims. It shall include a description of the test procedure, expected results, and actual results.
- A.92. Implementation/Operations Phase - During this phase the Contractor and HCFA shall assess the operational readiness of all required system components. This shall result in the establishment of the operational production environment in which all CoverKids dental claims shall be accurately and reliably processed, adjudicated and paid. HCFA shall have final approval for the elements of the operational production environment.
- A.92.1. The Contractor shall develop and prepare the operations documentation of all procedures of the Contractor's performance. This shall include, but may not be limited to: automated operations, data entry operations, prior authorization operations/interfaces, check and remittance fulfillment and member notifications.
- A.92.2. With the approval of HCFA, the Contractor shall develop production and report distribution schedules.
- A.92.3. The Contractor shall update the operations training plan for HCFA approval. The Contractor shall schedule and conduct training and develop the training materials for HCFA CoverKids staff, dental providers, and other identified stakeholders.
- A.92.4. The Contractor and HCFA shall prepare a final conversion plan and perform final conversion activities that include procedures for testing the conversion data. The conversion plan shall include loading fifteen (15) months of claims history from the current system. The plan shall also include migrating current prior authorizations overrides with their end dates into the Contractor's system, running other conversion programs, performing manual functions, performing quality control, reporting on outcomes, and converting files in preparation for system operation.

## READINESS REVIEW

- A.93. The State may conduct an on-site review to assess the readiness of the Contractor to effectively Administer and provide the services as defined in this Contract. The Contractor shall complete all implementation actions prior to "go-live" date of July 1, 2015, and according to the implementation timeline provided by the Contractor to HCFA. The Contractor shall receive HCFA's sign-off that each action has been completed successfully. Implementation action steps include the following minimum items:
- A.93.1. Benefit plan designs loaded, operable and tested;
- A.93.2. Perform comprehensive systems testing (including interface testing with all third parties) and quality assurance audits, with results reported to the HCFA prior to the "Go-Live";
- A.93.3. Eligibility feed formats loaded and tested end to end;
- A.93.4. Operable and tested toll-free numbers;
- A.93.5. Account management, Help Desk and Prior Authorization staff hired and trained;
- A.93.6. Established billing/banking requirements;
- A.93.7. Complete notifications to dentists regarding contractor change, and
- A.93.8. Each component shall be met by an agreed upon deadline in an implementation timeline provided by Contractor to HCFA. Implementation action requirements may



include other items necessary to meet the claims processing commencement date of July 1, 2015.

## **BUSINESS CONTINUITY/DISASTER RECOVERY PLAN**

- A.94. The Contractor shall submit evidence that they have a Business Continuity/Disaster Recovery plan for their Central Processing Site. If requested, test results of the plan shall be made available to HCFA. The plan shall be able to meet the requirements of any applicable state and federal regulations. The Contractor's Business Continuity/Disaster Recovery Plan shall include sufficient information to show that they meet the following requirements:
- A.94.1. Documentation of emergency procedures that include steps to take in the event of a natural disaster by fire, water damage, sabotage, mob action, bomb threats, etc. This documentation shall be in the form of a formal Disaster Recovery Plan. The Contractor shall apply recognized industry standards governing Disaster Preparedness and Recovery including the ability to continue processing in the event that the central site is rendered inoperable;
  - A.94.2. Employees at the site shall be familiar with the emergency procedures;
  - A.94.3. Smoking shall be prohibited at the site;
  - A.94.4. Heat and smoke detectors shall be installed at the site both in the ceiling and under raised floors (if applicable). These devices shall alert the local fire department as well as internal personnel;
  - A.94.5. Portable fire extinguishers shall be located in strategic and accessible areas of the site. They must be vividly marked and periodically tested;
  - A.94.6. The site shall be protected by an automatic fire suppression system, and
  - A.94.7. The site shall be backed up by an uninterruptible power source system.

## **FRAUD AND ABUSE**

- A.95. The Contractor shall assist the State in identifying fraud and assist with fraud investigations of Members and providers in consultation with the State, for the purpose of recovery of overpayments due to fraud. The Contractor shall provide all documentation, records, and data to HCFA Office of Program Integrity and the Division of State Audit within the Office of the Comptroller of the Treasury for the purpose of investigating suspected fraud and abuse cases in a form and manner described by the State. The State shall review the information and inform the Contractor whether it wishes the Contractor to:
- A.95.1. discontinue further investigation if there is insufficient justification; or
  - A.95.2. continue the investigation and report back to HCFA, the Office of the Inspector General or the Division of State Audit; or
  - A.95.3. continue the investigation with the assistance of the Division of State Audit; or
  - A.95.4. discontinue the investigation and turn the Contractor's findings over to the Division of State Audit or the Office of Inspector General for its investigation.
- A.96. Cooperation – The Contractor and its Providers, Subcontractors, and/or employees and consultants shall cooperate fully in any investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include



providing, upon request, information, access to records, and access to interview the Contractor and its Providers, subcontractors, and/or employees and consultants, including, but not limited to, those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.

- A.96.1. HCFA, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCU, DOJ and their authorized agents, as well as any authorized state or federal agency or entity shall have the right to access through inspection, evaluation, review or request, whether announced or unannounced, any HCFA records pertinent to this Contract including, but not limited to medical records, billing records, financial records including 1099 forms, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution. Such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the requesting agency.
- A.96.2. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records at no cost to the requesting agency. Contractor acknowledges that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to HCFA, OIG, TBI MFCU, DHHS OIG and DOJ and their authorized agents. Any authorized state or federal agency or entity, including, but not limited to HCFA, OIG, TBI MFCU, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for medical audit, medical review, utilization review and administrative, civil or criminal investigations and prosecutions. In addition to surrendering medical records, Provider and its employees are required to cooperate with the evaluating agency or entity in their investigation as needed, to explain or demonstrate office policies, records systems, business practices, conduct or other matters raised by the investigation.
- A.97. Internal Controls - The Contractor shall create a Fraud and Abuse Compliance plan in a form and manner subject to review by HCFA. The Contractor shall have adequate staffing and resources to investigate potential fraud and abuse and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities. The Contractor shall comply with all federal and state requirements regarding fraud and abuse, including, but not limited to, Sections 1128, 1156, and 1902(a) (68) of the Social Security Act.
  - A.97.1 Providers Screening – The Contractor shall require Providers to screen their employees and sub-contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The provider shall be required to immediately report to the Contractor any exclusion information discovered. The provider shall be informed that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to CoverKids members.

#### **NON-DISCRIMINATION COMPLIANCE**

- A.98. Non-Discrimination Compliance Requirements
  - A.98.1. The Contractor shall comply with Contract Section D.7 of this Contract regarding non-discrimination, proof of non-discrimination, and notices of non-discrimination.
  - A.98.2. In order to demonstrate compliance with the applicable federal and state civil rights laws, which include, but are 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 Americans with Disabilities Act of 1990, and the Age Discrimination Act of 1975, the Contractor shall designate a staff person to be responsible for non-discrimination compliance as required in section A.48.10.c . The Contractor's Non-discrimination Compliance Coordinator shall be responsible for compliance with the requirements set forth in this section. This person shall develop a Contractor non-discrimination compliance training plan within thirty (30) days of Contract execution, to be approved by HCFA. This person shall be responsible for the provision of instruction regarding the plan to all staff providing services of this contract within sixty (60) days of Contract amendment execution, and for the provision of instruction regarding the plan to providers and direct service subcontractors within ninety (90) days of Contract amendment execution. The Contractor shall be able to show documented proof of such instruction.

- A.98.3. The Contractor's non-discrimination compliance plan shall include written policies and procedures that demonstrate non-discrimination in the provision of services to members. The policies shall include topics, such as, the provision of language services for members with Limited English Proficiency and those requiring communication assistance in alternative formats. These and providing assistance to individuals with disabilities. The nondiscrimination policies and procedures shall be prior approved in writing by HCFA.
- A.98.4. The Contractor shall, at a minimum, emphasize non-discrimination in its personnel policies and procedures as it relates to hiring, promoting, operational policies, contracting processes and participation on advisory/planning boards or committees.
- A.98.5. The Contractor shall request all staff providing services of this contract to provide their race or ethnic origin and sex. The Contractor is required to request this information from all Contractor and subcontractor staff providing services of this contract, however, staff response is voluntary. The Contractor is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts.
- A.98.6. The Contractor shall ask all providers for their race or ethnic origin. Provider response is voluntary. The Contractor is prohibited from utilizing information obtained pursuant to such a request as a basis for decision regarding participation in the Contractor's provider network or in determination of compensation amounts.
- A.98.7. All discrimination complaints against the, Contractor, Contractor's employees, Contractor's providers, Contractor's provider's employees and Contractor's subcontractors shall be resolved according to the provisions of this Section A.98.7.
- A.98.7(a) Discrimination Complaints against the Contractor and/or Contractor's Employees. When complaints concerning alleged acts of discrimination committed by the Contractor and/or its employees related to the provision of and/or access to CoverKids covered services are reported to the Contractor, the Contractor's nondiscrimination compliance officer shall send such complaints within two (2) business days of receipt to HCFA. HCFA shall investigate and resolve all alleged acts of discrimination committed by the Contractor and/or its employees. The Contractor shall assist HCFA during the investigation and resolution of such complaints. HCFA reserves the right to request that the Contractor's nondiscrimination compliance officer assist with conducting the initial investigations and to suggest resolutions of alleged discrimination complaints. If a request for assistance with an initial investigation is made by HCFA, the Contractor's nondiscrimination compliance officer shall provide HCFA with all requested information, including but not limited to, the identity of the party filing the complaint; the complainant's relationship to the Contractor; the circumstances of the complaint; date complaint filed; and the Contractor's suggested resolution. HCFA shall review



the Contractor's initial investigations and determine the appropriate resolutions for the complaints as set forth in Section A.98.7(c) below. Any documentation or materials related to such investigation shall be considered confidential and not subject to disclosure to any third party, unless disclosure is otherwise required by law.

- A.98.7(b) Discrimination Complaints against the Contractor's Providers, Provider's Employees and/or Provider's Subcontractors. Should complaints concerning alleged acts of discrimination committed by the Contractor's providers, provider's employees and/or subcontractors related to the provision of and/or access to CoverKids covered services be reported to the Contractor, the Contractor's nondiscrimination compliance officer shall inform HCFA of such complaints within two (2) business days from the date Contractor learns of such complaints. If HCFA requests that the Contractor's nondiscrimination compliance officer assist HCFA with conducting the initial investigation, the Contractor's nondiscrimination compliance officer within five (5) business days from the date of the request shall start the initial investigation. Once an initial investigation has been completed, the Contractor's nondiscrimination compliance officer shall report his/her determinations to HCFA. At a minimum, the Contractor's nondiscrimination compliance officer's report shall include the identity of the party filing the complaint; the complainant's relationship to the Contractor; the circumstances of the complaint; date complaint filed; and the Contractor's suggested resolution. HCFA shall review the Contractor's initial investigations and determine the appropriate resolutions for the complaints as set forth in Section A.89.7(c) below. HCFA reserves the right to investigate and resolve all complaints concerning alleged acts of discrimination committed by the Contractor's providers, and subcontractors.
- A.98.7(c) Corrective Action Plans to Resolve Discrimination Complaints. If a discrimination complaint against the Contractor, Contractor's employees, Contractor's providers, Contractor's provider's employees, or Contractor's subcontractors is determined by HCFA to be valid, HCFA shall, at its option and pursuant to Section A.56, either (i) provide the Contractor with a corrective action plan to resolve the complaint, or (ii) request that the Contractor submit a proposed corrective action plan to HCFA for review and approval that specifies what actions the Contractor proposes to take to resolve the discrimination complaint. Upon provision of the corrective action plan to Contractor by HCFA, or approval of the Contractor's proposed corrective action plan by HCFA, the Contractor shall implement the approved corrective action plan to resolve the discrimination complaint. HCFA, in its sole discretion, shall determine when a satisfactory discrimination complaint resolution has been reached and shall notify Contractor of the approved resolution. A discrimination complaint resolution corrective action plan may consist of approved nondiscrimination training on relevant discrimination topics. Prior to use, the nondiscrimination training material shall be reviewed and approved by HCFA. Time periods for the implementation of the corrective action plan nondiscrimination training shall be designated by HCFA.
- A.98.8. The Contractor shall use and have available to members or complainants, CoverKid's Discrimination complaint form located on CoverKid's website under the nondiscrimination link at [http://www.covertn.gov/web/coverkids\\_fair\\_treatment.html](http://www.covertn.gov/web/coverkids_fair_treatment.html). The discrimination complaint form shall be provided to members and complainants upon request and in the member handbook. This complaint form shall be considered a Vital Document and shall be available at a minimum in the English and Spanish languages. When requests for assistance to file a discrimination complaint are made by enrollees, the Contractor shall assist the enrollees with submitting complaints to HCFA. In addition, the Contractor shall inform its employees, providers, and subcontractors how to assist members with obtaining discrimination complaint forms and assistance from the Contractor with submitting the forms to CoverKids and the Contractor.



A.98.9. The Contractor shall report on non-discrimination activities as described in this Contract, which includes, but is not limited to Section A.99.

A.99. Non-Discrimination Compliance Reports

- A.99.1. On an annual basis the Contractor shall submit a copy of the Contractor's non-discrimination policy that demonstrates non-discrimination in the provision of services to members. The policy shall also demonstrate non-discrimination in the provision of services for members with Limited English Proficiency and those requiring communication assistance in alternative formats. This shall include a report that lists all interpreter/translator services used by the Contractor in providing services to members with Limited English Proficiency or that need communication assistance in an alternative format. The listing shall identify the provider by full name, address, phone number, languages spoken, and hours services are available.
- A.99.2. The Contractor shall submit an annual Summary Listing of Servicing Providers. The listing shall include, at a minimum, provider name, address, race or ethnic origin, language spoken other than English and shall be sorted by provider type (e.g., pediatrician, surgeon, etc.). The Contractor shall use the following race or ethnic origin categories: American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin as indicated by HCFA..
- A.99.3. Annually, HCFA shall provide the Contractor with a Nondiscrimination Compliance Plan Template. The Contractor shall answer the questions contained in the Compliance Plan Template and submit the completed *Compliance Plan* to HCFA within ninety (90) days of the end of the calendar year with any requested documentation, which shall include, but is not limited to, the Assurance of Nondiscrimination. The signature date of the Contractor's Nondiscrimination Compliance Plan shall be the same as the signature date of the Contractor's Assurance of Nondiscrimination. These deliverables shall be in a format specified by HCFA.
- A.99.4. The Contractor shall submit a quarterly Non-discrimination Compliance Report which shall include the following:
- a. A summary listing totaling the number of supervisory personnel providing services of this contract by race or ethnic origin and sex. This report shall provide the number of male supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnicity as indicated by HCFA and number of female supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/ethnic origin females as indicated by HCFA;
  - b. A listing of all complaints filed by employees, members, providers and subcontractors in which discrimination is alleged related to the provision of and/or access to CoverKids covered services provided by the Contractor. Such listing shall include, at a minimum, the identity of the party filing the complaint, the complainant's relationship to the Contractor, the circumstances of the complaint, date complaint filed, the Contractor's resolution, date of resolution, and the name of the Contractor staff person responsible for adjudication of the complaint; and
  - c. A listing of all member requests for language and communication assistance. The report shall list the member, the member's identification number, the date of the request, the date the service was provided and the name of the service provider.



- A.100. Transition Upon Termination Requirements. At the expiration of this Contract, or if at any time the state should terminate this Contract, the Contractor shall cooperate with any subsequent Contractor who might assume administration of the dental benefits program. HCFA shall withhold final payment to the Contractor until transition to the new Contractor is complete. The state will give the Contractor sixty (60) days notice that a transfer will occur.

## **OBLIGATIONS OF THE STATE**

- A.101. HCFA shall provide the Contractor, as necessary for the Performance of the Contractor obligations, the rules, policies and procedures regarding the benefits and claims payments applicable to coverage under the Dental Program.
- A.102. HCFA shall be responsible for enrollment of eligible persons in the Contractor's plan and for disenrollment of ineligible persons from the Contractor's plan. HCFA will arrange for the Contractor to have updated eligibility information in the form of on-line computer access and will notify the Contractor when HCFA determines that there is any change in a member's demographic information.
- A.103. HCFA shall provide a means for dental providers to verify Member eligibility on line. The Contractor may provide additional means of eligibility verification to its contracted dentists.
- A.104. HCFA shall pay the Contractor pursuant to Section C.1 of this Contract for the Contractor's performance of all duties and obligations hereunder. No additional payment shall be made to Contractor by HCFA for the services required under this Contract.

## **B. CONTRACT PERIOD:**

This Contract shall be effective for the period beginning January 2, 2015 and ending on June 30, 2020. Actual delivery of dental services shall begin on July 1, 2015, after completion of transition and satisfactory completion of readiness review. The Contractor hereby acknowledges and affirms that the State shall have no obligation for services rendered by the Contractor which were not performed within this specified contract period.

## **C. PAYMENT TERMS AND CONDITIONS:**

- C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed One Hundred Seventeen Million Sixty-Nine Thousand Nine Hundred Twenty Eight Dollars (\$117,069,928.00). The payment rates in section C.3 shall constitute the entire compensation due the Contractor for all service and Contractor obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the payment rates detailed in section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

- C.2. Compensation Firm. The payment rates and the maximum liability of the State under this Contract are firm for the duration of the Contract and are not subject to escalation for any reason unless amended.



C.3. Payment Methodology. The Contractor shall be compensated based on the payment rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in section C.1.

- a. The Contractor's compensation shall be contingent upon the satisfactory completion of units, milestones, or increments of service defined in section A.
- b. The Contractor shall be compensated for said units, milestones, or increments of service based upon the following payment rates for services performed from July 1, 2015 through June 30, 2020, based on the number of enrollees certified by the Eligibility Determination Contractor to the Contractor:

	Distribution of Premium to Administration and Benefits Component	Per Member Monthly Premium Rates July 1, 2015- June 30, 2016	Per Member Monthly Premium Rates July 1, 2016- June 30, 2017	Per Member Monthly Premium Rates July 1, 2017- June 30, 2018	Per Member Monthly Premium Rates July 1, 2018- June 30, 2019	Per Member Monthly Premium Rates July 1, 2019- June 30, 2020
Group One Child (monthly) <sup>1</sup>	Amount of Premium	\$17.55	\$17.90	\$18.25	\$18.62	\$18.99
Group Two Child (monthly) <sup>2</sup>	Amount of Premium	\$20.33	\$20.74	\$21.15	\$21.58	\$22.01
AI/AN Child (monthly) <sup>3</sup>	Amount of Premium	\$21.15	\$21.57	\$22.01	\$22.44	\$22.89

<sup>1</sup> Group One Child is defined as a covered child who is in a family with an income between 150 percent and 250 percent of FPL.

<sup>2</sup> Group Two Child is defined as a covered child who is in a family with an income below 150 percent of FPL and therefore subject to reduced copayments.

<sup>3</sup> AI/AN Child is defined as a covered child who is (a) certified American Indian/Alaskan Native (AI/AN) and (b) a member of a family with an income less than or equal to 250 percent of the FPL, as reported by the Eligibility Determination Contractor to the Contractor for the coverage period.

- c. In the event that the coverage of an enrollee is terminated on a retroactive basis, the State shall reimburse any claims payments made by the Contractor for services rendered during the period of the retroactive cancellation.
- d. For the purpose of the payments amount detailed in C.3.b., the premium for children and for low income children will be payable on a monthly basis for each month of coverage.

C.4. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.

C.5. Invoice Requirements. The Contractor shall invoice the State only for completed increments of service and for the amount stipulated in section C.3, above, and present said invoices no more often than monthly, with all necessary supporting documentation, to:

Division of Health Care Finance and Administration

310 Great Circle Road  
Nashville, TN 37243



- a. Each invoice shall clearly and accurately detail all of the following required information (calculations must be extended and totaled correctly).
- (1) Invoice Number (assigned by the Contractor)
  - (2) Invoice Date
  - (3) Contract Number (assigned by the State)
  - (4) Customer Account Name: Division of Health Care Finance and Administration, Division of Health Care Finance and Administration
  - (5) Customer Account Number (assigned by the Contractor to the above-referenced Customer)
  - (6) Contractor Name
  - (7) Contractor Tennessee Edison Registration ID Number Referenced in Preamble of this Contract
  - (8) Contractor Contact for Invoice Questions (name, phone, and/or fax)
  - (9) Contractor Remittance Address
  - (10) Description of Delivered Service
  - (11) Complete Itemization of Charges, which shall detail the following:
    - i. Service or Milestone Description (including name & title as applicable) of each service invoiced
    - ii. Number of Completed Units, Increments, Hours, or Days as applicable, of each service invoiced
    - iii. Applicable Payment Rate (as stipulated in Section C.3.) of each service invoiced
    - iv. Amount Due by Service
    - v. Total Amount Due for the invoice period
- b. The Contractor understands and agrees that an invoice under this Contract shall:
- (1) include only charges for service described in Contract Section A and in accordance with payment terms and conditions set forth in Contract Section C;
  - (2) only be submitted for completed service and shall not include any charge for future work;
  - (3) not include sales tax or shipping charges; and
  - (4) initiate the timeframe for payment (and any discounts) only when the State is in receipt of the invoice, and the invoice meets the minimum requirements of this section C.5.
- C.6. Payment of Invoice. A payment by the State shall not prejudice the State's right to object to or question any payment, invoice, or matter in relation thereto. A payment by the State shall not be construed as acceptance of any part of the work or service provided or as approval of any amount invoiced.
- C.7. Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the State, on the basis of audits conducted in accordance with the terms of this Contract, not to constitute proper remuneration for compensable services.
- C.8. Deductions. The State reserves the right to deduct from amounts, which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the State of Tennessee any amounts, which are or shall become due and payable to the State of Tennessee by the Contractor.
- C.9. Prerequisite Documentation. The Contractor shall not invoice the State under this Contract until the State has received the following documentation properly completed.



- a. The Contractor shall complete, sign, and present to the State an "Authorization Agreement for Automatic Deposit (ACH Credits) Form" provided by the State. By doing so, the Contractor acknowledges and agrees that, once said form is received by the State, all payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee shall be made by Automated Clearing House (ACH).
- b. The Contractor shall complete, sign, and present to the State a "Substitute W-9 Form" provided by the State. The taxpayer identification number detailed by said form must agree with the Contractor's Federal Employer Identification Number or Tennessee Edison Registration ID referenced in this Contract.

**D. STANDARD TERMS AND CONDITIONS:**

- D.1. Required Approvals. The State is not bound by this Contract until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).
- D.2. Modification and Amendment. This Contract may be modified only by a written amendment signed by all parties hereto and approved by both the officials who approved the base contract and, depending upon the specifics of the contract as amended, any additional officials required by Tennessee laws and regulations (said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).
- D.3. Termination for Convenience. The State may terminate this Contract without cause for any reason. Said termination shall not be deemed a breach of contract by the State. The State shall give the Contractor at least sixty (60) days written notice before the effective termination date. The Contractor shall be entitled to compensation for satisfactory, authorized service completed as of the termination date, but in no event shall the State be liable to the Contractor for compensation for any service which has not been rendered. Upon such termination, the Contractor shall have no right to any actual general, special, incidental, consequential, or any other damages whatsoever of any description or amount.
- D.4. Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor violates any terms of this Contract, the State shall have the right to immediately terminate the Contract and withhold payments in excess of fair compensation for completed services. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any breach of this Contract by the Contractor.
- D.5. Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the services performed under this Contract without obtaining the prior written approval of the State. If such subcontracts are approved by the State, each shall contain, at a minimum, sections of this Contract below pertaining to "Conflicts of Interest," "Nondiscrimination," and "Records" (as identified by the section headings). Notwithstanding any use of approved subcontractors, the Contractor shall be the prime contractor and shall be responsible for all work performed.
- D.6. Conflicts of Interest. The Contractor warrants that no part of the total Contract Amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Contractor in connection with any work contemplated or performed relative to this Contract.

The Contractor acknowledges, understands, and agrees that this Contract shall be null and void if the Contractor is, or within the past six months has been, an employee of the State of Tennessee



or if the Contractor is an entity in which a controlling interest is held by an individual who is, or within the past six months has been, an employee of the State of Tennessee.

- D.7. Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor on the grounds of handicap or disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law. The Contractor shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.
- D.8. Prohibition of Illegal Immigrants. The requirements of *Tennessee Code Annotated*, Section 12-4-124, *et seq.*, addressing the use of illegal immigrants in the performance of any Contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.
- a. The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document at Attachment B, hereto, semi-annually during the period of this Contract. Such attestations shall be maintained by the Contractor and made available to state officials upon request.
  - b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the period of this Contract, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Contract. Attestations obtained from such subcontractors shall be maintained by the Contractor and made available to state officials upon request.
  - c. The Contractor shall maintain records for all personnel used in the performance of this Contract. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.
  - d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of *Tennessee Code Annotated*, Section 12-4-124, *et seq.* for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this Contract.
  - e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Contract.
- D.9. Records. The Contractor shall maintain documentation for all charges under this Contract. The books, records, and documents of the Contractor, insofar as they relate to work performed or money received under this Contract, shall be maintained for a period of three (3) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon



reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

- D.10. Prevailing Wage Rates. All contracts for construction, erection, or demolition or to install goods or materials that involve the expenditure of any funds derived from the State require compliance with the prevailing wage laws as provided in *Tennessee Code Annotated*, Section 12-4-401, *et seq.*
- D.11. Monitoring. The Contractor's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.
- D.12. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.
- D.13. Strict Performance. Failure by any party to this Contract to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the parties hereto.
- D.14. Independent Contractor. The parties hereto, in the performance of this Contract, shall not act as employees, partners, joint venturers, or associates of one another. It is expressly acknowledged by the parties hereto that such parties are independent contracting entities and that nothing in this Contract shall be construed to create an employer/employee relationship or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purpose whatsoever.
- The Contractor, being an independent contractor and not an employee of the State, agrees to carry adequate public liability and other appropriate forms of insurance, including adequate public liability and other appropriate forms of insurance on the Contractor's employees, and to pay all applicable taxes incident to this Contract.
- D.15. State Liability. The State shall have no liability except as specifically provided in this Contract.
- D.16. Force Majeure. The obligations of the parties to this Contract are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including, but not limited to, natural disasters, riots, wars, epidemics, or any other similar cause.
- D.17. State and Federal Compliance. The Contractor shall comply with all applicable State and Federal laws and regulations in the performance of this Contract.
- D.18. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Contractor agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Contract. The Contractor acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising therefrom, shall be subject to and limited to those rights and remedies, if any, available under *Tennessee Code Annotated*, Sections 9-8-101 through 9-8-407.
- D.19. Completeness. This Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.



- D.20. Severability. If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Contract are declared severable.
- D.21. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.
- D.22. HIPAA Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Health Information Technology for Economic and Clinical Health (HITECH) Act and any other relevant laws and regulations regarding privacy (collectively the "Privacy Rules").
- a. Contractor warrants to the State that it is familiar with the requirements of the Privacy Rules, and will comply with all applicable requirements in the course of this Contract.
  - b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by the Privacy Rules, in the course of performance of the Contract so that both parties will be in compliance with the Privacy Rules.
  - c. The State and the Contractor will sign documents, including but not limited to business associate agreements, as required by the Privacy Rules and that are reasonably necessary to keep the State and Contractor in compliance with the Privacy Rules. This provision shall not apply if information received or delivered by the parties under this Contract is NOT "protected health information" as defined by the Privacy Rules, or if the Privacy Rules permit the parties to receive or deliver such information without entering into a business associate agreement or signing another such document.
  - d. The Contractor will indemnify the State and hold it harmless for any violation by the Contractor or its subcontractors of the Privacy Rules. This includes the costs of responding to a breach of protected health information, the costs of responding to a government enforcement action related to the breach, and any fines, penalties, or damages paid by the State because of the violation.

**E. SPECIAL TERMS AND CONDITIONS:**

- E.1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, these special terms and conditions shall control.
- E.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract, other than the information or data that is necessary for one or more contract deliverables, shall be in writing and shall be made by certified, first class mail, return receipt requested and postage prepaid, by overnight courier service with an asset tracking system, or by EMAIL or facsimile transmission with recipient confirmation. Any such communications, regardless of method of transmission, shall be addressed to the respective party at the appropriate mailing address, facsimile number, or EMAIL address as set forth below or to that of such other party or address, as may be hereafter specified by written notice.

The State:

Deputy Commissioner  
Department of Finance and Administration  
Division of Health Care Finance and Administration  
Bureau of HCFA



310 Great Circle Road  
Nashville TN 37243  
(615) 507-6443 (Phone)  
(615) 253-5607 (FAX)  
[Darin.j.gordon@tn.gov](mailto:Darin.j.gordon@tn.gov)

The Contractor:

Michele Blackwell  
Regional Vice President, Southeast - Region 2  
8300 NW 53rd Street, Suite 200  
Doral, FL 33166  
888-683-6725 (Toll-Free)  
262-387-3737 (Fax)  
[Michele.Blackwell@DentaQuest.com](mailto:Michele.Blackwell@DentaQuest.com)

All instructions, notices, consents, demands, or other communications shall be considered effectively given upon receipt or recipient confirmation as may be required.

- E.3. Subject to Funds Availability. The Contract is subject to the appropriation and availability of State and/or Federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate the Contract upon written notice to the Contractor. Said termination shall not be deemed a breach of Contract by the State. Upon receipt of the written notice, the Contractor shall cease all work associated with the Contract. Should such an event occur, the Contractor shall be entitled to compensation for all satisfactory and authorized services completed as of the termination date. Upon such termination, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.
- E.4. Tennessee Consolidated Retirement System. The Contractor acknowledges and understands that, subject to statutory exceptions contained in *Tennessee Code Annotated*, Section 8-36-801, *et. seq.*, the law governing the Tennessee Consolidated Retirement System (TCRS), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established pursuant to *Tennessee Code Annotated*, Title 8, Chapter 35, Part 3 accepts state employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of "employee/employer" and not that of an independent contractor, the Contractor, if a retired member of TCRS, may be required to repay to TCRS the amount of retirement benefits the Contractor received from TCRS during the period of this Contract.
- E.5. Tennessee Department of Revenue Registration. The Contractor shall be registered with the Department of Revenue for the collection of Tennessee sales and use tax. This registration requirement is a material requirement of this Contract.
- E.6. Breach. A party shall be deemed to have breached the Contract if any of the following occurs:
- failure to perform in accordance with any term or provision of the Contract;
  - partial performance of any term or provision of the Contract;
  - any act prohibited or restricted by the Contract, or
  - violation of any warranty.

For purposes of this Contract, these items shall hereinafter be referred to as a "Breach."

- a. Contractor Breach— The State shall notify Contractor in writing of a Breach.



- (1) In event of a Breach by Contractor, the State shall have available the remedy of Actual Damages and any other remedy available at law or equity.
- (2) **Monetary Assessments**— In the event of a Breach, the State may assess Monetary Assessments. The State shall notify the Contractor of amounts to be assessed as Monetary Assessments. The parties agree that due to the complicated nature of the Contractor's obligations under this Contract it would be difficult to specifically designate a monetary amount for a Breach by Contractor as said amounts are likely to be uncertain and not easily proven. Contractor hereby represents and covenants it has carefully reviewed the Monetary Assessments contained in Attachment C and agree that said amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of Breach, and are a reasonable estimate of the damages that would occur from a Breach. It is hereby agreed between the parties that the Monetary Assessments represent solely the damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party. The Contractor agrees that the Monetary Assessments amount is in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or other section of this Contract.

The State may continue to withhold the Monetary Assessments or a portion thereof until the Contractor cures the Breach, the State exercises its option to declare a Partial Default, or the State terminates the Contract. The State is not obligated to assess Monetary Assessments before availing itself of any other remedy. The State may choose to discontinue Monetary Sanctions and avail itself of any other remedy available under this Contract or at law or equity; provided, however, Contractor shall receive a credit for said Monetary Sanctions previously withheld except in the event of a Partial Default.

- (3) **Partial Default**— In the event of a Breach, the State may declare a Partial Default. In which case, the State shall provide the Contractor written notice of: (1) the date which Contractor shall terminate providing the service associated with the Breach; and (2) the date the State will begin to provide the service associated with the Breach. Notwithstanding the foregoing, the State may revise the time periods contained in the notice written to the Contractor.

In the event the State declares a Partial Default, the State may withhold, together with any other damages associated with the Breach, from the amounts due the Contractor the greater of: (1) amounts which would be paid the Contractor to provide the defaulted service; or (2) the cost to the State of providing the defaulted service, whether said service is provided by the State or a third party. To determine the amount the Contractor is being paid for any particular service, TennCare shall be entitled to receive within five (5) days any requested material from Contractor. The State shall make the final and binding determination of said amount.

The State may assess Monetary Assessments against the Contractor for any failure to perform which ultimately results in a Partial Default with said Monetary Sanctions to cease when said Partial Default is effective. Upon Partial Default, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount. Contractor agrees to cooperate fully with the State in the event a Partial Default is taken.

- (4) **Contract Termination**— In the event of a Breach, the State may terminate the Contract immediately or in stages. The Contractor shall be notified of the termination in writing by the State. Said notice shall hereinafter be referred to as



Termination Notice. The Termination Notice may specify either that the termination is to be effective immediately, on a date certain in the future, or that the Contractor shall cease operations under this Contract in stages. In the event of a termination, the State may withhold any amounts which may be due Contractor without waiver of any other remedy or damages available to the State at law or at equity. The Contractor shall be liable to the State for any and all damages incurred by the State and any and all expenses incurred by the State which exceed the amount the State would have paid Contractor under this Contract. Contractor agrees to cooperate with the State in the event of a Contract Termination or Partial Takeover.

- b. State Breach— In the event of a Breach of Contract by the State, the Contractor shall notify the State in writing within 30 days of any Breach of Contract by the State. Said notice shall contain a description of the Breach. Failure by the Contractor to provide said written notice shall operate as an absolute waiver by the Contractor of the State's Breach. In no event shall any Breach on the part of the State excuse the Contractor from full performance under this Contract. In the event of Breach by the State, the Contractor may avail itself of any remedy at law in the forum with appropriate jurisdiction; provided, however, failure by the Contractor to give the State written notice and opportunity to cure as described herein operates as a waiver of the State's Breach. Failure by the Contractor to file a claim before the appropriate forum in Tennessee with jurisdiction to hear such claim within one (1) year of the written notice of Breach shall operate as a waiver of said claim in its entirety. It is agreed by the parties this provision establishes a contractual period of limitations for any claim brought by the Contractor.

E.7. Incorporation of Additional Documents. Each of the following documents is included as a part of this Contract by reference. In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these items shall govern in order of precedence below.

- a. this Contract document with any attachments or exhibits (excluding the items listed at subsections b. through e., below);
- b. any clarifications of or addenda to the Contractor's proposal seeking this Contract;
- c. the State solicitation, as may be amended, requesting proposals in competition for this Contract;
- d. any technical specifications provided to proposers during the procurement process to award this Contract;
- e. the Contractor's proposal seeking this Contract.

E.8. Applicable Laws, Rules and Policies. The Contractor agrees to comply with all applicable federal and State laws, rules, regulations and executive orders.

E.9. Lobbying. The Contractor certifies, to the best of its knowledge and belief, that:

- a. No federally appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.



- b. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- c. The Contractor shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into and is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, *U.S. Code*.

E.10. Debarment and Suspension. The Contractor certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or agency;
- b. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in section b. of this certification; and
- d. have not within a three (3) year period preceding this Contract had one or more public transactions (federal, state, or local) terminated for cause or default.

The Contractor shall provide immediate written notice to the State if at any time it learns that there was an earlier failure to disclose information or that due to changed circumstances, its principals or the principals of its subcontractors are excluded or disqualified

E.11. Contractor Commitment to Diversity. The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity represented by the Contractor's proposal responding to RFP-31865-00377 (Attachment 6.6) and resulting in this Contract.

The Contractor shall assist the State in monitoring the Contractor's performance of this commitment by providing, as requested, a quarterly report of participation in the performance of this Contract by small business enterprises and businesses owned by minorities, women, and persons with a disability. Such reports shall be provided to the state of Tennessee Governor's Office of Diversity Business Enterprise in form and substance as required by said office.

E.12. Federal Funding Accountability and Transparency Act (FFATA). This Contract requires the Contractor to provide supplies and/or services that are funded in whole or in part by federal funds that are subject to FFATA. The Contractor is responsible for ensuring that all applicable requirements, including but not limited to those set forth herein, of FFATA are met and that the Contractor provides information to the State as required.

The Contractor shall comply with the following:



- a. Reporting of Total Compensation of the Contractor's Executives.
- (1) The Contractor shall report the names and total compensation of each of its five most highly compensated executives for the Contractor's preceding completed fiscal year, if in the Contractor's preceding fiscal year it received:
- i. 80 percent or more of the Contractor's annual gross revenues from Federal procurement contracts and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and
  - ii. \$25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts), and Federal financial assistance subject to the Transparency Act (and subawards); and
  - iii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at <http://www.sec.gov/answers/excomp.htm>.)
- Executive means officers, managing partners, or any other employees in management positions.
- (2) Total compensation means the cash and noncash dollar value earned by the executive during the Contractor's preceding fiscal year and includes the following (for more information see 17 CFR 229.402(c)(2)):
- i. Salary and bonus.
  - ii. Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.
  - iii. Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.
  - iv. Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.
  - v. Above-market earnings on deferred compensation which is not tax qualified.
  - vi. Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds \$10,000.
- b. The Contractor must report executive total compensation described above to the State by the end of the month during which this Contract is awarded.
- c. If this Contract is amended to extend its term, the Contractor must submit an executive total compensation report to the State by the end of the month in which the amendment to this Contract becomes effective.
- d. The Contractor will obtain a Data Universal Numbering System (DUNS) number and maintain its DUNS number for the term of this Contract. More information about obtaining a DUNS Number can be found at: <http://fedgov.dnb.com/webform/>



The Contractor's failure to comply with the above requirements is a material breach of this Contract for which the State may terminate this Contract for cause. The State will not be obligated to pay any outstanding invoice received from the Contractor unless and until the Contractor is in full compliance with the above requirements.

- E.13. Prohibited Advertising. The Contractor shall not refer to this Contract or the Contractor's relationship with the State hereunder in commercial advertising in such a manner as to state or imply that the Contractor or the Contractor's services are endorsed. It is expressly understood and agreed that the obligations set forth in this section shall survive the termination of this Contract in perpetuity.
- E.14. Employees Excluded from Medicare, Medicaid or CHIP. The Contractor does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly employ, in the performance of this Contract, employees who have been excluded from participation in the Medicare, Medicaid, and/or CHIP programs pursuant to Sections 1128 of the Social Security Act.
- E.15. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards.

The Contractor's obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the Contractor of this Contract; previously possessed by the Contractor without written obligations to the State to protect it; acquired by the Contractor without written restrictions against disclosure from a third party which, to the Contractor's knowledge, is free to disclose the information; independently developed by the Contractor without the use of the State's information; or, disclosed by the State to others without restrictions against disclosure. Nothing in this paragraph shall permit Contractor to disclose any information that is confidential under federal or state law or regulations, regardless of whether it has been disclosed or made available to the Contractor due to intentional or negligent actions or inactions of agents of the State or third parties.

It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Contract.

- E.16. Business Associate. Contractor hereby acknowledges its designation as a business associate under HIPAA and agrees to comply with all applicable HIPAA regulations. In accordance with the HIPAA regulations, the Contractor shall, at a minimum:
- a. Comply with requirements of the HIPAA, including, but not limited to, the transactions and code sets, privacy, security, and identifier regulations. Compliance includes meeting all required transaction formats and code sets with the specified data sharing agreements required under the regulations;
  - b. Transmit/receive from/to its providers, subcontractors, clearinghouses and HCFA all transactions and code sets required by HIPAA in the appropriate standard formats, utilizing appropriate and adequate safeguards, as specified under the law and as directed by HCFA so long as HCFA direction does not conflict with the law;
  - c. Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA standards, that it will be in breach of this Contract and will then take all reasonable steps to cure the



breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy and security requirements can bring basic business practices between HCFA and the Contractor and between the Contractor and its providers and/or subcontractors to a halt, if for any reason the Contractor cannot meet the requirements of this Section, HCFA may terminate this Contract.

- d. Ensure that Protected Health Information (PHI) exchanged between the Contractor and HCFA is used only for the purposes of treatment, payment, or health care operations and health oversight and its related functions. All PHI not transmitted for these purposes or for purposes allowed under the federal HIPAA regulations shall be de-identified to secure and protect the individual enrollee's PHI;
- e. Report to HCFA's Privacy Office immediately upon becoming aware of any use or disclosure of PHI in violation of this Contract by the Contractor, its officers, directors, employees, subcontractors or agents or by a third party to which the Contractor disclosed PHI;
- f. Specify in its agreements with any agent or subcontractor that will have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to the Contractor pursuant to this Section;
- g. Specify in its agreements with any agent or subcontractor that will have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to the Contractor pursuant to this Section;
- h.. Make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available to the U.S. Secretary of Health and Human Services for the purposes of determining compliance with the HIPAA regulations upon request;
- i. Create and adopt policies and procedures to periodically audit adherence to all HIPAA regulations;
- j. Agree to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted by or on behalf of HCFA agrees to use reasonable and appropriate safeguards to protect the PHI.
- k. Agree to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted by or on behalf of HCFA agrees to use reasonable and appropriate safeguards to protect the PHI.
- l.. If feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of an any data or compilations derived from and allowing identification of any individual who is a subject of that PHI upon termination, cancellation, expiration or other conclusion of the Agreement, and in accordance with this Section of this Contract. The Contractor shall complete such return or destruction as promptly as possible, but not later than thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement. The Contractor shall identify any PHI that cannot feasibly be returned or destroyed. Within such thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, the Contractor shall: (1) certify on oath in writing that such return or destruction has been completed; (2) identify any PHI which cannot feasibly be returned or destroyed; and (3) certify that it will only use or disclose such PHI for those purposes that make its return or destruction infeasible;
- m. Implement all appropriate administrative, physical and technical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Contract and, including, but not limited to, privacy, security and confidentiality requirements in 45 CFR Parts 160 and 164;



- n. Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure;
  - o. Create and implement policies and procedures to address present and future HIPAA regulatory requirements as needed, including, but not limited to: use and disclosure of data; de-identification of data; minimum necessary access; accounting of disclosures; enrollee's right to amend, access, request restrictions; notice of privacy practices and right to file a complaint;
  - p. Provide an appropriate level of training to its staff and employees regarding HIPAA related policies, procedures, enrollee rights and penalties prior to the HIPAA implementation deadlines and at appropriate intervals thereafter;
  - q. Track training of Contractor staff and employees and maintain signed acknowledgements by staff and employees of the Contractor's HIPAA policies;
  - r. Be allowed to use and receive information from HCFA where necessary for the management and administration of this Contract and to carry out business operations where permitted under the regulations;
  - s. Be permitted to use and disclose PHI for the Contractor's own legal responsibilities;
  - t. Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by Contractor employees and other persons performing work for the Contractor to have only minimum necessary access to PHI and personally identifiable data within their organization;
  - u. Continue to protect and secure PHI and personally identifiable information relating to enrollees who are deceased; and
  - v. Track all security incidents as defined by HIPAA and, as required by the HIPAA Reports. The Contractor shall periodically report in summary fashion such security incidents.
- E.17. Information Holders. HCFA and the Contractor are "information holders" as defined in TCA 47-18-2107. In the event of a breach of the security of Contractor's information system, as defined by TCA 47-18-2107, the Contractor shall indemnify and hold HCFA harmless for expenses and/or damages related to the breach. Such obligations shall include, but not be limited to, mailing notifications to affected enrollees. Substitute notice to written notice, as defined by TCA 47-18-2107(e)(2)and(3), shall only be permitted with HCFA's express written approval. The Contractor shall notify HCFA's Privacy Office immediately upon becoming aware of any security incident that would constitute a "breach of the security of the system" as defined in TCA 47-18-2107.
- E.18. Notification of Breach and Notification of Suspected Breach. - The Contractor shall notify HCFA's Privacy Office immediately upon becoming aware of any incident, either confirmed or suspected, that represents or may represent unauthorized access, use or disclosure of encrypted or unencrypted computerized data that materially compromises the security, confidentiality, or integrity of enrollee PHI maintained or held by the Contractor, including any unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the Contractor 's system. This includes, but is not limited to, loss or suspected loss of remote computing or telework devices such as laptops, PDAs, Blackberrys or other Smartphones, USB drives, thumb drives, flash drives, CDs, and/or disks.
- E.19. All information or data that is necessary for one or more deliverable set forth in this Contract shall be transmitted between HCFA and Contractor via the data transfer method specified in advance by HCFA. This may include, but shall not be limited to, transfer through HCFA's SFTP system. Failure by the Contractor to transmit information or data that is necessary for a deliverables in the manner specified by HCFA, may, at the option of HCFA, result in Monetary Assessments as set forth on Contract Attachment C hereto.
- E.20. Social Security Administration (SSA) Required Provisions for Data Security. The Contractor shall comply with limitations on use, treatment, and safeguarding of data under the Privacy Act of 1974



(5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget guidelines, the Federal Information Security Management Act of 2002 (44 U.S.C. § 3541, *et seq.*), and related National Institute of Standards and Technology guidelines. In addition, the Contractor shall have in place administrative, physical, and technical safeguards for data.

- a. The Contractor shall not duplicate in a separate file or disseminate, without prior written permission from HCFA, the data governed by the Contract for any purpose other than that set forth in this Contract for the administration of the HCFA program. Should the Contractor propose a redisclosure of said data, the Contractor must specify in writing to HCFA the data the Contractor proposes to redisclose, to whom, and the reasons that justify the redisclosure. HCFA will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the HCFA program.
- b. The Contractor agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Contract.
- c. The Contractor shall provide a current list of the employees of such contractor with access to SSA data and provide such lists to HCFA.
- d. The Contractor shall restrict access to the data obtained from HCFA to only those authorized employees who need such data to perform their official duties in connection with purposes identified in this Contract. The Contractor shall not further duplicate, disseminate, or disclose such data without obtaining HCFA's prior written approval.
- e. The Contractor shall ensure that its employees:
  - (1) properly safeguard PHI/PII furnished by HCFA under this Contract from loss, theft or inadvertent disclosure;
  - (2) understand that they are responsible for safeguarding this information at all times, regardless of whether or not the Contractor employee is at his or her regular duty station;
  - (3) ensure that laptops and other electronic devices/ media containing PHI/PII are encrypted and/or password protected;
  - (4) send emails containing PHI/PII only if encrypted or if to and from addresses that are secure; and,
  - (5) limit disclosure of the information and details relating to a PHI/PII loss only to those with a need to know.

Contractor employees who access, use, or disclose HCFA or HCFA SSA-supplied data in a manner or purpose not authorized by this Contract may be subject to civil and criminal sanctions pursuant to applicable federal statutes.

- f. **Loss or Suspected Loss of Data** – If an employee of the Contractor becomes aware of suspected or actual loss of PHI/PII, he or she must immediately contact HCFA immediately upon becoming aware to report the actual or suspected loss. The Contractor will use the Loss Worksheet located at [http://www.tn.gov/HCFA/forms/phi\\_piiworksheet.pdf](http://www.tn.gov/HCFA/forms/phi_piiworksheet.pdf) to quickly gather and organize information about the incident. The Contractor must provide HCFA with timely updates as any additional information about the loss of PHI/PII becomes available.



If the Contractor experiences a loss or breach of said data, HCFA will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the Contractor shall bear any costs associated with the notice or any mitigation.

- g. HCFA may immediately and unilaterally suspend the data flow under this Contract, or terminate this Contract, if HCFA, in its sole discretion, determines that the Contractor has: (1) made an unauthorized use or disclosure of HCFA SSA-supplied data; or (2) violated or failed to follow the terms and conditions of this Contract.
- h. In order to meet certain requirements set forth in the State's Computer Matching and Privacy Protection Act Agreement (CMPPA) with the SSA, the Parties acknowledge that this Section shall be included in all agreements executed by or on behalf of the State. The Parties further agree that FISMA and NIST do not apply in the context of data use and disclosure under this Agreement as the Parties shall neither use nor operate a federal information system on behalf of a federal executive agency. Further, NIST is applicable to federal information systems; therefore, although encouraged to do so, the State, its contractors, agents and providers are not required to abide by the NIST guidelines.
- i. This Section further carries out Section 1106(a) of the Act (42 U.S.C. 1306), the regulations promulgated pursuant to that section (20 C.F.R. Part 401), the Privacy of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget ("OMB") guidelines, the Federal Information Security Management Act of 2002 ("FISMA") (44 U.S.C. 3541 et seq.), and related National Institute of Standards and Technology ("NIST") guidelines, which provide the requirements that the SSA stipulates that the Contractor must follow with regard to use, treatment, and safeguarding data in the event data is exchanged with a federal information system.
- j. Definitions
  - (1) "SSA-supplied data" – information, such as an individual's social security number, supplied by the Social Security Administration to HCFA to determine entitlement or eligibility for federally-funded programs (CMPPA between SSA and F&A; IEA between SSA and HCFA).
  - (2) "Protected Health Information/Personally Identifiable Information" (PHI/PII) (45 C.F.R. 160.103; OMB Circular M-06-19) – Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.
  - (3) "Individually Identifiable Health Information" – information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
  - (4) "Personally Identifiable Information" – any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, date and place of birth, mother's maiden name,



biometric records, including any other personal information which can be linked to an individual.

- E.21. The Contractor shall comply and submit to HCFA the disclosure of ownership and control information in accordance with the requirements specified in 42 C.F.R. Part 455, Subpart B, using the form approved by HCFA provider registration process.
- E.22. Offer of Gratuities. By signing this contract, the Contractor signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the federal General Accounting Office, federal Department of Health and Human Services, the Center for Medicare and Medicaid Services, or any other state or federal agency has or will benefit financially or materially from this Contract. This Contract may be terminated by HCFA as provided in Section D.4, if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, its agent, or employees.

IN WITNESS WHEREOF,

CONTRACTOR LEGAL ENTITY NAME:

CONTRACTOR SIGNATURE

DATE December 11, 2014

Steven J. Pollock, President

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above) President

DEPARTMENT OF FINANCE AND ADMINISTRATION  
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION:

LARRY B. MARTIN, COMMISSIONER

12/12/2014

DATE



## TERMS AND DEFINITIONS

1. **AI/AN Child** - a child covered by CoverKids who is a certified American Indian/Alaskan Native and a member of a family with an income less than or equal to 250 percent of the FPL, as reported by the Plan Administrator to the Dental Benefits Manager for the coverage period.
2. **Benefits** – A schedule of benefits of dental services to be delivered to members covered by the Contractor.
3. **Cost Sharing** – the member has a 5% cost sharing of out-of-pocket expenses. The member is no longer required to pay a copayment for any service (medical or dental) once the member has met the 5% out-of-pocket cap.
4. **Dental Benefits Manager** – A competitively procured contractor approved by the Division of Health Care Finance and Administration (HCFA) to provide dental benefits to eligible CoverKids members.
5. **Disenrollment** – HCFA is responsible for the disenrollment of members from the Contractor's plan.
6. **Eligible person** – A member certified by HCFA to receive medical and dental benefits under the CoverKids program.
7. **Enrollment** – The process by which a person becomes a member of the Contractor's plan through the state.
8. **Group One Child** - a child covered by CoverKids who is in a family with an income between 150 percent and 250 percent of FPL.
9. **Group Two Child** – a child covered by CoverKids who is in a family with an income below 150 percent of FPL.
10. **HCFA** – Division of Health Care Finance and Administration
11. **Medically Necessary** - a service or supply that is required to diagnose or treat an injury, ailment or condition, disease or illness and determined by the Dental Benefits Manager to be appropriate with regard to standards of good professional practice, consistent with the diagnosis, not primarily for the convenience of a provider, a patient or a patient's family, and the most appropriate supply or level of service that can be safely provided to a member.
12. **Medical Plan Administrator** – A contractor approved by the HCFA to provide medical, pharmacy, vision and behavioral health benefits to members.
13. **Provider Network** – The Contractor establishes and maintains a provider dental network covering the entire State of Tennessee to provide dental services to CoverKids members.



**ATTACHMENT B**

**ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE**

SUBJECT CONTRACT NUMBER:	44466
CONTRACTOR LEGAL ENTITY NAME:	DentaQuest USA Insurance Company, Inc.
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	20-2970185

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

**CONTRACTOR SIGNATURE**

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. If said individual is not the chief executive or president, this document shall attach evidence showing the individual's authority to contractually bind the Contractor.

**Steven J. Pollock; President**

**PRINTED NAME AND TITLE OF SIGNATORY**

**December 11, 2014**

**DATE OF ATTESTATION**



**ATTACHMENT C**

**Performance Guarantees, Contract Requirements, Deliverables and Damages**

It is acknowledged by HCFA and the Contractor that in the event of failure to meet the requirements provided in this Contract and all documents incorporated herein, HCFA will be harmed. The actual damages which HCFA will sustain in the event of and by reason of such failure are uncertain and are extremely difficult and impractical to ascertain and determine. The parties therefore acknowledge that the Contractor shall be subject to damages and/or sanctions as described below. It is further agreed that the Contractor shall pay HCFA liquidated damages as directed by HCFA and not to exceed the fixed amount as stated below; provided however, that if it is finally determined that the Contractor would have been able to meet the Contract requirements listed below but for HCFA's failure to perform as provided in this Contract, the Contractor shall not be liable for damages resulting directly therefrom.

The table below summarizes Performance Guarantees, specific requirements and deliverables described in the Contract and the delivery schedules and monetary assessments for non-performance of these guarantees, requirements and deliverables. The performance standard for each Performance Guarantee described in the table below shall be in effect throughout the contract term. Monetary Assessments may be assessed in the amounts indicated below for the time period in which the deficiency occurs. Monetary Assessments may be retroactive to the date of the notice of deficiency and continue until such time as the Deputy Commissioner of HCFA determines the deficiency has been cured.

For Performance Guarantees measured in percentages, calculation for said percentages shall be made using the following standards: less than five-tenths (.5) of a percentage point will round down the nearest percentage point and five-tenths (.5) and over will round up to the nearest percentage point. The State has final determination and approval of the calculation method used for Performance Guarantees. In the sole discretion of the State, the Contractor shall not be held liable for any Monetary Assessments resulting from circumstances beyond the Contractor's control, such as unavailability of State technology systems or the inability to accept electronic data caused by entities outside of Contractor's control.

The State may choose to impose the Monetary Assessments as set forth below in the event the Contractor fails to properly perform its obligations under this Contract in a proper and/or timely manner. Upon determination that the Contractor is not completing one or more of the services or requirements described in this Contract in a proper and/or timely manner, the State shall notify the Contractor in writing of the deficiency and of the potential Monetary Assessment pursuant to the Control Memorandum Process set forth in Contract Section A.56.

A general Monetary Assessment of five hundred dollars (\$500.00) per calendar day/per occurrence, as applicable, may be assessed in the sole discretion of the State for any violation of a contract provision that is not specifically listed in the following table. The damage that may be assessed shall be \$500 per calendar day for each separate failure to comply with the Contract, plus, if applicable, an additional \$500 per calendar day for each affected CoverKids enrollee.

The State may also assess a Monetary Assessment for actual losses suffered by the State due to the Contractor's failure to meet Performance Standards or other requirements set forth in the Contract.

Any Monetary Assessment or actual damages may be deducted by the State from any monthly payment due to the Contractor.

<b>1. Claims Payment Dollar Accuracy</b>	
Guarantee	The average quarterly financial accuracy for claims payments shall be 99% or higher.
Definition	Claims Payment Dollar Accuracy is defined as the absolute value of financial errors, inclusive of both human and system generated, divided by the total paid value of Contractor audited dollars paid.



Monetary Assessment	\$500 for each full percentage point below 99% for each contracted quarter.
Compliance report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample of claims. The Contractor shall measure and report results quarterly for the life of the contract. Performance will be reconciled annually on a calendar year basis.
<b>2. Claims Processing Accuracy</b>	
Guarantee	The average quarterly processing accuracy shall be 97% or higher.
Definition	Claims Processing Accuracy is defined as the absolute number of claims with no in processing or procedural errors, divided by the total number of claims within the audit sample. <u>This excludes financial errors.</u>
Monetary Assessment	\$1000 for each full percentage point below 97%, for each contracted quarter.
Compliance report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample of claims agreed upon by both parties prior to commencement. The Contractor shall measure and report results quarterly. Performance will be reconciled annually on a calendar year basis.
<b>3. Claims Turnaround Time</b>	
Guarantee	The average quarterly claims payment turnaround time will not be greater than: 30 business days for 97% of all claims.
Definition	Claims Turnaround Time is measured from the date the claim is received in the office to the date processed, including weekends and holidays.
Monetary Assessment	\$500 for each full percentage point below the required minimum standard of 97% for all claims.
Compliance report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample agreed upon by both parties prior to commencement. The Contractor shall measure and report results quarterly for the life of the contract. Performance shall be reconciled annually on a calendar year basis.
<b>4. Telephone Response Time – Member Services Line</b>	
Guarantee	Average Speed of Answer (ASA) by a live member services representative of incoming Enrollee services calls will be 30 seconds or less.
Definition	Average Speed of Answer (ASA) is defined as the amount of time elapsing between the time a call is received into the phone system and when a live member services representative answers the phone.
Monetary Assessment	\$250 for each full second over the 30 second benchmark. Quarterly guarantee.
Compliance report	The Compliance Report is the Contractor's internal telephone support system reports. Performance will be measured quarterly through the life of the contract; reported and reconciled annually on a calendar year basis.
<b>5. Telephone Call Abandonment Rate (Unanswered calls) – Member Services Line</b>	
Guarantee	Less than 5% of telephone calls are abandoned by the Member Services Line
Definition	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period.
Monetary Assessment	\$250.00 for each full percentage point above 5% for calls abandoned before being answered by a live voice. Quarterly guarantee.
Compliance report	The Compliance Report is the Contractor's internal Member Services telephone support system reports. Performance will be measured quarterly; reported and reconciled annually.
<b>6. Telephone Response Time/Call Answer Timeliness – Provider Services Line</b>	
Guarantee	Eighty-five percent (85%) of incoming Provider Services calls shall be answered by a Provider Services representative within 30 seconds or the prevailing benchmark stabled by NCQA
Definition	Telephone Response Time is defined as the number of calls answered by a live voice within 30 seconds, divided by the number of calls received by the phone line (during hours of operation) during the measurement period
Monetary Assessment	\$250 for each percentage point below the 85% threshold for calls answered within 30 seconds or less. Quarterly guarantee.
Compliance report	The Compliance Report is the Contractor's internal telephone support system reports. Performance will be measured quarterly; reported and reconciled annually.
<b>7. Telephone Call Abandonment Rate (Unanswered calls) – Provider Services Line</b>	
Guarantee	Less than 5% of telephone calls are abandoned by the Provider Services Line
Definition	The number of calls abandoned by the caller or the system before being answered by a live voice divided by the number of calls received by the phone line (during open hours of operation) during the measurement period.
Monetary	\$250 for each full percentage point above 5% for calls abandoned before being answered by a



Assessment	live voice. Quarterly guarantee.	
Compliance report	The Compliance Report is the Contractor's internal Provider Services telephone support system reports. Performance will be measured quarterly; reported and reconciled annually.	
<b>8. Enrollee Satisfaction</b>		
Guarantee	The level of overall customer satisfaction, as measured annually by a State approved Enrollee Satisfaction survey(s), will be equal to or greater than 85% in the first year of the Contract, and 90% in all subsequent year(s) within the Contract term.	
Definition	Participant Satisfaction will be measured utilizing the most current National Committee on Quality Assurance (NCQA) Adult Participant Satisfaction Survey question that measures overall satisfaction.	
Monetary Assessment	\$3,000. Annual guarantee.	
Compliance report	The Compliance Report is the Contractor's results from National Committee Quality Assurance (NCQA) annual Adult Participant Satisfaction Survey. Performance will be measured, reported, and reconciled annually on a calendar year basis.	
<b>9. Member Handbooks ID, and Provider Network Directories Distributed</b>		
Guarantee	Member Handbooks and Provider Network Directories shall be distributed to Enrollees within ten (10) calendar days of the effective date of enrollment or to individuals requesting information within five (5) business days of the request. (The handbook and provider directory may be a single document).	
Definition	Member Handbook and Provider Network Directories shall be measured based on date of distribution.	
Monetary Assessment	Should either of the above listed documents not be distributed as required, the total assessment shall be \$2,500 per year in which the standard is not met.	
Compliance report	The Compliance Report reported by the Contractor. Annual guarantee is measured, reported, and reconciled annually on a calendar year basis.	
<b>10. Provider Network Accessibility</b>		
Guarantee	As measured by the GeoNetworks <sup>®</sup> Provider Network Accessibility Analysis, the Contractor's provider and facility network shall assure that during the first phase of the performance guarantee implementation period, 100% of all Enrollees shall have the Access Standard indicated below at the end of the first twelve (12) months of the contract effective date.	
Definition	<b>Provider Group</b>	<b>Access Standard</b>
	General or Pediatric Dentists	One (1) provider within 30 miles
Monetary Assessment	\$5,000 if the above listed standards is not met, measured monthly at the State's discretion.	
Guarantee	As measured by the GeoNetworks <sup>®</sup> Provider Network Accessibility Analysis, the Contractor's provider and facility network shall assure that during the second phase of the performance guarantee implementation period, 100% of all Enrollees shall have the Access Standard indicated below at the end of the second calendar year of the contract effective date and at the end of each successive calendar year.	
Definition	<b>Provider Group</b>	<b>Access Standard</b>
	General or Pediatric Dentists	One (1) provider within 30 miles
Monetary Assessment	\$5,000 if the above listed standard is not met, measured monthly at the State's discretion.	
Compliance report	Compliance report is the annual GeoNetworks Analysis submitted by Contractor. The Annual guarantee is measured, reported and reconciled annually on a calendar year basis.	
<b>11. Claims Data Quality</b>		
Guarantee	Claims Data Quality is measured by the Division of Health Care Finance and Administration, Office of Healthcare Informatics (HCI). The Contractor's quarterly data submission to HCI shall meet the following Data Quality measures.	
Definition	<i>Measure</i>	<i>Benchmark</i>
	Gender	Data missing for <= (less than or equal to) 3% of claims
	Date of birth	Data missing for <= 3% of claims
	Outpatient diagnosis coding	Data invalid or missing for <= 5% of outpatient claims
	Outpatient provider type missing	Data missing for <= 1.5% of outpatient claims
Monetary Assessment	\$2500 if any of the above listed standards is not met, either individually or in combination. Quarterly Guarantee.	
Compliance report	Compliance Report consists of HCI's Quarterly Data Quality report provided by HCI. Performance measured and reported by HCI quarterly; reconciled annually on a calendar year	



	basis.
<b>12. Submission of Monthly Claims Data</b>	
Guarantee	Monthly claims data shall be submitted by the Contractor to HCI no later than the 5 <sup>th</sup> business day of the month following the end of each calendar month.
Definition	Monthly claims data are received by HCI no later than the 5 <sup>th</sup> business day of the month following the end of each calendar month.
Monetary Assessment	Failure to submit monthly claims data no later than the 5 <sup>th</sup> business day of the month following the end of each month will result in an assessment of <b>\$100</b> per day for the first and second working days past the compliance date, and <b>\$500</b> for each working day thereafter, to a maximum of <b>\$10,000</b> per quarter.
Compliance report	Compliance reporting submitted by HCI upon receipt of monthly claims data. Performance is measured, reported monthly, and reconciled annually.
<b>13. Member ID Card Distribution</b>	
Guarantee	Member ID cards must be distributed (defined as "mailed") to a minimum of 98% of Enrollees within ten (10) calendar days of the receipt of enrollment information.
Definition	The actual distribution of member ID cards to 98% of all Enrollees by the specified dates.
Monetary Assessment	Should the above standard not be met, the total amount shall be <b>\$15,000</b> per year in which the standard is not met.
Compliance report	Compliance Report submitted by Contractor. Performance is measured, reported, and reconciled annually on a calendar year basis.
<b>14. External Quality Review Organization (EQRO) Provider Data Validation</b>	
Guarantee	As validated by the State's EQRO vendor quarterly, Contractor shall meet the following benchmark for the accuracy of the provider data information submitted to the State: the provider data information submitted to the State shall be at 90% or above accuracy per data element measured.
Definition	The State's EQRO vendor shall conduct a quarterly validation of the accuracy of the provider information reported by the Contractor to the State. The EQRO vendor shall utilize a telephonic survey of a random sample drawn from the most current provider enrollment file.
Monetary Assessment	Should the above standard not be met, <b>\$5,000 per data element</b> assessment for each quarter below the established benchmark. The \$5,000 per data element assessment may be lowered in the event that the Contractor provides a corrective action plan that is accepted by the state, or may be waived by the state if the Contractor submits sufficient documentation. Quarterly guarantee, reconciled annually.
Compliance report	Compliance report submitted by the State's EQRO vendor quarterly.
<b>15. External Quality Review Organization (EQRO) Annual Quality Survey (AQS)</b>	
Guarantee	As validated by the State's EQRO vendor annually, Contractor shall meet the following benchmark for the overall compliance with Quality Process Standards, Performance Activity File Review, and Credentialing/Rec credentialing Activities as submitted to the State with an 100% overall compliance.
Definition	The State's EQRO vendor shall assess the quality, timeliness, and accessibility of the care and services delivered to members, including assessing provider credentialing/rec credentialing activities. The EQRO vendor shall conduct an on-site comprehensive audit with the Contractor.
Monetary Assessment	Should the above standard not be met, \$25,000 assessment for each benchmark below 100%. In the event, an overall compliance score on the annual AQS survey of less than 75% will result in a \$100,000 assessment.
Compliance report	Compliance report submitted by the State's EQRO vendor annually.
<b>16. External Quality Review Organization (EQRO) – Provider Network Documentation</b>	
Guarantee	Each monthly Provider Enrollment file should have 100% of providers, including specialists, with a signed provider agreement with the Contractor.
Definition	Executed contract is a signed provider agreement with a provider to participate in the Contractor's network as a contract provider.
Monetary Assessment	<b>\$1,000</b> for each provider for which the Contractor cannot provide a signature page from the provider agreement between the provider and the Contractor. Reconciled Annually
Compliance Report	Compliance report is the monthly Provider Enrollment File and provider agreement signature page, upon request from HCFA.
<b>17. Requirements for Control Memoranda Process, On Request Reports (ORR) and Corrective Action Plans (CAP)</b>	
Guarantee	Each Control Memoranda will have specific deadline as specified by HCFA regarding



	<p>contractor's response.</p> <p>Each ORR will have a deadline of ten (10) business days from the date of the ORR by which it will be due unless the ORR specifies a different delivery deadline.</p> <p>Each request for a CAP will have a deadline of ten (10) business days from the date of the request for CAP by which it will be due unless the CAP request specifies a different delivery deadline.</p> <p>Each approved CAP will have a deadline by which the Contractor must fully implement the required actions.</p>
Definition	<p>Control Memoranda shall mean a process to be utilized by the State requiring the contractor to document submission of Contract deliverables, document required action, approval or disposition, including but not limited to disputes or appeals regarding actual or monetary assessments by the State.</p> <p>On Request Report (ORR) shall mean a request by HCFA for information pertaining to the fulfillment of the terms of this Contract by Contractor.</p> <p>Corrective Action Plan (CAP) means a plan of action proposed by the Contractor, at HCFA's request, to remedy a deficiency in Contractor's performance under this Contract. HCFA must approve each proposed CAP before it is implemented by the Contractor. The Contractor shall implement each approved CAP within the time specified by HCFA. HCFA, in its sole discretion, will determine when the approved CAP has been successfully implemented.</p>
Monetary Assessment	<p>A performance guarantee assessment of One Hundred Dollars (\$100) per business day may be made against the Contractor for each business day that the Contractor fails to comply with Control Memoranda.</p> <p>A performance guarantee assessment of One Hundred Dollars (\$100) per business day may be made against the Contractor for each business day that the ORR is late.</p> <p>A performance guarantee assessment of One Hundred Dollars (\$100) per business day may be made against the Contractor for each business day that the CAP has not been received by HCFA.</p> <p>A performance guarantee assessment of One Hundred Dollars (\$100) per business day may be made against the Contractor for each business day that the approved CAP is not fully implemented.</p>
Compliance Report	Incorporated into the approved CAP.
<b>18. Prevention of PHI Disclosure to Third Party</b>	
Guarantee	Ensure that all State data containing protected health information (PHI), as defined in HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5 on the HHS Web site which compromises the security or privacy of protected health information (See ancillary Business Associate Agreement executed between the parties)
Definition	The Contractor shall take all necessary steps to secure all protected health Information as prescribed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) ,Health Information Technology for Economic and Clinical Health Act (HITECH) under the American Recovery and Reinvestment Act of 2009 (ARRA) and their accompanying regulations and as specified by the Secretary of Health and Human Services under Public Law 115 and according to the Business Associate Agreement.
Monetary Assessment	Should the above standard not be met, an assessment of <b>(\$500)</b> per recipient per occurrence may be assessed, AND If the State deems credit monitoring and/or identity theft safeguards are needed to protect those State recipients whose PHI was placed at risk by Contractor's failure to comply with the terms of this Contract, the Contractor shall be liable for all costs associated with the provision of such safeguard services.
Compliance Report	Contractor shall issue a quarterly statement attesting to compliance. In the event of a breach of PHI security, the Contractor shall immediately file a report with the HCFA Privacy Office containing the details of the breach. All required follow up reports from the Contractor will be timely submitted to the HCFA Privacy Office as directed.



**Dental Service Categories by Dental CDT Codes**

Subject to a medical necessity determination by the Contractor, the following services must be covered by the dental coverage provided through CoverKids (subject to service and monetary limits specified in the *pro forma* contract Section A.11.).

DENTAL SERVICE CATEGORY	CDT CODES
<b>PREVENTATIVE</b>	
Prophylaxis Adult (14 years of age and older)	D1110
Prophylaxis Child (under 14 years of age)	D1120
Topical Fluoride Varnish	D1206
Topical Fluoride – Children and Adults	D1208
Oral Hygiene Instruction	D1330
Sealants	D1351
<b>DIAGNOSTIC SERVICES</b>	
Periodic Oral Examination	D0120
Emergency Oral Exam (After Regular Hours)	D0140
Comprehensive Oral Examination - new or established patient	D0150
Detailed and Extensive Oral Evaluation – Problem Focused	D0160
Re-Evaluation – Limited, Problem Focused	D0170
Comprehensive Periodontal Evaluation – New or Established Patient	D0180
<b>EMERGENCY SERVICES</b>	
Palliative (emergency) treatment of dental pain (minor procedure)	D9110
Office Visit (after regular office hours)	D9440
<b>PROFESSIONAL SERVICES</b>	
Hospital Visit	D9420
Office Visit, Regular Hours	D9430
<b>RESTORATIVE SERVICES</b>	
<b>Amalgam Restorations - Secondary and primary</b>	
Amalgam One Surface, Primary or Permanent	D2140
Amalgam Two Surfaces, Secondary and primary	D2150
Amalgam Three Surfaces, Secondary and primary	D2160
Amalgam Four or More Surfaces, Primary or Permanent	D2161
<b>Resin-Based Composite Restorations</b>	
One Surface, Anterior	D2330
Two Surfaces, Anterior	D2331
Three Surfaces, Anterior	D2332
Four or More Surfaces or involving incisal angle (anterior)	D2335
Resin Based Composite Crown – Anterior	D2390



One Surface, Posterior	D2391
Two Surface, Posterior	D2392
Three Surface, Posterior	D2393
Four or More Surfaces, Posterior	D2394
Onlay – Metallic – Three Surfaces	D2543
Onlay – Metallic – Four or More Surfaces	D2544
Onlay – Porcelain/Ceramic – Four or More Surfaces	D2644
<b>Crowns</b>	
Crown - porcelain/ceramic substrate	D2740
Crown - porcelain fused to high noble metal	D2750
Crown - porcelain fused to predominantly base metal	D2751
Crown - porcelain fused to noble metal	D2752
Crown – ¾ Cast Noble Metal	D2782
Crown – ¾ Porcelain/Ceramic	D2783
High Noble Metal Full Cast	D2790
Base Metal, Full Cast	D2791
Base Metal, Full Cast	D2792
Provisional Crown	D2799
Recement Inlay	D2910
Recement Crown	D2920
Prefabricated stainless steel Crown (primary tooth)	D2930
Prefabricated stainless steel Crown (permanent tooth)	D2931
Prefabricated resin crown - Composite Crown	D2932
Stainless Steel Crown, with resin window	D2933
Sedative Fillings	D2940
Core buildup including pins	D2950
Pin retention - per tooth, in addition to restoration	D2951
Cast post and core, in addition to crown	D2952
Prefabricated post and core	D2954
Laminate Veneer – Preformed	D2960
Veneer, Porcelain (Laboratory)	D2962
Additional Procedures to Construct New Crown under Existing Partial	D2971
Crown Repair	D2980
Unspecified Restorative Procedure	D2999
<b>EXTRACTIONS</b>	
Coronal Remnants – Deciduous Tooth	D7111
Extraction, Erupted Tooth or Exposed Root	D7140
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	D7210



Removal of impacted tooth - soft tissue	D7220
Removal of impacted tooth - partially bony	D7230
Removal of impacted tooth - completely bony	D7240
Removal of Impacted Tooth – Completely Bony, with unusually complications	D7241
Surgical removal of residual tooth roots (cutting procedure)	D7250
Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth (health check)	D7270
Surgical access of an unerupted tooth (health check ONLY)	D7280
Placement of device to facilitate eruption of impacted tooth	D7283
Biopsy of oral tissue - hard	D7285
Biopsy of oral tissue - soft	D7286
<b>RADIOGRAPHS</b>	
Intraoral - Complete Series	D0210
Intraoral - First Film	D0220
Intraoral - Each Additional Film	D0230
Occlusal – Single Film	D0240
Bitewing Single Film	D0270
Bitewing Two Films	D0272
Bitewing Four Films	D0274
Vertical Bitewings 7 to 8 Films	D0277
Temporomandibular Joint – Films (Series)	D0321
Panoramic Film	D0330
Cephalometric Film	D0340
Oral/Facial Images (Includes Intra and Extraoral Images)	D0350
Cone Beam – Three Dimensional Image Reconstruction Using Existing Data	D0360
Collection of Microorganisms for Culture and Sensitivity	D0415
Adjunctive Diagnostic Test that aids in Detection of Mucosal Abnormalities	D0431
Pulp Vitality Test	D0460
Diagnostic Casts	D0470
<b>THERAPEUTIC PULPOTOMY</b>	
Pulp Cap, Direct (Excluding Final Restoration)	D3110
Pulp Cap, Indirect (Excluding Final Restoration)	D3120
Pulpotomy - Therapeutic	D3220
Gross pulpal debridgement - primary and permanent	D3221
Pulpal therapy, anterior -primary	D3230
Pulpal therapy, posterior -primary	D3240
<b>ANESTHESIA</b>	
Deep Sedation/General Anesthesia-first 30 minutes	D9220
Deep Sedation/General Anesthesia, each additional 15 minutes	D9221
Analgesia, anxiolysis, inhalation of nitrous oxide (prior approval required)	D9230
Intravenous conscious sedation - first 30 minutes	D9241



Intravenous conscious sedation/ analgesia each additional 15 minutes	D9242
Non-Intravenous Conscious Sedation	D9248
<b>OTHER DENTAL SERVICES</b>	
Surgical	
Excision of Benign Lesion Up to 1.25 cm	D7410
Incision and drainage of abscess - intraoral soft tissue (health check)	D7510
Incision and drainage of abscess - extraoral soft tissue (health check)	D7520
<b>PERIODONTAL PROCEDURES</b>	
Gingivectomy or Gingivoplasty-four or more contiguous teeth or bounded teeth spaces per quadrant	D4210
Gingivectomy or gingivoplasty - one to three teeth per quadrant	D4211
Crown Lengthening, Hard and Soft Tissue	D4249
Osseous Surgery (Including Flapentry & Closure) 4 or more contiguous teeth	D4260
Osseous Surgery (Including Flap Entry and Closure) 1 to 3 teeth per quad	D4261
Bone Replacement Graft – first site in quadrant	D4263
Biologic Material to Aid in Soft and Osseous Tissue Regeneration	D4265
Guided Tissue Regeneration – Resorbable, per site, per tooth	D4266
Subepithelial Connective Tissue Graft	D4273
Provisional Splinting – Extracoronary	D4321
Periodontal Scaling and Root Planning four or more contiguous teeth or bounded teeth spaces per quadrant	D4341
Periodontal Scaling & Root Planning, 1 to 3 teeth, per quadrant	D4342
Full, Mouth Debridement to Enable Comprehensive Periodontal Evaluation	D4355
Localized Delivery of Chemotherapeutic Agents	D4381
Periodonal Maintenance Following Active Therapy	D4910
Unspecified Periodontal Procedure	D4999
<b>Root Canals</b>	
Anterior (excluding final restoration)	D3310
Bicuspid (excluding final restoration)	D3320
Root canal - molar (excluding final restoration)	D3330
Incomplete Endodontic Therapy, inoperable or fractured tooth	D3332
Retreatment of Previous Root Canal Therapy – Anterior	D3346
Retreatment of Previous Root Canal Therapy – Bicuspid	D3347
Retreatment of Previous Root Canal Therapy	D3348
<b>Preventative Space Management Therapy</b>	
Space maintainer - fixed – unilateral	D1510
Space maintainer – fixed – bilateral	D1515
Space maintainer - removable bilateral	D1525
Re-cementation of Space Maintainer	D1550
<b>Prosthodontic Services, Removable Complete Dentures</b>	



Complete denture maxillary	D5110
Complete denture mandibular	D5120
Immediate Upper Denture	D5130
Immediate Lower Denture	D5140
<b>Partial Dentures</b>	
Maxillary Partial-Resin Base (age 0-16 yr) (Including any Conventional Clasps, Rests and Teeth) (>age 16 yrs)	D5211
Mandibular Partial-Resin Base (age 0-16 yr) (Including Conventional Clasps, Rests and Teeth) (>age 16 yrs)	D5212
Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5213
Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	D5214
Maxillary Partial Denture – Flexible Base (Including, Clasps, Rest & Teeth)	D5225
Mandibular Partial Denture – Flexible Base (Including Clasps, Rests, & Teeth)	D5226
Removable Unilateral Partial Denture One Piece Casting- Chrome	D5281
<b>Repairs to Dentures</b>	
Repair broken complete denture base	D5510
Replace missing or broken teeth - complete denture (each tooth)	D5520
Repair resin denture base	D5610
Repair cast framework	D5620
Repair or replace broken clasp	D5630
Replace broken teeth - per tooth	D5640
Add tooth to existing partial denture	D5650
Add clasp to existing partial denture	D5660
Reline complete maxillary denture (chairside)	D5730
Reline complete mandibular denture (chairside)	D5731
Reline partial maxillary denture (chairside)	D5740
Reline partial mandibular denture (chairside)	D5741
Reline complete maxillary denture (laboratory)	D5750
Reline complete mandibular denture (laboratory)	D5751
Reline partial maxillary denture (laboratory)	D5760
Reline partial mandibular denture (laboratory)	D5761
Upper Denture – Temporary (Partial Stayplate)	D5820
Lower Denture – Temporary (Partial Stayplate)	D5821
Tissue Conditioning – Upper	D5850



Precision Attachment	D5862
<b>IMPLANT SERVICES</b>	
Surgical Placement of Implant Body; Endosteal Implant	D6010
Prefabricated Abutment	D6056
Custom Abutment	D6057
Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)	D6059
Implant Supported Porcelain/Ceramic Crown	D6065
Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy...)	D6066
Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Nobel Metal)	D6069
Porcelain Fused to High Noble Metal	D6240
Porcelain Fused to Base Metal	D6241
Porcelain Fused to Noble Metal	D6242
Retainer-Cast Metal for Resin Bonded Fixed Prosthesis	D6545
Crown – Porcelain/Ceramic	D6740
Porcelain fused to High Noble Metal	D6750
Porcelain Fused to Base Metal	D6751
Porcelain Fused to Nobel Metal	D6752
Recement Bridge	D6930
Precision Attachment	D6950
Prefabricated Post and Core (In Addition to Bridge Retainer)	D6972
Core Build Up for Retainer, Including Any Pins	D6973
<b>ALVEOPLASTY</b>	
Alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quad	D7310
Alveoloplasty in Conjunction with Extractions; 1 to 3 teeth per quadrant	D7311
Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quad	D7320
<b>APEXIFICATION/RECALCIFICATION</b>	
Apexification/recalcification - initial	D3351
Apexification/recalcification - interim	D3352
Apexification/recalcification - final	D3353
<b>APICOECTOMY/PERIRADICULAR SERVICES</b>	
Apicoectomy - Separate Surgical Procedure	D3410
Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	D3421
Apicoectomy/Periradicular Surgery - Molar (First Root)	D3425
Retrograde Filling (Per Root)	D3430
<b>ORTHODONTICS</b>	
Limited Orthodontic Treatment of the Transitional Dentition	D8020
Interceptive Orthodontic Treatment of the Primary Dentition	D8050
Interceptive Orthodontic Treatment of the Transitional Dentition	D8060
Comprehensive Orthodontic Treatment – Transitional Dentition	D8070
Comprehensive Orthodontic Treatment of the Adolescent Dentition	D8080
Comprehensive Orthodontic Treatment – Adult Dentition	D8090
Removable Appliance Therapy – Minor Habit Control	D8210
Fixed Appliance Therapy – Minor Habit Control	D8220
Pre-Orthodontic Treatment Visit	D8660
Periodic or Treatment Visit (As Part of Contract)	D8670



Orthodontic Retention	D8680
Orthodontic Treatment (Alternative Billing to Control Fee)	D8690
Replacement of Lost or Broken Retainer	D8692
Unspecified Orthodontic Procedure	D8999
<b>DRUGS</b>	
Therapeutic Drug Injection	D9610
Other Drugs/Medicaments	D9630
Application of Desensitizing Medicaments	D9910
Application of Desensitizing Resin for Cervical and/or Root Surface, per tooth	D9911
<b>OTHER REPAIR PROCEDURE</b>	
Occlusal Orthotic Device	D7880
Bone Replacement Graft for Ridge Preservation; Per Site	D7953
Frenulectomy (frenectomy or frenotomy) - separate procedure	D7960
<b>MISCELLANEOUS SERVICES</b>	
Complications (Postsurgical) unusual circumstances	D9930
Occlusal Guard	D9940
Occlusal Adjustment, Limited	D9951
Odontoplasty 1 – 2 Teeth: Includes Removal of Enamel Projections	D9971
External Bleaching – Per Arch	D9972
Unspecified (To Be Described by Attending DDS)	D9999



**Management Reporting Requirements**

Contract Management Reports by which the State can assess the CoverKids Dental program costs and usage. Reports shall be submitted in an electronic format as referenced in Section A.70 (Management reports). Management Reports shall include:

- 1) **Performance Guarantee Reports**, as detailed at Contract Attachment C (each component to be submitted at the frequency indicated), shall include:
  - o Status report narrative
  - o Detail report on each performance measure by appropriate time period
  
- 2) **Quarterly CoverKids Dental Benefit Savings and Payments Report**, must be submitted as follows distinguishing between in-network and out-of-network:

**GROUP ONE CHILD**

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Total						

**GROUP TWO CHILD**

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Total						



**AMERICAN INDIAN/ ALASKAN NATIVE CHILD**

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
<b>Total</b>						

**3) Quarterly Provider and Out-of-Network Claims Utilization by:**

- o Submitted charges
- o Benefits paid
- o Member Utilization

**4) Quarterly Enrollment Summary Plan Report:**

Premium Category	Subscribers	Premium	Total Claims
Group One Child			
Group Two Child			
American Indian/ Alaskan Native Child			
<b>Total</b>			

**5) Quarterly Network Changes Update Report, displaying the following:**

- o Present Network of Participating Providers by Specialty
- o Additions to the Network by Name, Specialty and Location
- o Terminations to the Network by Name, Specialty and Location
- o Targeted areas for recruitment

