

**ATTACHMENT I
SCOPE OF SERVICES**

**MEDICAID PREPAID DENTAL
HEALTH PLAN
CONTRACT
Miami-Dade**

**Division of Medicaid
Agency for Health Care Administration**

SEPTEMBER 1, 2006 THROUGH JUNE 30, 2008



COVER PAGE1
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10.0 COVERED SERVICES AND ELIGIBLE BENEFICIARIES

10.1 GENERAL

The Prepaid Dental Health Plan Vendor, hereinafter referred to as PDHP, shall comply with all the provisions of this contract and its amendments, if any, and shall act in good faith in the performance of the contract provisions. The PDHP shall develop and maintain written policies and procedures to implement the provisions of this contract. The PDHP agrees that failure to comply with these provisions may result in the assessment of penalties and/or termination of the contract in whole, or in part, as set forth in this contract.

The PDHP shall comply with all pertinent Agency rules in effect throughout the duration of the contract.

The PDHP shall comply with all Agency handbooks referenced in or incorporated by reference in rules relating to the provision of services set forth in Sections 10.4, Covered Services, except where the provisions of the contract alter the requirements set forth in the handbooks. In addition, the PDHP shall comply with the limitations and exclusions in the Agency handbooks unless otherwise specified by this contract. In no instance may the limitations or exclusions imposed by the PDHP be more stringent than those specified in the handbooks. Pursuant to 42 CFR 438.210(a), the PDHP must furnish services up to the limits specified by the Medicaid Program. The PDHP may exceed these limits. However, service limitations shall not be more restrictive than the Florida fee-for-service program, pursuant to 42 CFR 438.201(a)(3)(i).

The PDHP may offer services to enrolled Medicaid beneficiaries in addition to those covered services specified in Sections 10.4, Covered Services, and 10.7, Manner of Service Provision. These services must be specifically defined in regards to amount, duration, and scope, and must be approved in writing by the Agency prior to implementation. The PDHP will ensure continuity of care and reimbursement to providers for active orthodontia until completion of care, regardless of provider network affiliation.

The PDHP shall have a quality improvement program that ensures enhancement of quality of care and emphasizes quality patient outcomes.

This contract with numbered attachments represents the entire agreement between the PDHP and the Agency with respect to the subject matter in it and supersedes all other contracts between the parties when it is duly signed and authorized by the PDHP and the Agency. Correspondence and memoranda of understanding do not constitute part of this contract. In the event of a conflict of language between the contract and the attachments, the provisions of the contract shall govern. However, the Agency reserves the right to clarify any contractual relationship in writing and such

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clarification shall govern. Pending final determination of any dispute over an Agency decision, the PDHP shall proceed diligently with the performance of the contract and in accordance with the Agency’s Division of Medicaid direction.

10.2 ELIGIBLE BENEFICIARIES

All categories of Miami-Dade County Medicaid eligible beneficiaries, under 21 years of age with the exception of those stated in Section 10.3, are eligible to be enrolled in the PDHP. Also eligible are Title XXI MediKids, Foster Care and Adoption Subsidy children.

10.3 INELIGIBLE BENEFICIARIES

The following categories describe beneficiaries who are not eligible to enroll in the PDHP:

- a. Beneficiaries age 21 or older.
- b. Medicaid eligible beneficiaries who, at the time for enrollment in the PDHP, are domiciled or residing in state hospitals.
- c. Medicaid eligible beneficiaries whose Medicaid eligibility has been determined through the medically needy program.
- d. Medicaid eligible beneficiaries who are also members of a Medicaid-funded health maintenance organization (HMO) that is capitated for children’s dental services.
- e. At the time for enrollment in the PDHP, participants who are in the Sub-acute Inpatient Psychiatric Program (SIPP).
- f. Medicaid eligible beneficiaries who, at the time for enrollment in the PDHP, are domiciled or residing in intermediate care facilities for the developmentally disabled (ICF/DD).

10.4 COVERED SERVICES

The PDHP shall ensure the provision of the following covered healthcare services as defined and specified in Section 10.7, Manner of Service Provision:

Diagnostic Services	Surgical and Extraction Services
Preventive Services	Orthodontic Services
Restorative Services	Adjunctive General Services
Endodontic Services	Injectable Medications

Periodontic Services

Oral and Maxillofacial Surgery Services

Removable Prosthodontic Services

10.5 EXPANDED SERVICES

These services are defined as those offered by the PDHP and approved by the Agency, which are as follows:

- a. Services in excess of the amount, duration, and scope of those listed in Sections 10.4, Covered Services.
- b. Services and benefits not listed in Section 10.4.

10.6 EXCLUDED SERVICES

The PDHP is not obligated to provide for the services that are not specified in Sections 10.4, Covered Services, and 10.5, Expanded Services. PDHP members who require services available through Medicaid but not covered by this contract shall receive these services through the existing Medicaid fee-for-service reimbursement system or their managed care plan. The PDHP shall determine the need for these services and refer the member to the appropriate service provider.

10.7 MANNER OF SERVICE PROVISION

The Florida Medicaid Program provides multiple dental services for Medicaid eligible children. The PDHP must cover all these services. The PDHP must furnish services up to the limits specified by the Medicaid program. The PDHP may exceed these limits. However, in no instance may any service's limitations be more restrictive than those that exist in the Florida Medicaid fee-for-service program. The PDHP is responsible for contracting with providers who meet all provider and service or product standards specified in the Agency's current Medicaid Dental Services Coverage and Limitations Handbook, which is incorporated by reference, unless different standards are specified elsewhere in this contract or the standard is waived in writing by the Division of Medicaid on a case-by-case basis when the member's dental needs would be equally or better served in an alternative care setting or using alternative therapies or devices within the prevailing dental community. This includes professional licensure and certification standards for all service providers

10.7.1 DENTAL SERVICES

Dental services are those services and procedures rendered by a Florida licensed dentist in an office, clinic, hospital, ambulatory surgical center, or elsewhere when dictated by the need for diagnostic, preventive, therapeutic, or palliative care, or for the treatment of a particular injury as specified in the current Medicaid Dental Services Coverage and Limitations Handbook. Medicaid children's dental services include

diagnostic services, preventive treatment, restorative treatment, endodontic treatment, periodontal treatment, surgical procedures and/or extractions, orthodontic treatment, and complete and partial dentures, as well as complete and partial denture relines and repairs. Also included are adjunctive general services, injectable medications, and oral and maxillofacial surgery services. All dental services are to be provided in accordance with guidelines established in the current Medicaid Dental Services Coverage and Limitations Handbook, as well as any limitations and/or exclusions put forth in the Handbook. Policy requirements include:

- a. The PDHP shall follow the generally accepted dental standards of the American Academy of Pediatric Dentistry and the American Dental Association. The current Medicaid Dental Services Coverage and Limitations Handbook shall take precedence in the event of a conflict.
- b. The PDHP will urge members to see their primary care dentist at least once every six months for regular check-ups, preventive pediatric health care, and any services necessary to meet the member's diagnostic, preventive, restorative, surgical, and emergency dental needs.
- c. The PDHP shall exclude the provision of experimental and clinically unproven procedures.
- d. The PDHP must make a good faith effort to contract with FQHCs. Pursuant to Section 4712 of the Balanced Budget Act of 1997, PDHPs contracting with Federally Qualified Health Centers (FQHCs) must reimburse those entities at rates comparable to those rates paid for similar services in the FQHC's community.

10.7.1.1 ORTHODONTIC SERVICES

Orthodontic services are limited to a child whose malocclusion creates a disability and is an impairment to his physical development. The PDHP is not obligated to provide orthodontic services that are primarily for cosmetic purposes.

For guidelines on the criteria for Medicaid orthodontic approval, see Appendix A in the current Medicaid Dental Services Coverage and Limitations Handbook and Section 110, Exhibits.

10.7.1.2 ORAL AND MAXILLOFACIAL SURGERY SERVICES

Oral and maxillofacial surgery services provide medically/dentally necessary treatment of any disease or injury to the maxillary or mandibular areas of the head or any structure contiguous to those areas, and the reduction of any fracture in those areas. These are services furnished by a dentist that would be considered physician services if a physician had furnished those services. The more complex of these procedures are usually provided in an inpatient or outpatient hospital or ambulatory surgical center setting, although not exclusively. Oral and maxillofacial surgery is

provided for an enrollee through procedure codes listed in Appendix D of the current Medicaid Dental Services Coverage and Limitations Handbook.

10.7.1.3 FACILITY SETTING DENTAL TREATMENT

Any treatment provided in a facility setting, as opposed to a non-facility office setting, that is related to one of the following conditions must be clearly documented in the member's dental record:

The recipient's health will be so jeopardized that the procedures cannot be performed safely in the office; or

The recipient is uncontrollable due to emotional instability or developmental disability and sedation has proven to be an ineffective intervention.

The PDHP is responsible for coordinating this care. Additionally, the PDHP is responsible for the payment of any dental claims associated with the facility episode.

10.8 MEMBER INCENTIVE PROGRAMS

The PDHP may offer incentives for members to receive preventive care services. The request for approval must contain a detailed description of the program and its mission. The PDHP shall receive written approval from the Agency prior to the implementation and/or use of any special incentive items for members. Any incentive program offered must be provided to all eligible individuals and will not be used to direct individuals to select providers. Additionally, any limitations and requirements below apply to all incentive programs.

- a. Incentives shall be limited to a dollar value of \$10, and not to exceed \$20.00 in the case of incentives for the completion of a series of services, health education, classes, or other educational activities.

20.0 SCOPE OF WORK

20.1 AVAILABILITY/ACCESSIBILITY OF SERVICES

The PDHP shall make available and accessible facilities, service locations, service sites, and personnel sufficient to provide the covered services. In accordance with Section 1932(b)(7) of the Social Security Act (as enacted by Section 4704(a) of the Balanced Budget Act of 1997), the PDHP shall provide the Agency with adequate assurances that the PDHP, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the PDHP: 1) offers the appropriate range of services and access to preventive and primary care services for the populations expected to be enrolled in such service area, and 2) maintains a sufficient number, mix, and geographic distribution of providers of services. Emergency dental care as required by this agreement shall be available on a

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24-hour-a-day, seven-day-a-week basis. The PDHP must assure that primary care dental services and referrals to specialists are available on a timely basis, to comply with the following standards: urgent care must be scheduled within one day; sick dental care within two weeks; and routine dental care within one month. Follow-up dental services shall be offered within one month after assessment. The PDHP must have general and specialty dental providers that maintain hospital privileges required for the appropriate performance of PDHP services. The PDHP shall have telephone call policies and procedures that shall include requirements for call response times, maximum hold times, and maximum abandonment rates approved by the Agency.

Primary care dentists and pedodontists must be available within 30 minutes typical travel time and specialty dentists must be available within 60 minutes typical travel time from the member's residence. For rural areas, if the PDHP is unable to contract with specialty or ancillary providers who are within the typical travel time requirements, the Agency may waive, in writing, these requirements.

Each PDHP shall provide the Agency with documentation of compliance with access requirements no less frequently than the following:

- a. At the time it enters into a contract with the Agency.
- b. At any time there has been a significant change in the PDHP's operations that would affect adequate capacity and services, including but not limited to:
 1. Changes in PDHP services, benefits, geographic service area, or payments.
 2. Enrollment of a new population in the PDHP.
 3. Significant change in provider network and/or termination of providers.

The PDHP shall allow and cover a second opinion from a qualified health care professional, within or outside of the network, at no cost to the enrollee.

If the PDHP is unable to provide medically necessary services covered under the contract to a particular beneficiary, the PDHP must adequately and timely cover these services outside of the network for the beneficiary for as long as the PDHP is unable to provide them.

The PDHP must require out-of-network providers to coordinate with respect to payment and must ensure there is no cost to the beneficiary.

The PDHP will ensure, in conjunction with Medicaid eligibility, continuity of care for active orthodontia until completion of care and reimbursement to providers, regardless of provider network affiliation.

20.2 MINIMUM STAFFING STANDARDS

Minimum staffing standards shall be as follows, regardless of whether staff is employed or subcontracted:

- a. The PDHP must ensure primary care dentists sufficient to ensure adequate accessibility to all primary care services in accordance with the enrolled beneficiaries' ages.
- b. The PDHP's staff of dentists and dental hygienists must each hold a valid and active license to practice dentistry or dental hygiene pursuant to the provisions of Chapter 466, F.S.
- c. The PDHP's staff shall include general practice dentists or dentists who meet all education and training criteria for general dentistry, at a number equal to a ratio of one full time equivalent (FTE) general practice dentist per 1,500 enrollees (includes Medicaid, commercial, and fee-for-service patients). The general dentists are to be distributed for availability within thirty minutes typical travel time for all enrolled beneficiaries throughout the geographic area.
- d. The PDHP's staff shall include board certified pediatric dentists or pediatric dentists who meet all education and training criteria for board certification at a rate of 1 pediatric dentist to every 12,000 members. The pediatric dentists are to be distributed for availability within 30-minute typical travel time for all enrolled beneficiaries throughout the geographic area. At least two board certified or board eligible pediatric dentists must provide the experience and office facilities necessary to accommodate and treat children with special needs.
- e. The PDHP's staff shall include at least two board certified endodontic specialists or two who meet all education and training criteria for board certification. The endodontic specialists are to be distributed for availability within a reasonable amount of travel time for all enrolled beneficiaries throughout the geographic area.
- f. The PDHP's staff shall include at least two board certified oral and maxillofacial surgeons or two who meet all education and training criteria for board certification. The oral and maxillofacial surgeons are to be distributed for availability within a reasonable amount of travel time for all enrolled beneficiaries throughout the geographic area.
- g. The PDHP's staff shall include at least two board certified orthodontists or two who meet all education and training criteria for board certification. The orthodontists are to be distributed for availability within a reasonable amount of travel time for all enrolled beneficiaries throughout the geographic area.

- h. The PDHP shall provide access to emergency services, within 30 minutes typical travel time, providing care on a 24-hours-a-day, seven-days-a-week basis. The Agency may waive, in writing, the travel time requirement in rural areas.
- i. The PDHP shall have facilities with access for persons with disabilities, adequate space, supplies, good sanitation, be smoke free, and have fire and safety procedures in operation.

Pursuant to Section 4707(a) of the Balanced Budget Act of 1997 and upon development by the federal government, the PDHP must require each provider who provides Medicaid services to have a unique identifier in accordance with the system established under Section 1173(b) of the Social Security Act.

20.3 ADMINISTRATION AND MANAGEMENT

The PDHP's governing body shall set policy and has overall responsibility for the organization. The PDHP shall be responsible for the administration and management of all aspects of this contract. Any delegation of activities does not relieve the PDHP of this responsibility. This includes all subcontracts, employees, agents, and anyone acting for or on behalf of the PDHP.

- a. If the PDHP delegates claims adjudication functions to a third party administrator (TPA), the TPA must be licensed to do business as a TPA in the state of Florida.
- b. The relationship between management personnel and the governing body shall be set forth in writing, including each person's authority, responsibilities, and function. The provision of position descriptions for key personnel shall meet this requirement.
- c. If any function of the administration or management of the PDHP is delegated to another entity, the PDHP shall:
 - 1. Adhere to all requirements set forth in Section 70.18, Subcontracts, in relation to the delegated entity and any further subcontractors.
 - 2. Notify the Agency within 10 working days after such functions are delegated (full or partial delegation), specify what functions are delegated, identify the PDHP staff who is/are responsible for the monitoring of the delegated functions, and define how the PDHP will routinely monitor such functions. Additionally, the PDHP shall submit a list including addresses and phone numbers of all entities to which the PDHP has delegated any functions.
- d. The PDHP and its subcontractors shall have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services. Pursuant to 42 CFR 438.210(b)(2), the PDHP is responsible for ensuring consistent application of review criteria (including clinical review criteria) for

authorization decisions and consulting with the requesting provider when appropriate.

- e. If any service authorization function is delegated to another entity, the PDHP shall ensure that such entity's service authorization system(s) provide for the following as specified in the PDHP's policies and procedures:
 - 1. Timely authorizations.
 - 2. Effective dates for the authorization, if appropriate.
 - 3. Written confirmation of adverse determination to the provider and the member.
- f. Any delegation of service authorization, claims payment and/or member services shall include a requirement that the provider and any further subcontractor adhere to the PDHP's telephone requirements for call response times, maximum hold times, and maximum abandonment rates.
- g. The PDHP must have written policies and procedures for selection and retention of providers. These policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments.
- h. Pursuant to 42 CFR 438.236(b), the PDHP shall adopt practice guidelines that meet the following requirements:
 - 1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
 - 2. Consider the needs of the enrollees.
 - 3. Are adopted in consultation with contracting health care professionals.
 - 4. Are reviewed and updated periodically as appropriate.
- i. The PDHP shall disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. The decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply shall be consistent with the guidelines.

20.4 STAFF REQUIREMENTS

The staffing for the PDHP developed under this contract must be capable of fulfilling all contractual requirements. The minimum staff requirements are as follows:

- a. A full-time administrator specifically identified to administer the day-to-day business activities of the contract. This person cannot be designated for any other position in this subsection.
- b. Sufficient dental and professional support staff to conduct daily business in an orderly manner, including having member services staff directly available during business hours for membership services consultation, as determined through management and treatment reviews. The PDHP shall maintain sufficient dental staff available 24 hours per day to handle emergency care inquiries.
- c. A full-time, licensed dentist to serve as dental director to oversee and be responsible for the proper provision of covered services to members. The PDHP's dental director shall be licensed in accordance with Chapter 466, F.S.
- d. A designated person, qualified by training and experience, to be responsible for the dental record system. This person shall maintain dental record standards and ensure subcontractor's compliance with the PDHP's and the Agency's dental records requirements.
- e. A person trained and experienced in data processing and data reporting as required to ensure that computer system reports that are provided to the Agency are accurate, and that computer systems operate in an accurate and timely manner.
- f. A designated person, qualified by training and experience, in quality improvement.
- g. A designated person, qualified by training and experience, to be responsible for the PDHP's utilization management program.
- h. A designated person, qualified by training and experience, in the processing and resolution of grievances.
- i. Sufficient case management staff, qualified by training and experience, to plan, direct, and coordinate the dental health care and utilization of dental health services as defined in Section 100.0, Glossary.

20.4.1 FRAUD PREVENTION POLICIES AND PROCEDURES

The PDHP shall develop and maintain written policies and procedures for fraud prevention that contain the following:

- a. A comprehensive employee training program to investigate potential fraud.
- b. A review process for claims that shall include:
 1. Review of providers who consistently demonstrate a pattern of encounter or service reports that did not occur.

2. Review of providers who consistently demonstrate a pattern of overstated reports or up-coded levels of service.
3. Review of providers who altered, falsified, or destroyed clinical record documentation.
4. Review of providers who make false statements about credentials.
5. Review of providers who misrepresent medical information to justify referrals.
6. Review of providers who fail to render medically necessary covered services that they are obligated to provide according to their subcontracts.
7. Review of providers who charge Medicaid recipients for covered services.

The policies and procedures for fraud prevention shall provide for use of the List of Excluded Individuals and Entities (LEIE), or its equivalent, to identify excluded parties during the process of enrolling providers to ensure the PDHP providers are not in a non-payment status or excluded from participation in federal health care programs under Section 1128 or Section 1128A of the Social Security Act. The PDHP must not employ or contract with excluded providers and must terminate providers if they become excluded.

20.5 LICENSURE OF STAFF

The PDHP is responsible for assuring and demonstrating that all persons, whether they be employees, agents, subcontractors, or anyone acting for or on behalf of the PDHP, are properly licensed under applicable state law and/or regulations and are eligible to participate in the Medicaid program. The PDHP shall credential and recredential all PDHP dentists and dental hygienists. However, the PDHP is prohibited from collecting duplicate core credentialing data from any health care practitioner if the information is available from the Department of Health.

20.5.1 CREDENTIALING AND RECREDENTIALING POLICIES AND PROCEDURES

The PDHP's credentialing and recredentialing policies and procedures shall include the following:

- a. Written policies and procedures for credentialing.
- b. Formal delegations and approvals of the credentialing process.
- c. A designated credentialing committee.
- d. Identification of providers who fall under its scope of authority.

- e. A process that provides for verification of the following core credential information:
 - 1. The practitioner's current valid license. Practitioner's current license must be on file at all times.
 - 2. The practitioner's current valid Drug Enforcement Administration (DEA) certificate where applicable.
 - 3. Proof of the practitioner's dental school graduation, completion of a residency, and other postgraduate training. Evidence of board certification shall suffice in lieu of proof of dental school graduation, residency, and other postgraduate training.
 - 4. Evidence of specialty board certification, if applicable.
 - 5. Evidence of the practitioner's professional liability claims history.
 - 6. History of final disciplinary actions.
 - 7. Any sanctions imposed on the practitioner by Medicare or Medicaid.

- f. The credentialing process must also include verification of the following information:
 - 1. The practitioner's work history.
 - 2. The PDHP must obtain a statement from each practitioner applicant regarding the following:
 - (a) Any physical or mental health problems that may affect the practitioner's ability to provide health care.
 - (b) Any history of chemical dependency/substance abuse.
 - (c) Any history of loss of license and/or felony convictions.
 - (d) Any history of loss or limitation of privileges or disciplinary activity.
 - (e) Attestation to correctness/completeness of the practitioner's application.
 - 3. Documentation of an initial visit to the office of each primary care dentist to review the site. Documentation shall include the following:
 - (a) The PDHP has evaluated the provider site against the PDHP's organizational standards.

- (b) The PDHP has evaluated the dental record keeping practices at each site to ensure conformity with the PDHP's organizational standards.
- (c) The PDHP has determined that the following documents are posted, prominently displayed in the reception area of the provider: the Agency's statewide Consumer Call Center's phone number (888-419-3456) including hours of operation and a copy of the summary of Florida Patient's Bill of Rights and Responsibilities, in accordance with Section 381.026, F.S. A complete copy of the Florida Patient's Bill of Rights and Responsibilities shall be available, upon request by a member, at each primary care dentist's offices. The Florida Patient's Bill of Rights is found in Section 110.1, Florida Patient's Bill of Rights and Responsibilities.
- g. The process for periodic recredentialing, which shall include the following:
 - 1. The procedure for recredentialing shall be implemented at least every three years.
 - 2. The PDHP shall verify the current standing for each practitioner in Sections 20.5.1 e. and f. of this contract.
 - 3. Documentation of periodic visits to the primary care dental offices documenting site reviews, including review of the items listed in Section 20.5.1 f. 3 of this contract to ensure continued conformance with the PDHP's standards.
- h. The PDHP shall develop and implement policies and procedures for approval of new providers, and imposition of sanctions, termination, suspension, or restrictions of existing providers.
- i. The PDHP shall develop and implement a mechanism for identifying quality deficiencies that result in the PDHP's restriction, suspension, termination, or sanctioning of a practitioner.
- j. The PDHP shall develop and implement an appellate process for sanctions, restrictions, suspensions, and terminations imposed by the PDHP against practitioners.
- k. The PDHP shall submit provider networks for initial or expansion review to the Agency for approval only when the PDHP has satisfactorily completed the minimum standards required in Section 20.2, Minimum Staffing Standards, and the minimum credentialing steps required in Sections 20.5.1 e. and f.

20.6 Choice of Dentist

The PDHP agrees to offer each member a choice of primary care dentists. After making a choice, each enrolled member shall have a single primary care dentist.

For Title XXI MediKids, the PDHP shall assign primary care dentists taking into consideration last primary dental care provider of service (if the provider is known and available in the PDHP's network), closest location within the service area, zip code location, and keeping children within the same family together. The PDHP shall inform members of the following: (1) their primary care dentist assignment, (2) their ability to choose a different primary care dentist, (3) a list of providers from which to make a choice, and (4) the procedures for making a change. The PDHP shall provide this written notice to members by the first day of enrollment.

20.7 SPECIALTY COVERAGE

The PDHP shall assure the availability of the following specialists, as appropriate for pediatric members, on at least a referral basis: pediatric dentist, endodontist, periodontist, oral surgeon, orthodontist, and prosthodontist.

The PDHP must use specialists with pediatric expertise when the need for pediatric specialty care is significantly different from the need for a general dentist practitioner.

20.8 CASE MANAGEMENT/CONTINUITY OF CARE

The PDHP shall be responsible for the management of dental care and continuity of care for all enrolled Medicaid beneficiaries. Pursuant to 42 CFR 438.208(b), the PDHP must implement procedures to deliver primary care to and coordinate health care service for all enrollees that:

- a. Ensure that each enrollee has an ongoing source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.
- b. Coordinate the services the PDHP furnishes to the enrollee with the services the enrollee receives from any other managed care entity during the same period of enrollment.
- c. Share with other managed care organizations serving the enrollee with special health care needs the results of its identification and assessment of the enrollee's needs to prevent duplication of those activities.
- d. Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR Part 160 and 164 Subparts A and E, to the extent that they are applicable.

The PDHP shall maintain written case management continuity of care protocol(s) that include the following minimum functions:

- a. Appropriate referral of and scheduling assistance for members needing specialty dental care.
- b. Documentation of referral services in members' dental records, including results.
- c. Monitoring of members with ongoing dental conditions and coordination of services for high users such that the following functions are addressed as appropriate: acting as a liaison between the member and providers, ensuring the member is receiving routine dental care, ensuring that the member has adequate support at home, and assisting members who are unable to access necessary care due to their medical or emotional conditions or who do not have adequate community resources to comply with their care.
- d. Documentation in dental records of member emergency encounters with appropriate indicated follow-up.

20.8.1 MEMBERS WITH DEVELOPMENTAL DISABILITIES

The PDHP is responsible for providing dental services to members who have a developmental disability. When a member has a developmental disability, the PDHP shall determine the member's ongoing dental condition by asking the member or parent/guardian if the member is receiving services through the Department of Children and Families (DCF), Office of Developmental Disabilities (DD). If the member is receiving services through DD, the PDHP shall:

- a. Contact the member, or parent/guardian, as appropriate, for DD contact information and obtain authorization (if not already obtained) to seek further information from the member's DD support coordinator.
- b. Contact the member's DD support coordinator to obtain DD service information and review the need to coordinate care.
- c. Continue to contact the member or the member's parent/guardian and provider regarding the ongoing coordination of care, as appropriate.

20.8.2 INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS

The PDHP shall implement mechanisms for identifying, assessing and ensuring the existence of a treatment plan for individuals with special health care needs, as specified in Section 20.12, Quality Improvement. Mechanisms shall include evaluation of health risk assessments, claims data, and, if available, CDT, CPT/ICD-9 codes. Additionally, the PDHP shall implement a process for receiving and considering provider and enrollee input.

In accordance with this contract and 42 CFR 438.208(c)(3), a treatment plan for an enrollee determined to need a course of treatment or regular care monitoring must be developed by the enrollee's care provider with enrollee participation and in consultation with any specialists caring for the enrollee; approved by the PDHP in a timely manner if this approval is required; and developed in accordance with any applicable Agency quality assurance and utilization review standards.

Pursuant to 42 CFR 438.208(c)(4), for enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with 42 CFR 438.208(c)(2)) to need a course of treatment or regular care monitoring, each PDHP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

20.8.3 NEW MEMBER PROCEDURES

The PDHP shall contact each new member at least two times, if necessary, within 60 calendar days of enrollment, to urge scheduling of an initial appointment with the primary care dentist for the purpose of an oral health evaluation.

- a. For this subsection, contact is defined as mailing a notice to or telephoning a member at the most recent address or telephone number available.
- b. The PDHP will urge members to see their primary care dentist within 60 days of enrollment.
- c. The PDHP shall contact each new member within 30 calendar days of enrollment to request that the member authorize release of his or her dental records to the PDHP or its health services subcontractors from practitioners who treated the member prior to PDHP enrollment. The PDHP shall request or assist the member's new practitioner in requesting dental records from the previous practitioners.
- d. The PDHP must contact, up to two times if necessary, any members who are more than six months behind in the dental schedule to urge those members or their legal representative to make an appointment for a dental examination visit.
- e. A member may contact the PDHP at any time and request to be assigned to the PDHP network dentist of their choice.

20.8.4 CONTINUED CARE FROM TERMINATED PROVIDERS

The PDHP shall provide continued care from terminated providers as follows. The PDHP shall develop and maintain policies and procedures for the provision of such care.

The PDHP shall allow members for whom treatment is active to continue care with a terminated treating provider when medically necessary, through completion of treatment of a condition for which the member was receiving care at the time of the termination, until the member selects another treating provider, but not longer than 6 months after the termination of the contract.

These requirements do not prevent a provider from refusing to continue to provide care to a member who is abusive or non-compliant.

For care continued under this section, the PDHP and the provider shall continue to abide by the same terms, conditions, and payment arrangements that existed in the terminated contract.

These requirements shall not apply for treating providers who have been terminated from the PDHP for cause.

20.8.5 OUT-OF-NETWORK SPECIALTY QUALIFIED PROVIDERS

The PDHP shall determine when exceptional referrals to out-of-network specialty qualified providers are needed to address any unique dental needs of a member (for example, when a member's dental condition requires the placement of a maxillofacial prosthesis for the correction of an anatomical deficiency). Financial arrangements for the provision of such services shall be agreed to prior to the provision of services. The PDHP shall develop and maintain policies and procedures for such referrals.

20.9 OUT-OF-NETWORK USE OF NON-EMERGENCY SERVICES

Unless otherwise specified in this contract, where a member utilizes services available under the PDHP other than emergency services from a non-contract provider, the PDHP shall not be liable for the cost of such utilization unless the PDHP referred the member to the non-contract provider or authorized such out-of-network PDHP utilization. The PDHP shall provide timely approval or denial of authorization of out-of-network use through the assignment of a prior authorization number, which refers to and documents the approval. A PDHP may not require paper authorization as a condition of receiving treatment if the PDHP has an automated authorization system. Written follow-up documentation of the approval must be provided to the out-of-network provider within one business day from the request for approval. The member shall be liable for the cost of such unauthorized use of contract-covered services from non-contract providers.

20.10 EMERGENCY CARE REQUIREMENTS

The PDHP shall make provisions for and advise all members of the provisions governing emergency use. Emergency-related definitions are in Section 100.0, Glossary, of this contract.

Requirements for the PDHP to provide emergency services and care are as follows:

- a. In providing for emergency services and care as a covered service, the PDHP shall not:
 1. Require prior authorization for emergency services and care.
 2. Indicate that emergencies are covered only if care is secured within a certain period of time.
 3. Use terms such as “life threatening” or “bona fide” to qualify the kind of emergency that is covered.
 4. Deny payment based on the member’s failure to notify the PDHP in advance or within a certain period of time after the care is given.
- b. When a member is present at a hospital seeking emergency services and care, the determination as to whether an emergency dental condition (provided in Section 100.0, Glossary) exists shall be made, for the purpose of treatment, by a dentist or a physician of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of the hospital dentist or physician. The dentist or physician or the appropriate personnel shall indicate in the patient’s chart the results of the screening, examination, and evaluation. The PDHP shall compensate the dental provider for any dental services that are incidental to the screening, evaluations, and examination that are reasonably calculated to assist the health care provider in arriving at a determination as to whether the patient’s condition is an emergency dental condition. The PDHP shall compensate the dental provider for emergency dental services and care. If a determination is made that an emergency dental condition does not exist, the PDHP is not responsible for payment for services rendered subsequent to that determination.
- c. The PDHP shall not deny payment for emergency services and care.
- d. If the member’s primary care dentist responds to the notification, the hospital-based provider and the primary care dentist may discuss the appropriate care and treatment of the member. Notwithstanding any other state law, a hospital may request and collect insurance or financial information from a patient in accordance with federal law to determine if the patient is a member of the PDHP, if emergency services and care are not delayed.

- e. As described in Section 409.9128(5), reimbursement for services provided to a member of a PDHP under this section by a provider that does not have a contract with the PDHP shall be the lesser of the following:
 - 1. The provider's charges,
 - 2. The usual and customary provider charges for similar services in the community where the services were provided,
 - 3. The charge mutually agreed to by the PDHP and the provider within 60 calendar days after submittal of the claim, or
 - 4. The Medicaid rate.
- f. The PDHP shall not deny emergency services claims for claims submitted by a non-contracting provider solely based on the period between the date of service and the date of clean claim submission unless that period exceeds 365 days.
- g. Notwithstanding the requirements stated above, payment by the PDHP for claims for emergency services rendered by a non-contract provider shall be made as described in Section 641.3155, F.S. If third party liability exists, payment of claims shall be determined in accordance with Section 70.20, Third Party Resources.
- h. The PDHP must review and approve or disapprove emergency service claims based on the definition of emergency services and care specified in Section 100.0, Glossary.
- i. In accordance with 42 CFR 438.114, the PDHP must also cover dental poststabilization services without authorization regardless of whether the enrollee obtains the service within or outside the PDHP's network. Only those poststabilization services that are specifically dental services shall be the responsibility of the PDHP.
- j. The Agency will conduct an annual audit of outpatient claims. If the audit of Emergency Room claims reveals an increase (compared to previous state fiscal year or contract period) in Medicaid fee-for-service utilization for dental related services, the Agency may request a corrective action plan. Also, fraud and abuse investigations may be conducted including administrative action and recoupment.

20.11 GRIEVANCE SYSTEM REQUIREMENTS

The PDHP shall refer all members and providers who are dissatisfied with the PDHP to the grievance coordinator for the appropriate follow-up and documentation in accordance with approved grievance procedures. The PDHP shall develop and implement grievance procedures, subject to Agency written approval, prior to

implementation. The grievance procedures shall meet the requirements as described in Section 641.511, F.S., and the following policies and guidelines.

- a. Both informal and formal steps shall be available to resolve grievances. A grievance is not considered formal until it is written and signed by a complainant or completed on such forms as prescribed and received by the PDHP. A definition for complaint and grievance is provided in Section 100.00, Glossary. A complaint is not considered a grievance until the complaint is written and received by the PDHP.
- b. Procedural steps must be clearly specified in the member handbook for members and the provider manual for providers, including the address, toll free telephone number, and office hours of the grievance coordinator.
- c. Grievance forms must be available at each service site.
- d. Upon request, the PDHP or the PDHP's grievance assistant, as appropriate, shall provide the member or provider with a grievance form(s) within three (3) business days of request.
- e. The PDHP's grievance procedure shall state that the complainant has the right to pursue a Medicaid Fair Hearing as provided by Section 65-2.042, F.A.C., in addition to pursuing the PDHP's grievance procedure. It shall also state that the complainant always has the right to appeal to the Agency.
- f. The PDHP shall offer to meet with the complainant during the formal grievance process. The location of the meeting shall be at the administrative offices of the PDHP within the service area or at a location within the service area that is convenient to the complainant.
- g. The PDHP shall maintain a log of all grievances filed and grievance forms requested and shall maintain an accurate record of each formal grievance. Each record shall include the following:
 1. A complete description of the grievance, the complainant's name and address, the provider's name and address, and the PDHP's name and address.
 2. If there was an expedited request.
 3. The type of grievance, including status (see #5).
 4. A complete description of the PDHP's factual findings, conclusions after completion of the full formal grievance procedure, the final disposition and date of disposition of the grievance.

5. A statement as to which levels of the grievance procedure the grievance has been processed and how many more levels of the grievance procedure are remaining before the grievance has been processed through the PDHP's entire grievance procedure.
- h. A record of complaints received, which are not grievances, shall be maintained and shall include date, complainant's name, nature of complaint, and disposition. The PDHP shall submit this report upon request by the Agency.
- i. If the PDHP is unable to resolve the grievance to the complainant's satisfaction, the PDHP shall provide a final decision letter to the complainant that includes the following:
 1. A notice of the right to appeal upon completion of the full grievance procedure and supply the Agency with a copy of the final decision letter. In addition, for expedited grievances, the PDHP shall provide the complainant notice of the right to appeal immediately upon request.
 2. As described in Section 641.511, 408.7056, and 409.912, F.S. that the complainant may request a review of the PDHP's decision concerning the grievance by the Statewide Provider and Subscriber Assistance Panel, and that such request must be made by the complainant within 365 days after receipt of the final decision letter from the PDHP. The PDHP shall inform the complainant how to initiate such a review, and shall include the panel's address and telephone number as follows: Agency for Health Care Administration, Bureau of Managed Health Care, Building 1, Room 339, 2727 Mahan Drive, Tallahassee, Florida 32308, (850) 921-5458; toll free number is 1-888-419-3456. In accordance with Section 408.7056, F.S., the Statewide Provider and Subscriber Assistance Panel will not consider a grievance taken to Medicaid Fair Hearing.
 3. That the complainant retains the right to pursue a Medicaid Fair Hearing in addition to pursuing the PDHP's grievance procedure, and may contact the Department of Children and Families at the following address to pursue a Medicaid Fair Hearing: Office of Appeals Hearings, 1317 Winewood Boulevard, Building 5, Room 203, Tallahassee, Florida 32399-0700.
- j. The PDHP shall have an expedited grievance review process as described in Section 641.511, F.S., for urgent grievances, as defined in Section 641.47, F.S., and in Section 100.0, Glossary.

The PDHP shall supply the Agency with a copy of the final decision letter.

20.12 QUALITY IMPROVEMENT

The PDHP shall have a quality improvement program with written policies and procedures that ensure enhancement of quality of care and emphasize quality patient

outcomes. The quality improvement program must be approved, in writing, by the Agency prior to the enrollment of any Medicaid beneficiaries. Approval of a quality improvement program shall be based on the PDHP's adherence to the minimum standards listed below.

- a. The PDHP shall have a quality improvement review authority that shall direct and review all quality improvement activities, assure that quality improvement activities take place in all areas of the PDHP, review and suggest new or improved quality improvement activities, direct task forces/committees in the review of focused concern, designate evaluation and study design procedures, publicize findings to appropriate staff and departments within the PDHP, report findings and recommendations to the appropriate executive authority, and direct and analyze periodic reviews of members' service utilization patterns.
- b. The PDHP shall provide for a quality improvement staff that has the responsibility for working with personnel in each clinical and administrative department to identify problems related to quality of care for all covered health care and professional services, prioritizing problem areas for resolution and designing strategies for change, implementing improvement activities and measuring success, and determining if dental care is acceptable under current state and federal standards.
- c. The PDHP shall monitor and evaluate the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to members through performance improvement projects (PIPs), medical record audits, performance measures, surveys, and related activities.
 1. The PDHP shall perform no less than three (3) Agency approved performance improvement projects (PIPs). The PIPs will focus on clinical and non-clinical areas.
 - (a). These activities shall include, but not be limited to, analyses of the following: formal and informal provider complaints, timely claims and capitation payment, termination reasons, policies and procedures, and any pertinent internal plan implemented to improve provider satisfaction.
 - (b). Each PIP must include a statistically significant sample of Enrollees or Providers, as applicable.
 - (c). At least one (1) of the PIPs must focus on provider satisfaction and participation. The PIP will focus on addressing issues identified in the University of Florida evaluation, dated June 27, 2006.
 - (d). Two PIPs must focus on quality of care delivered to Enrollees.

- d. All PIPs by the PDHP must achieve, through ongoing measurements and intervention, significant improvement to the quality of care and service delivery, sustained over time, in both clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction.

Each PIP must be completed in a reasonable time period so as to allow the PDHP to evaluate the information drawn from them and to use the results of the analysis to improve quality of care and service delivery every year.

- e. The performance improvement projects shall:

1. Target specific conditions and specific health service delivery issues for focused individual practitioner and system-wide monitoring and evaluation.
2. Use clinical care standards or practice guidelines to objectively evaluate the care that the entity delivers or fails to deliver for the targeted clinical conditions.
3. Use quality indicators derived from the clinical care standards of practice guidelines to screen and monitor the care and services delivered.
4. Implement system interventions to achieve improvement in quality.
5. Evaluate the effectiveness of the interventions.
6. Plan and initiate activities for increasing or sustaining improvement.

- f. Within two (2) months of the execution of this Contract, the PDHP shall submit, in writing, a description of each of the PIPs to the Agency for written approval. The detailed description shall include:

- (1) An overview explaining how and why the project was selected, as well as its relevance to the PDHP's members and providers;
- (2) The study question;
- (3) The study population;
- (4) The quantifiable measures to be used, including a goal or benchmark;
- (5) Baseline methodology;
- (6) Data sources;
- (7) Data collection methodology;

- (8) Data collection cycle;
 - (9) Data analysis cycle;
 - (10) Results with quantifiable measures;
 - (11) Analysis with time period and the measures covered;
 - (12) Analysis and identification of opportunities for improvement; and
 - (13) An explanation of all interventions to be taken.
- g. The PDHP shall report to the Agency the results and corrective action plan to be implemented to improve outcomes for the enrolled every six months. The PDHP shall report to the Agency the results and corrective action plan to be implemented to improve provider satisfaction and participation every three months. The report shall be filed with the Agency within 30 days of the reporting period. Each study shall have been through the PDHP's quality process, including reporting and assessments by the quality committee and reporting to the board of directors.
- h. Each performance improvement project must be completed in a reasonable time period to allow information on the success of performance improvement projects in the aggregate and produce new information on quality of care every year. The Centers for Medicare and Medicaid Services (CMS), in consultation with states and other stakeholders, may specify performance measures and topics for performance improvement projects.
- i. Pursuant to 42 CFR 438.208(c)(1), the PDHP shall implement mechanisms to identify persons with special health care needs, as those persons are defined by the Agency.
- j. The PDHP will partner with its dental providers to conduct outreach to their Medicaid beneficiaries and develop innovative methods to increase the provision of preventive dental services, while using current Healthcare Common Procedure Coding System (HCPCS) procedure codes and descriptions / Current Dental Terminology (CDT) procedure codes and descriptions, for the associated calendar year of their use, codes D1000-D1999. As specified in section 80.6, Incentive Payments For Distribution To Subcontractor Providers, incentives shall be utilized to promote an increased awareness about the importance of preventive oral health among parents and caregivers of their Medicaid beneficiaries and reduce the incidence of early childhood caries. The PDHP shall pass the incentive payments on to Subcontractor Providers who have met or exceeded a utilization rate of 60% for preventive care service, CDT code D1120 or D1110, among enrolled children ages three through age 20 during each six month reporting period as referenced in Section 60.2.3.1 of this contract. Incentive

payments shall be made in accordance with Section 80.6, Incentive Payments for Distribution to Subcontractor Providers.

The PDHP's quality improvement information shall be used in such processes as recredentialing, recontracting, and annual performance ratings of individuals. It shall also be coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member grievances. There shall also be a link between other management activities such as network changes, benefits redesign, management systems (e.g., pre-certification), practice feedback to dentists/dental providers, patient education, and member services.

The PDHP's quality improvement program shall have a peer review component, including clinical peers, with the authority to review practice methods and patterns of individual dentists and other ancillary staff, and all grievances related to dental treatment; evaluate the appropriateness of care rendered by professionals; implement corrective action when deemed necessary; develop policy recommendations to maintain or enhance the quality of care provided to Medicaid enrollees; conduct a review process that includes the appropriateness of diagnosis and subsequent treatment, maintenance of dental records requirements, adherence to standards generally accepted by professional group peers, and the process and outcome of care; maintain written minutes of the meetings; receive all written and oral allegations of inappropriate or aberrant service; and educate beneficiaries and staff on the role of the peer review authority and the process to advise the authority of situations or problems.

20.12.1 UTILIZATION MANAGEMENT

The PDHP's quality improvement program shall have a utilization management component that includes the following:

- a. The PDHP must develop and have in place utilization management policies and procedures that include protocols for prior approval and denial of services, dentist profiling, and retrospective review of inpatient, outpatient, and ambulatory treatment meeting pre-defined criteria.
- b. The PDHP shall achieve a dental service utilization rate for **unduplicated** number of children receiving **any** dental services as defined by HCPC codes D0100-D9999 (ADA codes 00100-09999) of no less than 60 percent for those members who are age 3 through 20 and are continuously enrolled for at least six (6) months. Should a review reveal that the PDHP's performance is not acceptable, the Agency may require the PDHP to submit a corrective action plan. Failure to provide a corrective action plan within the time specified or failure to comply with the corrective action plan shall be cause for administrative action by the Agency.
- c. The PDHP must develop procedures for identifying patterns of over- and under-utilization of goods or services by members and for addressing potential problems identified as a result of these analyses.

- d. The PDHP's internal utilization management policies and procedures must be consistent with the utilization control program requirements in 42 CFR 434.34 and 42 CFR 456.
- e. The PDHP shall report fraud and abuse information identified through the utilization management program to the Agency in accordance with 42 CFR 455.1(a)(1).
- f. The PDHP's service authorization systems shall provide authorization numbers, effective dates for the authorization, and written confirmation to the provider of denials, as appropriate. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease in accordance with 42 CFR 438.210 (b)(3). The PDHP must notify the requesting provider of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested in accordance with 42 CFR 438.210(c). The PDHP must notify the enrollee in writing of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

The PDHP must give the enrollee written notice of any adverse determination as defined in Section 100.0, Glossary, within the time frames for each type of action. In accordance with 42 CFR 438.404(b) and 42 CFR 438.210(c), the notice must explain:

1. The action the PDHP has taken or intends to take.
2. The reasons for the action.
3. The enrollee's or the provider's right to file a grievance/appeal.
4. The enrollee's right to request a Medicaid Fair Hearing.
5. Procedures for exercising enrollee rights to appeal or grieve.
6. Circumstances under which expedited resolution is available and how to request it.
7. Enrollee rights to request that benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

In accordance with 42 CFR 438.404 (a) and (c), the notice must be in writing and must meet the language and format requirements of 42 CFR 438.10(c) and (d) to ensure ease of understanding.

The PDHP must mail the notice within the following time frames:

1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the time frames specified in 42 CFR 431.211, 431.213, and 42 CFR 431.214.
2. For denial of payment, at the time of any action affecting the claim.
3. For standard service authorization decisions that deny or limit services not to exceed 14 calendar days following receipt of the request for service as specified in 42 CFR 438.210(d)(1).
4. If the PDHP extends the 14 calendar day time frame in accordance with 42 CFR 438.210(d)(1), it must:

Give the enrollee written notice of the reason for the decision to extend the time frame and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

5. For service authorization decisions not reached within the time frames specified in 42 CFR 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the time frames expire.
6. For expedited service authorization decisions, no later than 3 working days after the receipt of the request for service in accordance with 42 CFR 438.210(d).
- g. Compensation to individuals or entities that conduct utilization management activities may not be structured so as to provide incentives to the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.
- h. The PDHP may receive an incentive payment to be distributed to Subcontractor Providers who have met or exceeded the qualifying criteria of an 60% utilization rate for the provision of dental prophylaxis, (CDT code D1120 or D1110) to enrolled children ages three through age 20 during each six month reporting period as referenced in Section 60.2.3.1 of this contract. Incentive payments shall be made in accordance with section 80.6, Incentive Payments For Distribution To Subcontractor Providers.
 1. The Agency will conduct a random sample audit of the report submitted by the PDHP.

2. The PDHP will comply with all audit requests by AHCA and will require its subcontractor providers to do so also.

20.12.2 MEMBER SATISFACTION SURVEYS

The PDHP shall participate in enhanced managed care quality improvement including at least the following:

- a. The PDHP shall participate in an Agency approved independent survey of member satisfaction, on an annual basis, contracted by the Agency.
- b. The PDHP shall use the results of their member satisfaction survey and any Agency approved contracted independent surveys to develop and implement plan-wide activities designed to improve member satisfaction. These activities shall include, but not be limited to, analyses of the following: formal and informal member complaints, timely claims payment, disenrollment reasons, policies and procedures, and any pertinent internal plan implemented to improve member satisfaction. The PDHP must report to the Agency annually all survey results and quarterly all improvement activities resulting from the annual member satisfaction survey.

The PDHP shall make aggregate survey results available to beneficiaries upon request.

20.12.3 PROVIDER SATISFACTION SURVEYS

The PDHP shall participate in and complete provider satisfaction surveys as follows:

- a. The PDHP shall participate in an Agency approved independent survey of provider satisfaction, on an annual basis, contracted by the Agency.
- b. The PDHP shall complete a Provider Satisfaction survey plan, including questions to be asked, to the Agency for written approval by the fourth (4th) month of this contract. The Health Plan shall conduct the survey annually for each contract year. The PDHP may request a waiver of this requirement if the Agency has contracted with an independent entity to conduct the survey. Such request must be submitted in writing.
- c. The PDHP shall use the results of their provider satisfaction survey and any Agency approved contracted independent surveys to develop and implement plan-wide activities designed to improved provider satisfaction. The PDHP must report to the Agency annually all survey results and quarterly all improvement activities resulting from the annual provider satisfaction survey.

The PDHP shall make aggregate survey results available to providers and enrollees upon request.

20.12.4 QUALITY REVIEWS

The Agency will review PDHP quality at least annually. Such reviews may incorporate onsite, focused, retrospective, reviews by external organizations, and tracking and trending of complaints and grievances. Should a review reveal that the PDHP's performance is not acceptable, the Agency may require the PDHP to submit a corrective action plan. Failure to provide a corrective action plan within the time specified or failure to comply with the corrective action plan shall be cause for administrative action by the Agency.

20.13 DENTAL RECORDS REQUIREMENTS

The PDHP shall ensure that dental records are maintained for each member enrolled under this contract in accordance with this section. The record shall include the quality, quantity, appropriateness, and timeliness of services performed under this contract.

- a. The following dental record standards must be included/followed in each member's records as appropriate:
 1. Identifying information on the member, including name, member identification number, date of birth, sex, and legal guardianship.
 2. Each record must be legible and maintained in detail.
 3. A current medical history listing past and current diagnosis or problems, allergies, untoward reactions to drugs, and current medications.
 4. All entries must be dated and signed.
 5. All entries must indicate the chief complaint or purpose of the visit, the objective findings of practitioner, diagnosis, and proposed treatment.
 6. All entries must indicate referrals and include referral reports.
 7. All entries must indicate treatment administered and prescriptions.
 8. All entries must include the name and profession of the practitioner rendering services, for example, D.D.S. (doctor of dental surgery), D.M.D. (doctor of dental medicine), and R.D.H. (registered dental hygienist), including signature or initials of practitioner.
 9. All entries must include the disposition, recommendations, instructions to the patient, evidence of whether there was follow-up, and outcome of services.
 10. All records must contain a record of emergency services.

11. All records must reflect the primary language spoken by the member and translation needs of the member.
 12. All records must identify members needing communication assistance in the delivery of health care services.
- b. The PDHP shall have a policy to ensure the confidentiality of patient records in accordance with 42 CFR 431, Subpart F; 42 CFR 438.224; and 45 CFR 160 and 164.
 - c. The PDHP shall have a policy to ensure compliance with the Privacy and Security provisions of the Health Insurance Portability and Accountability Act (HIPAA).
 - d. The PDHP shall have a procedure to capture in its dental records any services provided to its members by non-PDHP providers.

20.14 DENTAL RECORD REVIEW

The PDHP shall conduct dental record reviews of Medicaid members to ensure that practitioners provide high quality health care that is documented according to established standards. These standards, which must include all dental record documentation requirements addressed in this contract, must be distributed to all providers. The PDHP must conduct these reviews at all primary care practice sites. Practice sites include both individual offices and large group facilities. Each practice site meeting these criteria must be reviewed at least once annually. The PDHP must review a reasonable number of records at each site to determine compliance. A generally accepted target would be 10 percent or 50 enrollee records, whichever is fewer, of members who have received dental health care services during the previous year.

The PDHP must maintain a written strategy for conducting these reviews. This strategy must include designated staff who will perform this duty, the method of case selection, the anticipated number of reviews by practice site, and the tool that will be used. The PDHP must also indicate how the compiled information will be linked to other PDHP functions, such as quality improvement, credentialing, and peer review.

Review elements include management of specific chief complaints, appropriateness and timeliness of care, comprehensiveness of and management of the treatment plan of care, and evidence of special handling of high-risk individuals or conditions.

20.15 ANNUAL DENTAL RECORD AUDIT

The Agency may conduct an annual dental record audit of the PDHP. The PDHP shall furnish specific data requested by the Agency in order to conduct the audit. If the dental audit indicates that quality of care is not acceptable pursuant to contractual

requirements, the Agency will require a corrective action plan. Failure to provide a corrective action plan within the time specified or failure to comply with the corrective action plan shall be cause for administrative action by the Agency.

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30.0 MATERIALS AND ENROLLMENT

30.1 MEMBER MATERIALS

The PDHP shall ensure that all materials, including but not limited to, provider recruitment, member, grievance and appeal materials developed for the Medicaid population adheres to the following policies and procedures:

- a. All materials developed for the Medicaid population must be at or near the fourth-grade comprehension level so that the materials are understandable (in accordance with Section 1932(a)(5) of the Social Security Act as enacted by Section 4701 of the Balanced Budget Act of 1997), and be available in alternative communication methods (such as large print, video or audio recordings, or Braille) appropriate for persons with disabilities. Proposed materials shall be submitted to the Agency no later than 60 calendar days prior to contract renewal, and for any changes during the contract period, no later than 60 calendar days prior to implementation.
- b. The PDHP shall assure that appropriate foreign language versions of all materials are developed and available to members and potential members. The PDHP shall provide interpreter services in person where practical, but otherwise by telephone at no cost, for applicants or members whose primary language is a foreign language. Foreign language versions of materials are required if, as provided annually by the Agency, the population speaking a particular foreign (non-English) language in a county is greater than five percent.

30.2 MARKETING

The PDHP shall not market enrollment or conduct any pre-enrollment as pre-enrollment is defined in Section 409.912, F.S. Additionally, the PDHP shall not engage in any of the prohibited practices or activities which are listed in Section 409.912, F.S.,

The PDHP shall not make any presentations or engage in any recruitment activities.

Any violations of this section shall subject the PDHP to administrative action by the Agency as determined by the Agency. The PDHP may dispute such action pursuant to Section 70.10, Disputes.

30.2.1 PROHIBITED ACTIVITIES

The PDHP is prohibited from engaging in any of the following practices or activities:

- a. Practices that are discriminatory, including, but not limited to, attempts to discourage enrollment or re-enrollment on the basis of actual or perceived oral health status.

- b. Activities that could mislead or confuse beneficiaries, or misrepresent the organization, or the Agency. No fraudulent, misleading, or misrepresentative information shall be used including information regarding other governmental programs.
- c. PDHP representatives shall not directly solicit individuals for the purpose of enrolling in the PDHP.
- d. Offers of material or financial gain, other than the health benefits expressed in this contract, provided as an incentive to enroll or remain enrolled.
- e. Direct or indirect cold call marketing for solicitation of Medicaid beneficiaries, either by door-to-door, telephone, or other means. Cold call marketing is defined as any unsolicited personal contact with a potential enrollee by an employee or agent of a managed care entity for the purpose of influencing the individual to enroll with the entity.
- f. Offers of insurance, such as but not limited to, accidental death, dismemberment, disability, or life insurance.
- g. Enlisting the assistance of any employee, officer, elected official, or agent of the state in recruitment of Medicaid beneficiaries except as authorized in writing by the Agency.
- h. Claims that a Medicaid beneficiary will lose benefits under the Medicaid program or any other health or welfare benefits to which the beneficiary is legally entitled, if the beneficiary does not enroll with the PDHP.
- i. Offers of material or financial gain to any persons soliciting, referring, or otherwise facilitating beneficiary enrollment.
- j. Providing any gift, commission, or any form of compensation to the Agency's enrollment/disenrollment services contractor, including the contractor's full-time, part-time, or temporary employees and subcontractors.
- k. Any assertion or statement (whether written or oral) that the beneficiary must enroll in the PDHP in order to obtain benefits or in order to not lose benefits.
- l. The PDHP shall not subcontract with any brokerage firm or independent agent for purposes of marketing or enrollment activities.
- m. The Agency shall sanction the PDHP for any of the above actions in accordance with in Section 70.17, Sanctions.

30.2.2 SUBCONTRACTOR'S COMPLIANCE

The PDHP shall ensure its health care providers comply with the following :

- a. Health care providers may not make comparisons to other managed care plans and PDHPs when speaking to potential enrollees.
- b. Health care providers may co-sponsor events, such as health fairs.
- c. Health care providers cannot furnish lists of their fee-for-service beneficiaries to managed care plans or PDHPs with which they contract, nor can providers furnish other managed care plans' or PDHPs' membership lists to any other managed care plan or PDHP, nor can providers take applications in their offices.

30.3 ENROLLMENT

The Agency or its delegate shall be responsible for enrolling Miami-Dade beneficiaries in PDHPs.

The Agency or its delegate shall be responsible for:

- a. Determining the applicant's eligibility for enrollment in the PDHP.
- b. Forwarding to the PDHP a list of all new members on a monthly basis, which shall include any voluntary MediKids enrollees to be enrolled by the PDHP.

Membership begins at 12:01 a.m. on the first day of the calendar month that the member's name appears on the automated enrollment report. However, if the Agency requests the enrollment of a specific beneficiary, enrollment begins immediately upon notification. Membership is in whole months unless otherwise specified.

If the PDHP's contract is renewed, the enrollment status of all members shall continue uninterrupted.

The Agency or its delegate, shall forward to the PDHP a list of all new members on a monthly basis. Additional enrollment data shall be provided to the PDHP.

The Agency shall forward to the PDHP the enrollment status of the PDHP's current enrollees monthly.

The PDHP will not discriminate against individuals eligible to enroll on the basis of health status, need for health care services, race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on any basis including but not limited to health status, need for health care services, race, color, or national origin.

30.4 MEMBER NOTIFICATION

The PDHP shall develop and implement written enrollment procedures that shall be used to notify all new PDHP members of enrollment with the PDHP. The PDHP must give each beneficiary written notice of any change in the information required by this section, 42 CFR 438.10(f)(6), and 42 CFR 438.10(g) and (h), at least 30 days before the intended effective date of the change.

- a. Prior to, or upon enrollment, the PDHP shall provide the following information and reasonable written explanations to all new members of the PDHP:
 1. A written notice providing the actual or estimated date of enrollment, and the name, telephone number, and address of the member's primary care dentist. The primary care dentist assignment is done by the PDHP. The member can request a change in their primary care dentist by notifying the PDHP.
 2. As described in Section 409.912, F.S., a PDHP identification card or Medicaid identification card sleeve that includes the PDHP's name, address, and member services' telephone number, including a telephone number that a non-contract provider may call for billing information, the toll-free telephone number of the statewide Consumer Call Center (888-419-3456) on the back side of the card (which shall be less prominently displayed than the PDHP's member services number), and effective date of enrollment; a member services handbook; and a provider directory.
 3. An explanation that the member's parent or guardian may choose to have all eligible family members (children) served by the same primary care dentist or may choose different primary care dentists based on each member's needs.
 4. An explanation of the applicable restrictions of the PDHP, especially that the member must use PDHP providers and secure appropriate referrals to receive care from providers outside the PDHP.
 5. Information to the member that the PDHP will ensure each member receives complete dental care, including continuity of care. New members who are receiving "medically necessary" treatment with a provider not in the PDHP's network prior to the member's enrollment effective date, may continue receiving care from their current dentist for a period of one month after the effective date of enrollment or until the PHDP's primary dental provider assigned to that member reviews and assumes a responsibility for the member's treatment plan, whichever comes first. The PDHP will ensure continuity of care and reimbursement to providers for active orthodontia until completion of care, regardless of provider network affiliation. Any services that must be continued will be coordinated by the PDHP. The PDHP shall be responsible for payment of covered services to the existing treating provider at a prior negotiated rate or lesser of the provider's usual and customary rate or

the established Medicaid fee-for-service rate for such services until the PDHP is able to evaluate the need for ongoing services.

- b. The PDHP shall have procedures advising potential enrollees and members of PDHP service delivery and provider network changes, including the following:
 - 1. Restrictions on provider access, including providers who are not taking new patients. Current members shall be advised on at least a six-month basis.
 - 2. Termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. The PDHP must make a good faith effort to give written notice of such termination to the member.
 - 3. Provider's objections to counseling and referral services based on moral or religious grounds within 90 calendar days after the PDHP's change in policy regarding such a counseling or referral service as required by Section 1932(b)(3), Social Security Act (enacted by Section 4704 of the Balanced Budget Act of 1997).
 - 4. Members' option to change primary care dentists.
 - 5. Members' responsibility to notify the PDHP if they move out of the service area and to ask to disenroll.
- c. Pursuant to 42 CFR 438.10, the PDHP shall provide information on the PDHP's covered benefits, member rights and protection, grievance/appeal and fair hearing procedures, and service area provider information to any Medicaid beneficiary upon request. The PDHP shall provide a release form, in new member materials or in another format acceptable to the Agency, to each applicant authorizing the PDHP to release dental information to the federal and state governments or their duly appointed agents.
- d. If the applicant is recognized to be in foster care, the PDHP must receive written authorization for release of dental information to the federal and state governments or their duly appointed agents from (1) a parent, (2) legal guardian, or (3) the Department of Children and Families (DCF) or DCF's delegate. If a parent is unavailable, the PDHP shall obtain authorization from DCF or DCF's delegate.

30.4.1 MEMBER HANDBOOK

The member services handbook shall include the following information: terms and conditions of enrollment, including the reinstatement process; description of the open enrollment process; description of services provided, including limitations and general restrictions on provider access, exclusions, and out-of-network use; procedures for obtaining required services, including second opinions; the toll-free telephone number of the statewide Consumer Call Center; emergency services and procedures for obtaining services both in and out of the network service area; the extent to which, and

how, after-hours and emergency coverage are provided; explanation that poststabilization services are provided without prior authorization; member rights and responsibilities, including the extent to which, and how, members may obtain benefits from out-of-network providers; procedures for enrollment, including member rights and procedures; grievance procedures; and explanation that enrollment in a Medicaid funded HMO that provides children's dental care will cause disenrollment from the PDHP; explanation that oral interpretation services and alternative communication systems are available free of charge for all foreign languages and how to access these services; explanation that materials are available in alternative formats and how to access those formats; explanation that members may obtain from the PDHP information regarding quality performance indicators, including aggregate member satisfaction data; how and where to access any benefits that are available under the State plan but are not covered under the contract; explanation that the member has rights to request that benefits continue pending the resolution of the grievance/appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services; and information regarding the health care advance directives as described in Chapter 765, F.S.

30.4.2 PROVIDER DIRECTORY

The provider directory shall identify all service sites and specialists. The directory shall list by city in alpha order all primary care dentists, including location addresses and telephone numbers. For specialists, the directory shall include the providers' names, telephone numbers, and cities. Any lists of providers made available to Medicaid beneficiaries shall be arranged alphabetically, showing the individual provider's name, the name of the office or clinic, and the provider's specialty. Additionally, the specialties shall be listed categorically, with providers' names in alpha order, last name first.

30.4.3 MEMBER INFORMATION

The PDHP shall make available the following items to members upon request:

- a. A detailed description of the PDHP's authorization and referral process for dental care services, which shall include reasons for denial of services based on moral or religious grounds as required by Section 1932(b)(3), Social Security Act (enacted in Section 4704 of the Balanced Budget Act of 1997).
- b. A detailed description of the PDHP's process used to determine whether dental care services are medically necessary.
- c. A description of the PDHP's quality improvement program.
- d. Policies and procedures relating to the confidentiality and disclosure of the member's dental records.

- e. The decision-making process used for approving or denying experimental or investigational dental treatments.
- f. A detailed description of the PDHP's credentialing process.

The PDHP will provide enrollee information in accordance with 42 CFR 438.10(f). In accordance with 42 CFR 438.10(f)(2), the PDHP must notify enrollees at least on an annual basis of their right to request and obtain information.

30.4.4 NEW MEMBER MATERIALS

Immediately upon the beneficiaries' enrollment, the PDHP shall mail to the new member materials as required in Section 30.5, Member Notification, and the following additional materials:

- a. A request for the following information, including updates to this information: assigned member's name; address (home and mailing); county of residence; telephone number; social security number; and a completed, signed, and dated release form authorizing the PDHP to release dental information to the federal and state governments or their duly appointed agents.
- b. A notice that members who lose eligibility and are disenrolled will be re-enrolled in the PDHP when eligibility is regained.
- c. Each mailing shall include a postage paid, pre-addressed return envelope. The mailing envelope shall include a request for address correction.
- d. The initial mailing may be combined with the primary care dentist assignment notification specified in Section 20.6, Choice of Dentist. Each mailing shall be documented in the PDHP's records.

30.4.4.1 UNDELIVERABLE MATERIALS

For beneficiaries whose new member materials are returned to the PDHP as undeliverable, the PDHP shall report the occurrence to the Agency and keep the returned envelope in the members' files and may use any of the following methods to contact the members and document such methods in the members' files.

- a. Telephone contact at the telephone number obtained from the local telephone directory, directory assistance, city directory, or other directory.
- b. Telephone contact with the DCF Self-Sufficiency Services Office staff (DCF) or DCF's delegate to determine if they have updated address information and telephone number.

- c. Routine checks (at least once a month for the first three months of enrollment) on services or claims authorized or denied by the PDHP to determine if the member has received services and to locate updated address and telephone number information.

If a new address is secured and the PDHP materials requiring signature have not been received by the PDHP or are returned unsigned, the PDHP must mail the materials to the new address within ten working days of the receipt of the new address.

The PDHP may use other methods to locate members. The PDHP shall maintain policies and procedures on the methods used to locate members and to document such members' use of PDHP services.

30.5 ENROLLMENT REINSTATEMENTS

The Agency shall be responsible for processing all reinstatements. The PDHP is responsible for assigning all reinstated members to the primary care dentist who was treating them prior to loss of eligibility, unless the member specifically requests another primary care dentist, the primary care dentist no longer participates in the PDHP or is at capacity, or the member has changed geographic areas. A notation of the effective date of the reinstatement is to be conspicuously identified in the member's administrative file.

The PDHP shall notify, in writing, each person who is to be reinstated, of the effective date of the reinstatement and the assigned primary care dentist. The notification shall also instruct the beneficiary to contact the PDHP if a new member card and/or a new member handbook are needed. The PDHP shall provide such notice to each affected person by the first day of the month following the PDHP's receipt of the notice of reinstatement.

30.6 ENROLLMENT LEVELS

The PDHP is assigned maximum enrollment levels for the operational area(s) indicated in Section 90.0, Payment and Maximum Authorized Enrollment Levels, of this contract. The number of Medicaid beneficiaries enrolled in the PDHP may not exceed the maximum authorized enrollment level for Miami-Dade County. Medicaid uses the generally accepted ratio of one FTE primary care dentist per 1,500 patients (includes Medicaid, commercial, and fee-for-service). General dentistry practitioners and pediatric dentists are considered primary care dentists. The cost of care for any Medicaid beneficiaries enrolled over the maximum level per county is a liability for the PDHP and shall not be charged to the Agency or the enrolled beneficiary. The PDHP shall notify the Agency when enrollment has reached the maximum number authorized and request an increased enrollment level.

The PDHP shall annually provide to the Agency an attestation statement of the dentist to patient ratio which is inclusive of the total active patient load (all product lines, i.e.

Medicaid, Medicare, commercial, etc.). The Agency reserves the right to request an attestation at any other time within the contract period when deemed necessary.

30.7 DISENROLLMENT

The Agency shall be responsible for processing disenrollments.

The PDHP's responsibility is to ensure that disenrollees who wish to file a grievance are afforded the opportunity to do so, unless the proposed disenrollment is for one of the following reasons: disenrollment due to moving out of the service area; disenrollment due to loss of Medicaid eligibility; and disenrollment due to death.

The following are unacceptable reasons for the PDHP, on its own initiative, to request disenrollment of a member: pre-existing dental condition, changes in health status, periodically missed appointments, or utilization of services.

With proper written documentation, the PDHP shall promptly submit disenrollment requests to the Agency for members who have died. The PDHP shall ensure that disenrollment documents are maintained in an identifiable member record. The PDHP must report fraudulent use of the beneficiary ID card to DCF.

- a. If the PDHP discovers that an ineligible beneficiary has been enrolled, then it must notify the beneficiary in writing that the beneficiary shall be disenrolled the next contract month. Until the beneficiary is disenrolled, the PDHP shall be responsible for the provision of services to that beneficiary.
- b. On a monthly basis, the PDHP shall review its enrollment report to ensure that all members are residing in the PDHP's authorized service area. For beneficiaries with out-of-service-area addresses on the enrollment report, the PDHP shall notify the beneficiary in either by telephone or in writing that the beneficiary will be disenrolled and inform the beneficiary of the requirement to update their address on file at DCF or Social Security Administration (SSA).
- c. The PDHP shall assign a different dentist to a member whose behavior is disruptive, unruly, abusive, or uncooperative to the extent that his or her membership in the PDHP seriously impairs the organization's ability to furnish services to either the member or other members. The PDHP must maintain documentation of at least one oral and at least one written warning to the member regarding the implications of his or her actions. A written explanation of the reason for changing the primary care dentist must be given to the member.
- d. The PDHP shall provide disenrollment data via an Agency-approved transmission medium. Documentation must contain the following minimum information: name, address, telephone number, reason for disenrollment with brief explanation, date, and signature by PDHP staff.

- e. The PDHP shall keep a daily written log or electronic documentation of all oral and written enrollment change requests and the disposition of such requests. The log shall include the following: the date the request was received by the PDHP; the date of the letter advising them of the enrollment change procedure; and the reason that the member is requesting an enrollment change.

30.7.1 PRIMARY CARE DENTIST CHANGES

The PDHP may submit a request to the Agency plan analyst to assign a different primary care dentist to a member whose behavior is disruptive, unruly, abusive, or uncooperative to the extent that his or her membership in the PDHP seriously impairs the organization's ability to furnish services to either the member or other members. The PDHP must provide and maintain documentation of at least one oral and at least one written warning to the member regarding the implications of his or her actions. A written explanation of the reason for changing the primary care dentist must be given to the member.

The Agency plan analyst may approve such requests provided the PDHP documents that attempts were made to educate the member regarding his/her rights and responsibilities, assistance which would enable the member to comply was offered through case management, and it has been determined that the member's behavior is not related to the member's medical or behavioral condition.

Subsequent requests for a primary care dentist change will be considered by the Agency plan analyst for a member who has been subject to the primary dental provider change process outlined in the above paragraph but continues to exhibit behavior that is disruptive, unruly, abusive, or uncooperative to the extent that his or her membership in the PDHP seriously impairs the organization's ability to furnish services to either the member or other members. Such requests must be submitted at least 60 calendar days prior to the requested effective date. Any submitted request shall contain documentation regarding the provider's intervention, including any additional contact with the member. The documentation should cite the date, the behavior, to whom and what the consequences of continued behavior was addressed.

30.8 ENROLLMENT/DISENROLLMENT VERIFICATION

The Agency shall arrange for the PDHP to receive a monthly list of eligible members and a list of those members ineligible or disenrolled from the PDHP. The PDHP shall be responsible for notifying, in writing, enrollees disenrolled by the PDHP of the disenrollment effective date and the reason for disenrollment.

30.9 ENROLLMENT CHANGES

For enrollment changes, the managed care entity shall comply with the following requirements:

- a. At the time of enrollment for new members, notify each member of the right to change enrollment at any time and how to initiate the change process through the Agency's enrollment and disenrollment services contractor. Such notification must adhere to approved wording specifications provided by the Agency.
- b. The effective date for enrollment change shall be the last day of the month in which enrollment change was effectuated by the Agency, unless the Agency requests an earlier or later date.
- c. The managed care entity shall ensure that it does not restrict the member's right to change enrollment in any way.
- d. The managed care entity shall not provide or assist in the completion of an enrollment change, but must ensure that all written and oral enrollment change requests are promptly handled by referring members to the enrollment and disenrollment services contractor.
- e. The managed care entity shall keep a daily written log or electronic documentation of all oral and written enrollment change requests and the disposition of such requests. The log shall include the following: the date the request was received by the managed care entity; the date of the letter advising them of the enrollment change procedure; and the reason that the member is requesting an enrollment change.

40.0 ASSURANCES AND CERTIFICATIONS

40.1 MONITORING PROVISIONS

In addition to the monitoring requirements specified in the Agency's core contract, Section I.E.2., Monitoring, the PDHP shall permit the Agency, entities authorized by the Agency, and the Department of Health and Human Services (DHHS) to evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services provided under the contract.

40.2 MINORITY RECRUITMENT AND RETENTION PLAN

The PDHP shall implement and maintain a plan for recruitment and retention of minority administrators, managers, and providers. The PDHP shall have policies and procedures for the implementation and maintenance of such a plan. The minority recruitment and retention plan may be company-wide for all services or products.

40.3 OWNERSHIP AND MANAGEMENT DISCLOSURE

Federal and state laws require full disclosure of ownership, management, and control of Medicaid prepaid plans.

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a. Disclosure shall be made on forms prescribed by the Agency for the areas of ownership and control interest (42 CFR 455.104 Form CMS 1513, available through CMS Website at <http://www.cms.hhs.gov/forms>), business transactions (42 CFR 455.105), public entity crimes (Section 287.133, F.S.), and disbarment and suspension (52 Fed. Reg., pages 20360-20369, and 42 CFR 438). The forms are to be submitted to the Agency with the initial application for a Medicaid PDHP and then re-submitted on an annual basis. The PDHP shall disclose any changes in management as soon as those occur. In addition, the PDHP shall submit to the Agency full disclosure of ownership and control of Medicaid PDHPs at least 60 calendar days before any change in the PDHP's ownership or control occurs.

b. The following definitions apply to ownership disclosure:

1. A person with an ownership interest or control interest means a person or corporation that:

Owns, indirectly or directly, 5 percent or more of the PDHP's capital or stock, or receives 5 percent or more of its profits;

Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the PDHP or by its property or assets and that interest is equal to or exceeds 5 percent of the total property or assets; or

Is an officer or director of the PDHP if organized as a corporation, or is a partner in the PDHP if organized as a partnership.

2. The percentage of direct ownership or control is calculated by multiplying the percent of interest that a person owns by the percent of the PDHP's assets used to secure the obligation. Thus, if a person owns 10 percent of a note secured by 60 percent of the PDHP's assets, the person owns 6 percent of the PDHP.

3. The percent of indirect ownership or control is calculated by multiplying the percentage of ownership in each organization. Thus, if a person owns 10 percent of the stock in a corporation, which owns 80 percent of the PDHP stock, the person owns 8 percent of the PDHP.

c. The following definitions apply to management disclosure:

Changes in management are defined as any change in the management control of the PDHP. Examples of such changes are those listed below or equivalent positions by another title.

1. Changes in the Board of Directors or Officers of the PDHP, Dental Director, Chief Executive Officer, Administrator, and Chief Financial Officer.

2. Changes in the management of the PDHP where the PDHP has decided to contract out the operation of the PDHP to a management corporation. The PDHP shall disclose such changes in management control and provide a copy of the contract to the Agency for approval at least 60 calendar days prior to the management contract start date.
- d. As described in Section 409.912, F.S., the PDHP shall annually conduct a background check with the Florida Department of Law Enforcement on all persons with five percent or more ownership interest in the PDHP, or who have executive management responsibility for the PDHP, or have the ability to exercise effective control of the PDHP. The PDHP shall submit information to the Agency for such persons who have a record of illegal conduct according to the background check. The PDHP shall keep a record of all background checks to be available for Agency review upon request.
 1. As described in Section 409.907, F.S., PDHPs with an initial contract beginning on or after July 1, 1997, shall submit, prior to execution of a contract, complete sets of fingerprints of principals of the PDHP to the Agency for the purpose of conducting a criminal history record check.
 2. Principals of the PDHP shall be as defined in Section 409.907, F.S.
 - e. The PDHP shall submit to the Agency, within five working days, any information on any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent of the PDHP who has been found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to, any of the offenses listed in Section 435.03, F.S.
 - f. As described in Section 409.912, F.S., the Agency shall not contract with a PDHP that has an officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent of the PDHP who has committed any of the above listed offenses. In order to avoid termination, the PDHP must submit a corrective action plan acceptable to the Agency that ensures that such person is divested of all interest and/or control and has no role in the operation and management of the PDHP.

40.4 INDEPENDENT PROVIDER

It is expressly agreed that the PDHP and any subcontractors and agents, officers, and employees of the PDHP or any subcontractors, in the performance of this contract shall act in an independent capacity and not as officers and employees of the Agency or the State of Florida. It is further expressly agreed that this contract shall not be construed as a partnership or joint venture between the PDHP or any subcontractor and the Agency and the State of Florida.

40.5 GENERAL INSURANCE REQUIREMENTS

The PDHP shall obtain and maintain at all times adequate insurance coverage, including general liability insurance, professional liability and malpractice insurance, fire and property insurance, and directors' omission and error insurance. All insurance coverage must comply with the provisions set forth in Section 4-191.069, F.A.C., except that the reporting, administrative, and approval requirements shall be to the Agency rather than to the Department of Financial Services. All insurance policies must be written by insurers licensed to do business in the State of Florida and in good standing with the Department of Financial Services. All policy declaration pages must be submitted to the Agency annually. Each certificate of insurance shall provide for notification to the Agency in the event of termination of the policy.

40.6 WORKER'S COMPENSATION INSURANCE

The PDHP shall secure and maintain during the life of the contract, worker's compensation insurance for all of its employees connected with the work under this contract. Such insurance shall comply with the Florida Worker's Compensation Law, Chapter 440, F.S. Policy declaration pages must be submitted to the Agency annually.

40.7 STATE OWNERSHIP

The Agency shall have the right to use, disclose, or duplicate all information and data developed, derived, documented, or furnished by the PDHP resulting from this contract. Nothing herein shall entitle the Agency to disclose to third parties data or information that would otherwise be protected from disclosure by state or federal law.

40.8 SYSTEMS COMPLIANCE

The PDHP warrants that each item of hardware, software, and/or firmware required for the provision of service under this contract shall be able to accurately process data.

40.9 CERTIFICATION OF REPORTED DATA

Data reported as provided in Section 60.0, Reporting Requirements, and data specified in 42 CFR 438.604 and as described in 42 CFR 438.606, must be certified by one of the following: the PDHP's chief executive officer, the chief financial officer, or an individual who has delegated authority to sign for and who reports directly to the PDHP's chief executive officer or chief financial officer.

Based on best knowledge, information, and belief, the certification must attest to the accuracy, completeness, and truthfulness of the data and of the documents specified by the Agency. The PDHP must submit the certification concurrently with the certified data.

50.0 FINANCIAL REQUIREMENTS**50.1 INSOLVENCY PROTECTION**

The PDHP shall be in compliance with Section 636.046, F.S., and if requested by the Agency the PDHP agrees to make an additional deposit not to exceed \$50,000 to the insolvency account on file with the Department of Financial Services.

50.2 SURPLUS REQUIREMENT

The PDHP shall be in compliance with Section 636.045, F.S. The PDHP will be responsible for notifying the Agency in writing regarding any financial impairment or financial non-compliance issue relating to Chapter 636, F. S.

The Agency will proceed immediately with contract termination should the PDHP fail to disclose its non-compliance with Section 636.045, F.S.

50.3 FIDELITY BONDS

The PDHP shall secure and maintain during the life of this contract a blanket fidelity bond on all personnel. This bond shall be filed with the Department of Financial Services pursuant to the guidelines put forth in Chapter 636, F.S.

50.4 INSPECTION AND AUDIT OF FINANCIAL RECORDS

The state and DHHS may inspect and audit any financial records of the PDHP or its subcontractors. In accordance with Section 1903(m)(4)(A) of the Social Security Act and State Medicaid Manual 2087.6(A-B), non-federally qualified PDHPs must report to the state, upon request, and to the Secretary and the Inspector General of DHHS, a description of certain transactions with parties of interest as defined in Section 1318(b) of the Social Security Act.

50.5 SUBSTANTIAL FINANCIAL RISK

Pursuant to the guidelines put forth in 42 CFR 422.208, 422.210, and 438.6(h), if provider/group is put at substantial financial risk for services not provided by provider/group the PDHP must ensure adequate stop-loss protection to individual providers and conduct annual enrollee surveys.

60.0 REPORTING REQUIREMENTS

60.1 AGENCY REPORTS

1. The following information will be provided by the Agency or the Agency delegate to the Contract Medicaid PDHP:
 - a) Disenrollment Report (FLMR8200 – R003) - Lists those persons who are no longer eligible for Medicaid or who have been disenrolled from the PDHP as of the report's effective date.
 - b) New Enrollees (FLMR8200 – R001) - Lists new Enrollees.
 - c) Ongoing Report (FLMR8200 – R004) - Lists all Enrollees in the PDHP as of the report's effective date.
 - d) Reinstatement Report (FLMR8200 – R009) – Lists all Enrollees who are reinstated in the PDHP after having lost eligibility, but regaining it within a 60 day window.
 - e) Supplemental Disenrollment Report (FLMR8200 - R011) – Lists Enrollees who were disenrolled from the PDHP after losing Medicaid eligibility between the penultimate Saturday and the last day of the month. These Enrollees would have previously been reported as on the Ongoing Report (FLMR8200-R004).
2. The PDHP shall review these reports for accuracy and notify the Agency if discrepancies are found. These proprietary enrollment reports will be in use until the Agency adopts the X12N 834 transaction as the single vehicle for reporting and maintaining membership in all managed care programs. The PDHP shall become proficient and able to use this file format exclusively in processing the 834 transaction when this change occurs.

60.2 PDHP REPORTING REQUIREMENTS

1. The PDHP is responsible for complying with all the reporting requirements established by the Agency. All reports identified in Table 1 below that are subject to the federal HIPAA regulations must be in full compliance. The PDHP is responsible for assuring the accuracy and completeness of the reports as well as the timely submission of each report. The Agency requires certification of all data as provided in 42 CFR 438.606.
2. The Agency reserves the right to modify the reporting requirements to which the PDHP must adhere but will allow the PDHP 60 calendar days to complete the implementation, unless otherwise required by law. The Agency shall provide the PDHP written notification of modified reporting requirements. The reporting requirements specifications are outlined in this section. Failure of the PDHP to

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submit required reports accurately and within the time frames specified may result in sanctions being levied.

3. When reporting utilization or user data, the PDHP shall report services provided by all the PDHP's providers of dental services. This includes both staff and contracted primary and specialty care providers.
4. The Agency is developing a Medicaid comprehensive managed care encounter information system. During this time, the PDHP is expected to participate in needs assessment, design/testing, and other related tasks towards the creation of this information system. This effort will be performed in collaboration with the Agency, managed care plans, and other relevant parties. The PDHP must be able to submit all data, meet all the requirements, and be certified by the Agency in order to continue as a contractor. Pursuant to HIPAA, encounter data must be reported using the HIPAA-compliant X12N format.
5. All Agency templates will include reporting format and instructions for completion.

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**Table 1.
Summary of Reporting Requirements
for Medicaid Contracted Prepaid Dental Health Plans**

Medicaid PDHP Reports Required by AHCA			
Report Name	Level of Analysis	Frequency	Submission Media
Service Utilization Summary Report Section 60.2.1, No. 2 , 2a., 2b., 2c.	PDHP Level	Quarterly, within 45 days of the end of calendar quarter	Email attachment via the Internet or CD/diskette submission. The Agency-supplied template must be used.
Enrollee and Dental User Report, Section 60.2.1, No.3, 3a., Table 2	PDHP Level	Quarterly, within 45 days of the end of the calendar quarter	Email attachment via the Internet or CD/diskette submission. The Agency-supplied template must be used.
Grievance Report Section 60.2.1, No. 4, 4a., Table 3	Individual Level	Quarterly, within 45 days of the end of calendar quarter	Secure file transfer method via the Internet or CD/diskette submission. The Agency-supplied template must be used.
Provider Network Report Section 60.2.2, No. 1	PDHP Level	Quarterly, within 45 days of the end of calendar quarter	Email attachment via the Internet or CD/diskette submission. The Agency-supplied template must be used.
Dental Health Check-Up Report (CMS 416) Section 60.2.3, No. 1, 2, Table 5	PDHP Level	Annually, for previous federal fiscal year (Oct – Sept) unaudited report due by January 15, audited report due by October 1.	Email attachment via the Internet or CD/diskette submission. The Agency-supplied template must be used.
Child Dental Check-Up Report (60% Treatment Ratio) Section 60.2.3, No. 3, Table 6	PDHP Level	Annually, for previous federal fiscal year (Oct – Sept) unaudited report due by January 15, audited report due by October 1.	Email attachment via the Internet or CD/diskette submission. The Agency-supplied template must be used.
Child Preventive Dental Services Report Section 60.2.3.1, No. 1, Table 7	PDHP Level	Biannually, due 30 calendar days after the end of each reporting period	Secure file transfer method via the Internet or CD/diskette submission. The Agency-supplied template must be used.

Incentive Payment Distribution Report Section 60.2.3.2, No. 1, Table 8	PDHP Level	Biannually, due no more than 45 days after the receipt of incentive monies	Secure file transfer method via the Internet or CD/diskette submission. The Agency-supplied template must be used.
Minority Participation Report Section 60.2.4	PDHP Level	Monthly, by the 15th of each subsequent month (unless waiver approval has been granted by the Agency)	Utilization Report Form for Commodities/Services, (Attachment V) submit by email to the Agency's Contract Manager.
Suspected Fraud Report Section 60.2.5	Individual Level	Upon suspicion of a fraudulent claim by a provider	This report should be completed in narrative fashion and addressed to the plan analyst in the Agency's Bureau of Managed Care.
Financial Report Section 60.2.6	PDHP Level	Quarterly, within 45 days of the end of the quarter	Email attachment via the Internet or CD/diskette submission. The Agency-supplied template must be used.

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5. Definitions for Table 1

a) Level of Analysis

- 1) Individual Level: One (1) record is required for each Enrollee or provider who meets the report criteria.
- 2) PDHP Level: One (1) record is required for the entire PDHP.

b) Submission Media

- 1) Reports must be submitted using Agency supplied templates unless otherwise specified. All templates include Agency instructions for proper completion. Proper method of submission of reports is dependent upon content. Any report containing protected health information (PHI) must be submitted via the Agency's secure file transfer protocol (FTP) server. Summary data (without PHI) must be submitted via attachment to an internet email message addressed to PDHPDATA@ahca.myflorida.com. CDs or diskettes may be mailed to the Agency at the following address:

Agency for Health Care Administration
Division of HQA
Bureau of Managed Health Care, Data Analysis Unit
2727 Mahan Drive, Mail Stop #26
Tallahassee, FL 32308

60.2.1 PDHP QUARTERLY REPORTING

1. Within 45 days of each reporting quarter, the PDHP must complete and submit the following reports, using templates provided by the Agency.
2. The PDHP Quarterly reports must include an attestation of the percentage of encounters submitted as a percentage of actual encounters. Actual encounters may be reported as a projection based on a statistically valid sample of audited records representing 100% of actual encounters. All such sampling and auditing must be prior approved by the Agency. The PDHP shall submit the sampling and auditing methodology to the Agency for approval at least 45 days prior to the submission of the first quarterly report due in this contract. The first quarterly report will establish a benchmark and must represent at least seventy percent (70%) of actual encounters. Subsequent quarters must demonstrate a fifteen percent (15%) improvement until one hundred percent (100%) of actual encounters reported is reached. Failure to reach these established reporting benchmarks will result in sanctions against the PDHP, up to and including termination of the contract, as defined in Section 70.17 of this contract.

3. **SERVICE UTILIZATION SUMMARY** - The Service Utilization Summary is used to report utilization information by age group and dental code. The Service Utilization Summary's template, provided by the Agency, includes only Medicaid-compensable codes. To ensure comprehensive and accurate reporting, the PDHP must supply additional summary data for all other valid codes that have appeared in their billing or encounter claims with their direct service providers. These additional codes must be presented in the same spreadsheet format as the Agency-supplied template.

The template includes a general instruction worksheet, a summary that compiles the data automatically, and three separate tabbed worksheets as follows:

- a. **All Injectable Medications** - For each of the age categories listed, the PDHP must provide the total number of injectable medications provided during the reporting quarter. This includes all services categorized by CDT Codes J0120 through J7120. These codes are referenced in Appendix C of the Medicaid Dental Services Coverage and Limitations Handbook.
- b. **All Oral and Maxillofacial Surgeries** - For each of the age categories listed, the PDHP must provide the total number of oral and maxillofacial surgeries provided during the reporting quarter. This includes all services categorized by CDT Codes 10060 through 99285. These codes are referenced in Appendix D of the Medicaid Dental Services Coverage and Limitations Handbook.
3. **ENROLLEE AND DENTAL USER REPORT**

- a. The Enrollee and Dental User Report gives basic utilization information through a summary of number of unduplicated recipients, by age group, enrolled in the PDHP as compared to the number of recipients receiving at least one dental service during the same period of time. The data must be submitted using the Agency-supplied template. Table 2 provides an example of this reporting template.

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Table 2. ENROLLEE AND DENTAL USER TEMPLATE

ENROLLEE AND DENTAL USER INFORMATION							
Seven Digit Medicaid Provider Number :				THIS REPORT IS DUE 45 DAYS FROM END OF QUARTER (MAY 15TH)			
PDHP Name :							
Federal Fiscal Year :							
						1ST QUARTER	
Age Groups							
	JANUARY	Less than 1 year	1-5 Years	6-13 Years	FEMALE 14-20 Years	MALE 14-20 Years	Total All Years
1.	Total Individuals Eligible for Dental Services (Unduplicated)						
2.	Total Eligibles Receiving ANY Dental Services (Unduplicated)						
	FEBRUARY	Less than 1 year	1-5 Years	6-13 Years	FEMALE 14-20 Years	MALE 14-20 Years	Total All Years
1.	Total Individuals Eligible for Dental Services (Unduplicated)						
2.	Total Eligibles Receiving ANY Dental Services (Unduplicated)						
	MARCH	Less than 1 year	1-5 Years	6-13 Years	FEMALE 14-20 Years	MALE 14-20 Years	Total All Years
1.	Total Individuals Eligible for Dental Services (Unduplicated)						
2.	Total Eligibles Receiving ANY Dental Services (Unduplicated)						
1ST QUARTER TOTALS		Less than 1 year	1-5 Years	6-13 Years	FEMALE 14-20 Years	MALE 14-20 Years	Total All Years
1.	Total Individuals Eligible for Dental Services (Unduplicated)						
2.	Total Eligibles Receiving ANY Dental Services (Unduplicated)						

4. GRIEVANCE REPORT

- a. The Grievance Report gives detailed information about each Grievance filed by a PDHP Enrollee, including Enrollee information, the dates of filing and disposition, the type of Grievance, if there was an expedited request, the disposition, and current status. Using the Agency-supplied template, the PDHP must submit this report quarterly, within 45 days of each reporting quarter. Any Grievance reported as “unresolved” at the end of a reporting quarter, must be carried over to the following quarter and reported until the issue is resolved. Table 3. is an example of a worksheet from the Grievance Reporting template.

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Table 3. GRIEVANCE REPORTING TEMPLATE

Grievance Types: 1. Quality of Care 8. Enrollment/Disenrol 2. Access to Care 9. Services after Term 3. Emergency Service 10. Unauthorized out- 4. Not Medically Necess 11. Unauthorized in p 5. Benefit Dispute 12. Experimental/Inve 6. Billing Dispute 13. Other - provide ex 7. Member's Rights Violation				Disposition Types: 1. Referral made to specialist 8. In PDHP Grievance Process 2. PCDP Appointment made 9. Referred to Area Office 3. Bill Paid 10. Lost contact with member 4. Procedure Scheduled 11. Hospitalized/Institutionalized 5. Reassigned PCDP 12. Confirmed original decision 6. Disenrolled Self 13. Other - provide explanation 7. In PDHP QA Review								
1st Quarter Report						Total Resolved Complaints		0				
PDHP Medicaid Provider Number: <input style="width: 100px;" type="text"/>						Total Unresolved Complaints		0				
PDHP Name: <input style="width: 100px;" type="text"/>						Total Complaints		0				
Fiscal Year: <input style="width: 100px;" type="text"/>												
Recipient Information				Grievance Information						R =	Total #	
Medicaid ID#:	Last Name:	First Name:	Mdl Int.	Treating Provider's License #	Date of Grievance	Expedited Request Yes/No	(1-13) Type of Grievance	Date of Disposition	(1-13) Type of Disposition	Resolved U =	Other: Explanation	Days Open
												0
												0
												0
												0
												0
												0
												0
												0

60.2.2 PROVIDER NETWORK REPORT

1. The PDHP must submit a database (dbf or mdb format) of provider network information each quarter. The file must be submitted within 45 days of the end of the reporting quarter and must meet the following specifications:

Field Name	Field Type	Field Length	Description
LAST	Character	25	Last name
FIRST	Character	20	First name
TITLE	Character	2	Courtesy title, such as Dr., Ms., Mr., etc.
SUFFIX	Character	3	Examples include DDS, DMD, etc.
LICENSE	Character	9	The provider's license number, as issued by the Florida Department of Health Medical Quality Assurance
PROVID	Character	9	The provider's Medicaid ID number, if applicable
SPEC	Character	2	Use the following designations: 71 General Dentistry 72 Oral Surgeon 73 Pedodontist 74 Other Dentist 88 Orthodontia
ADDRESS	Character	30	
CITY	Character	25	
ZIP	Character	5	
AREACODE	Character	3	The 3-digit telephone area code
PHONE	Character	8	The telephone number, formatted as xxx-xxxx
EXT	Character	5	The telephone extension, if applicable
GENDER	Character	1	Gender of the dental services provider
RESTRICT	Memo	30	Record patient age restrictions, if any
ACCESS	Logical	1	Y if wheelchair accessible; N if not
AFF	Memo	50	Record all hospital affiliations, by name of hospital

60.2.3 DENTAL HEALTH CHECK-UP REPORTING

1. This annual report provides basic information on participation in the Medicaid PDHP. Two separate templates are used to report the data. The PDHP must submit both templates annually, covering a 12-month time frame beginning October 1 and ending September 30. Each template must be submitted as unaudited data first, due by January 15th following the end of the reporting period. No later than the following October 1, the PDHP must submit to the Agency an audited copy of each completed template along with the auditor's opinion letter. Note: The age groupings that are used for this reporting task are based on the groupings defined at the federal level for reporting of well-child care. These age groups differ from those that are used in other reporting templates, which comport to the groupings used throughout the Agency's internal systems. Further details about each of these reports is provided below.
2. Dental Health Check-Up Report (CMS-416)
 - a. This data is used for annual federal Medicaid Title XIX reporting. It must be limited to Medicaid data only, so no utilization for Title XXI MediKids should be included. The data is supplied using the Agency-supplied template. A new template is provided to the PDHP for each annual report, and comprehensive instructions are always included. Table 5. provides an example of the reporting worksheet from this template

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Table 5. DENTAL HEALTH CHECK-UP REPORT (CMS-416) TEMPLATE:

DENTAL HEALTH CHECK-UP REPORT (CMS-416)									
Seven Digit Medicaid Provider Number :		This report is due on or before January 15.							
PDHP Name :									
Federal Fiscal Year :									
		Age Groups							
		Less than 1 Year	1-2 Years	*3-5 Years	6-9 Years	10-14 Years	15-18 Years	19-20 Years	Total All Years
1.	Total Individuals Eligible for Dental Services (Unduplicated)								
2.	Total Eligibles Receiving ANY Dental Services - Codes D0100-D9999 (Unduplicated)								
3.	Total Eligibles Receiving Preventive Dental Services - Codes D1000-D1999 (Unduplicated)								
4.	Total Eligibles Receiving Dental Treatment Services - Codes D2000-D9999 (Unduplicated)								
5.	Total Months of Eligibility								

Audited report due no later than October 1

*Child Health Check-Up requires physician to refer for an assessment by a dentist at age 3 years

3. Child Dental Check-Up 60% Treatment Ratio Report

- a) The PDHP shall achieve a service utilization rate for **unduplicated** number of children receiving **any** dental services as defined by CDT codes D0100-D9999 of no less than sixty (60) percent for those enrollees who are age 3 through 20 and are continuously enrolled for at least six (6) months. The entire PDHP population, both Medicaid and MediKids eligibles, are considered in completing the Agency-supplied template. A new template is provided to the PDHP for each annual report, and comprehensive instructions are always included. Table 6 provides an example of the reporting worksheet from this template

Table 6. DENTAL CHECK-UP 60% TREATMENT RATIO REPORT TEMPLATE:

Enter Data in Blue Colored Out-Lined Cells Only		CHILD DENTAL CHECK-UP 60% TREATMENT RATIO REPORT							
Seven Digit Medicaid Provider Number :								This report is due no later than January 15.	
PDHP Name :								Audited Report Due October 1	
Federal Fiscal Year :		October 1, 2003 - September 30, 2004							
		Age Groups							
		Less than 1 Year	1-2 Years	*3-5 Years	6-9 Years	10-14 Years	15-18 Years	19-20 Years	Total All Years
1.	Total Individuals Continuously Enrolled for at least 6 months								
2a.	Total Eligibles Receiving ANY Dental Services (Unduplicated)								
2b.	Total Eligibles Receiving Preventative Dental Services (Unduplicated)								
2c.	Total Eligibles Receiving Dental Treatment Services (Unduplicated)								
3.	60% Treatment Ratio								

*Child Health CheckUp requires dental referrals beginning at age 3 unless medically necessary earlier

60.2.3.1 CHILD PREVENTIVE DENTAL SERVICES REPORT

- As a requirement of this Contract, this biannual reporting (covering each six (6) month period of this Contract) provides information on provider participation in the Medicaid prepaid child health dental program and is used to assess the utilization rate of the provision of dental prophylaxis, (CDT code D1120 or D1110), among enrolled children ages three (3) through twenty (20) regardless of length of enrollment in the PDHP. The Agency-supplied template must be used. Table 7 provides an example of this reporting template. The PDHP shall list each treating dentist who provided the qualifying services under this amendment to Medicaid beneficiaries. The PDHP shall file the above information with the Agency no later than thirty (30) calendar days after each six-(6) month period ending date. The first (6) six-month period ending date shall be June 30, 2005.

Table 7. CHILD PREVENTIVE DENTAL SERVICES REPORT TEMPLATE:

CHILD PREVENTIVE DENTAL SERVICES					
		Seven Digit Medicaid Provider #:			
		PDHP Name :			
		Report Period:			
Codes: D1120 and D1110 (Prophylaxis-Child and Adult)			Ages 3 through 20		
Line #	Dental License Number	Dental Provider Name	Total Eligibles		
			# Members	#Services	80%
1					
2					
3					
4					
5					

60.2.3.2 INCENTIVE PAYMENT DISTRIBUTION REPORT

- The PDHP must submit a report to the Agency within forty-five (45) calendar days of receipt of biannual incentive monies reporting the distribution made to Subcontractor Providers. The report must contain identifiable Subcontractor Provider information to include: Subcontractor Provider name, dental license number, address, amount of payment, date of payment, method of payment, payment ID number, and the utilization percentage which qualified the provider for the incentive payment. The PDHP shall provide the information required by this paragraph in the Agency supplied template “Incentive Payment Distribution Report” referenced in Table 8. The PDHP shall list each treating dentist who provided the qualifying services to Medicaid beneficiaries.

Table 8. INCENTIVE PAYMENT DISTRIBUTION TEMPLATE

INCENTIVE PAYMENT DISTRIBUTION REPORT								
Per Section 60.2.3.2 Medicaid PDHP Contract		Seven Digit Medicaid Provider #:		PDHP Name:		Report Period:		
						Ages 3 - 20 Only		
Contract: Prophylaxis - Codes D1120 (child) and D1110 (adult)								
Line #	Provider License Number	Provider Name	Provider Address	Amount of Payment	Date of Payment	Method of Payment	Payment ID Number	Qualify %
1								

60.2.4 MINORITY PARTICIPATION REPORTING

1. The Agency for Health Care Administration encourages the PDHP to use Minority and Certified Minority businesses as subcontractors when procuring commodities or services to meet the requirement of the Contract.
2. The Agency requires information regarding the PDHP’s use of minority owned businesses as subcontractees under this Contract. This information will be used for assessment and evaluation of the Agency’s Minority Business Utilization Plan. During the term of the Contract, it will be necessary to provide this information monthly by the 15th of each subsequent month. A minority owned business is defined as any business enterprise owned and operated by the following ethnic groups:

ETHNIC GROUP	MINORITY CODE	
	CERTIFIED	NON-CERTIFIED
African American	H	N
Hispanic American	I	O
Asian American	J	P
Native American	K	Q
American Woman	M	R

3. The PDHP is required to provide the following information:
 - a) Complete Subcontractor Utilization Report Form for Commodities/Services, (Attachment V); or
 - b) Complete a statement that no minority subcontractees were used during the reporting period.
 - c) Attachment V shall be completed and submitted with each invoice. Failure to provide Attachment V with an invoice shall result in a delay in processing the invoice for payment.

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60.2.4.1 MINORITY PARTICIPATION REPORTING WAIVER

1. The Minority Participation Reporting requirement can be waived by the Agency if the PDHP demonstrates that it is either at least fifty-one percent (51%) minority owned, at least fifty-one percent (51%) of its board of directors are a minority, at least fifty-one percent (51%) of its officers are a minority, or if the PDHP is a not for profit corporation and at least fifty-one percent (51%) of the population it serves belong to a minority. A request for a minority participation reporting waiver must be made to the Agency contract manager in writing with the supporting documentation fulfilling the requirements for a waiver and approved by the Agency.
2. The waiver is valid for the fiscal year and must be renewed at the beginning of each new fiscal year.
3. In the event the minority composition changes during the fiscal year, the PDHP is required to indicate the change to the Agency, and unless an alternative cause for a waiver exists, it will be necessary to submit monthly reports thereafter.

60.2.5 SUSPECTED FRAUD REPORTING

1. Upon suspicion of a fraudulent claim by a provider, the PDHP shall file a report with the Agency. At a minimum, the report shall contain the name of the provider, the provider number or the tax identification number, and a description of the suspected fraudulent act. This report may be sent in narrative fashion to the Agency's plan analyst.

60.2.6 FINANCIAL REPORTING

1. General Information, Definitions, and Instructions
 - a) The PDHP is required to submit to the Agency annual audited financial statements and quarterly unaudited financial performance reports.
 - b) The audited financial statements are due no later than three (3) calendar months after the end of the provider's fiscal year. The Agency will accept audited financial statements that have been prepared in conformity with accounting practices prescribed or permitted by the Department of Financial Services. The accountant preparing the audited financial statements must be an independent certified public accountant. The unaudited quarterly performance reports are due no later than forty-five (45) days after the calendar quarter and shall include a Statement of Revenues and Expenses. This report shall be filed on diskette, or by Internet e-mail to MMCFIN@ahca.myflorida.com using the Agency supplied excel spreadsheet template.

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- c) Financial information submitted shall be specific to the operation of the PDHP rather than to a parent or umbrella organization.

2. The financial template contains the following:

Master Financial Sheet – this is the consolidated revenue and expense statement. This statement reflects four (4) quarters plus the PDHP’s fiscal year totals. Ratios have been created to monitor or detect material weakness in the plan.

- a. Profit and Loss Sheets – contains (3) sheets to track individual performance by commercial, Medicare, and Medicaid product lines.
- b. Certification Page – shows the PDHP name, PDHP address, telephone number, etc.

DEFINITIONS OF REVENUES AND EXPENSES

1. **Premium** - Revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of dental services over a defined period of time, normally three months.
2. **Fee-for-Service** - Revenue recognized by the PDHP for provision of dental services to non-members by plan providers and to members through provision of dental services excluded from their prepaid benefit packages.
3. **Title XIX – Medicaid** - Revenue as a result of an arrangement between a plan and a Medicaid state agency for services to a Medicaid beneficiary.
4. **Interest** - Interest earned from all sources, including the federal loan in escrow and reserve accounts.
5. **Reinsurance Recoveries** - Income from the settlement of stop-loss (reinsurance) claims.
6. **Other Revenue/Aggregate Write-Ins** - Revenue from sources not covered in the previous revenue accounts, such as recovery of bad debts or gain on sales of capital assets, etc.
7. **Total Revenue** - Total of the revenue accounts.

Dental and Medical - Expenses for dental service delivery including the following components:

-
- 8. Dental Services** - Expenses for dentist services provided under contractual arrangement to the plan including the following: salaries, including fringe benefits, paid to dentists for delivery of dental services; capitated payments paid by the PDHP to dentists for delivery of dental services to PDHP subscribers; and fees paid by the PDHP to dentists on a fee-for-service basis for delivery of dental services to PDHP subscribers. This includes capitated referrals.
 - 9. Other Professional Services** - Compensation, including fringe benefits, paid by the PDHP to non-dental providers engaged in the delivery of dental services and to personnel engaged in activities in direct support of the provision of dental services.
 - 10. Outside Referrals** – Expenses for providers not under provider arrangement such as consultations.
 - 11. Emergency Room, Out-of-Area, Other** - Expenses for other non-contracted health delivery services incurred by PDHP Enrollees for which the PDHP is responsible on a fee-for-service basis. These include Emergency Room costs and out-of-area emergency dental and medical costs.
 - 12. Reinsurance Expenses** - Expenses for Reinsurance or “stop-loss” insurance.
 - 13. Drugs and other Medical** - Costs directly associated with the delivery of dental services under PDHP arrangement that are not appropriately assignable to the dental expense categories defined above, e.g., costs of dental supplies, prescription drugs, and malpractice insurance.
 - 14. Total Dental and Medical Expenses** - Total of the above categories.

Administration - Costs associated with the overall management and operation of the PDHP including the following components:

- 15. Compensation** - All expenses for administrative services including compensation and fringe benefits for personnel time devoted to or in direct support of administration. Include expenses for management contracts.
- 16. Interest Expenses** – Interest on loans paid during period.
- 17. Occupancy, Depreciation and Amortization** - Expenses associated with administrative services including the costs of occupancy to the PDHP which are directly associated with PDHP administration. Included in occupancy are costs of using a facility, fire and theft insurance, utilities, maintenance, lease, etc.
- 18. Other/Aggregate Write-Ins** - Costs which are not appropriately assignable to the dental plan administration categories defined above. Included are costs to update enrollee records, servicing of enrollee inquiries and complaints, claims adjudication

and payment, legal, audit, data processing, accounting, insurance, bad debts, all taxes except federal income taxes, etc.

19. Total Administration - Total of the above categories.

20. Total Expenses - Total of dental, Medicaid, and administration Expenses.

21. Operating Income (Loss) - Total revenues minus total expenses.

60.2.7 ENCOUNTER DATA

The Agency is developing a Medicaid Encounter Data System (MEDS) to collect all encounter data from health plans reimbursed on a capitated basis. Encounter data collection will be required from all Florida capitated health plans, including the PDHP, for all health care services rendered to its members.

The information required to support encounter reporting and submission will be defined by the Agency in the MEDS Companion Guide and MEDS Operations Manual. Other information contained within the MEDS Companion Guide and MEDS Operations Manual will be Managed Care Organization testing requirements for SFY 06-07 and thereafter. The Companion Guide and Operations Manual will be distributed to the PDHP in a manner that makes them easily accessible.

Upon the request of the Agency, the PDHP shall be prepared to submit encounter data to the Agency or its designee. The PDHP shall have a comprehensive automated and integrated Encounter Data System that is capable of meeting the requirements listed below:

1. All encounters shall be submitted in the standard HIPAA transaction formats, namely the ANSI X12N 837 Transaction formats (P - Professional, I - Institutional, and D – Dental), and the National Council for Prescription Drug Programs NCPDP format (for Pharmacy services).
2. The PDHP shall collect and submit to the Agency or its designee, enrollee service level encounter data for all covered services. The PDHP will be held responsible for errors or noncompliance resulting from their own actions or the actions of an agent authorized to act on their behalf.
3. The PDHP shall have the capability to convert all information that enters their claims systems via hard copy paper claims to encounter data to be submitted in the appropriate HIPAA compliant formats.
4. Complete and accurate encounters shall be provided to the Agency. The PDHP will implement review procedures to validate encounter data submitted by providers. The historical encounter data submission shall be retained for a period not less than five years following generally accepted retention guidelines.

5. Health Plans will designate sufficient IT and staffing resources to perform these encounter functions as determined by generally accepted best industry practices.

70.0 TERMS AND CONDITIONS

70.1 AGENCY CONTRACT MANAGEMENT

The Bureau of Health Systems Development, Division of Medicaid, shall make all statewide policy decisions, regulatory decisions, and contract interpretations. The Bureau of Managed Health Care within the Agency shall be responsible for monitoring the contract. Contract management of the PDHP shall be conducted in good faith with the best interest of the state and the beneficiaries it serves being the prime consideration. The Agency shall provide final interpretation of general Medicaid policy. When interpretations are required, the PDHP shall submit written requests to the Agency.

70.2 APPLICABLE LAWS AND REGULATIONS

The PDHP agrees to comply with all applicable federal and state laws, rules, and regulations, including but not limited to, Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C; Title 45 CFR, Part 74, General Grants Administration Requirements; Chapters 409, 636 and 641, F.S.; all applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 USC 1857, et seq.); Title VI of the Civil Rights Act of 1964 (42 USC 2000d) in regard to persons served; Title IX of the Education Amendments of 1972 (regarding education programs and activities); 42 CFR 438; 42 CFR 431, Subpart F, Section 409.907, F.S., and Section 59G-8.100 (24)(b), F.A.C. in regard to the contractor safeguarding information about beneficiaries; Title VII of the Civil Rights Act of 1964 (42 USC 2000e) in regard to employees or applicants for employment; Section 59G, F.A.C.; Section 504 of the Rehabilitation Act of 1973, as amended, 29 USC. 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance; Chapter 636, F.S., in regard to managed care; the Age Discrimination Act of 1975, as amended, 42 USC. 6101 et. seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance; the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance; Medicare - Medicaid Fraud and Abuse Act of 1978; the federal omnibus budget reconciliation acts; Americans with Disabilities Act (42 USC 12101, et seq.); the Balanced Budget Act of 1997; and the Health Insurance Portability and Accountability Act of 1996. The PDHP is subject to any changes in federal and state law, rules, or regulations.

70.3 ASSIGNMENT

Except as provided below or with the prior written approval of the Agency that approval shall not be unreasonably withheld, this contract and the monies which may become due are not to be assigned, transferred, pledged, or hypothecated in any way by the PDHP, including by way of an asset or stock purchase of the PDHP, and shall not be subject to execution, attachment, or similar process by the PDHP.

- a. As provided by Section 409.912, F.S., when a merger or acquisition of a PDHP has been approved by the Department of Financial Services pursuant to Section 628.4615, F.S., the Agency shall approve the assignment or transfer of the appropriate Medicaid PDHP contract upon the request of the surviving entity of the merger or acquisition if the PDHP and the surviving entity have been in good standing with the Agency for the most recent 12-month period, unless the Agency determines that the assignment or transfer would be detrimental to the Medicaid beneficiaries or the Medicaid program.
- b. To be in good standing, a PDHP must not have failed accreditation or committed any material violation of the requirements of Section 641.52, F.S., Chapter 409 and 636, F.S., and must meet the Medicaid contract requirements.
- c. For the purposes of this section, a merger or acquisition means a change in controlling interest of a PDHP, including an asset or stock purchase.

70.4 ATTORNEY'S FEES

In the event of a dispute, each party to the contract shall be responsible for its own attorneys' fees except as otherwise provided by law.

70.5 CONFLICT OF INTEREST

The contract is subject to the provisions of Chapter 112, F.S. The PDHP must disclose the name of any officer, director, or agent who is an employee of the State of Florida, or any of its agencies. Further, the PDHP must disclose the name of any state employee who owns, directly or indirectly, an interest of five percent or more in the offerer's firm or any of its branches. The PDHP covenants that it presently has no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of the services hereunder. The PDHP further covenants that in the performance of the contract no person having any such known interest shall be employed. No official or employee of the Agency and no other public official of the State of Florida or the federal government who exercises any functions or responsibilities in the review or approval of the undertaking of carrying out the contract shall, prior to completion of this contract, voluntarily acquire any personal interest, direct or indirect, in this contract or proposed contract

70.6 CONTRACT VARIATION

If any provision of the contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both the Agency and the PDHP shall be relieved of all obligations arising under such provisions. If the remainder of the contract is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed. In addition, if the laws or regulations governing this contract should be amended or judicially interpreted as to render the fulfillment of the contract impossible or economically infeasible, both the Agency and the provider shall be discharged from further obligations created under the terms of the contract. However, such declaration or finding shall not affect any rights or obligations of either party to the extent that such rights or obligations arise from acts performed or events occurring prior to the effective date of such declaration or finding.

70.7 COURT OF JURISDICTION OR VENUE

For purposes of any legal action occurring as a result of or under this contract, between the PDHP and the Agency, the place of proper venue shall be Leon County.

70.8 CROSSOVER CLAIMS FOR MEDICAID/MEDICARE ELIGIBLE MEMBERS

The PDHP shall reimburse non-participating providers for Medicare deductibles and co-insurance payments for Medicare dually eligible members according to the lesser of the following: the rate negotiated with the provider or the reimbursement amount as stipulated in Section 409.908, F.S.

The PDHP agrees to make payment to all subcontractors pursuant to 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45 (d)(3), 42 CFR 447.45 (d)(5) and 42 CFR 447.45 (d)(6). If third party liability exists, payment of claims shall be determined in accordance with Section 70.20, Third Party Resources. The PDHP shall reimburse providers for such services no later than 35 calendar days after submittal of a clean claim, which includes an explanation of Medicare benefits, or, if no explanation of Medicare benefits is provided, the PDHP shall comply with the third party payer requirements in Section 70.20, Third Party Resources.

70.9 DAMAGES FOR FAILURE TO MEET CONTRACT REQUIREMENTS

In addition to any remedies available through this contract, in law or equity, the PDHP shall reimburse the Agency for any federal disallowances or sanctions imposed on the Agency as a result of the provider's failure to abide by the terms of this contract.

70.10 DISPUTES

Any disputes which arise out of or relate to this contract shall be decided by the Agency's Division of Medicaid upon receipt of a complete written request by the PDHP. The

Division of Medicaid shall reduce its decision to writing and serve a copy on the PDHP. Said request must be delivered by U.S. mail to the subject Agency contract manager and the request shall set forth all of the following: a) the Agency's case file number or number which the Agency uses in identifying the matter, b) the name, address, and telephone number of the requesting PDHP and the PDHP's representative for this issue, c) an explanation of how the issue affects the PDHP, d) a statement of all disputed and undisputed facts (with each appropriately delineated), e) a statement of the law and contract provisions which support the PDHP's position, and f) the action which the PDHP is asking the Agency to take. The PDHP may request a review of this decision within twenty-one days of receipt of said decision. Said review request must be in writing, delivered by U.S. mail to the subject Agency contract manager and must set forth all of the following: a) the Agency's case file number or number which the Agency uses in identifying the matter, b) the name, address, and telephone number of the requesting PDHP and the PDHP's representative for this issue, c) an explanation of how the issue affects the PDHP, d) a statement of all disputed and undisputed facts (with each appropriately delineated), e) a statement of the law and contract provisions which support the PDHP's position, f) any relevant documents, and g) the action which the PDHP is asking the Agency to take. The written decision of the Agency's Division of Medicaid shall be final and conclusive. The Division will render its final decision based upon the written submission of the PDHP and the Agency, unless, at the sole discretion of the Division director, the Division allows an oral presentation by the PDHP and the Agency. If such a presentation is allowed, the information presented will be considered in rendering the Division's decision. The PDHP may only appeal the Agency's final decision by requesting arbitration within 30 calendar days of receipt of this final decision. Should the PDHP challenge an Agency decision through arbitration as provided herein, the action shall not be stayed except by order of the arbitrator. Said arbitration shall be held in the city of Tallahassee, Florida, and administered by the American Arbitration Association in accordance with its applicable rules and the Florida Arbitration Code (Chapter 682, F.S.) to the degree that said rules and statute does not conflict with this contract. Judgment upon any award rendered by the arbitrator may be entered by the Circuit Court in and for the Second Judicial Circuit, Leon County, Florida. The chosen arbitrator must be a member of the Florida Bar actively engaged in the practice of law with expertise in the process of deciding disputes and interpreting contracts in the health care field. Any arbitration award shall be in writing and shall specify the factual and legal bases for the award. Either party may appeal a judgment entered pursuant to an arbitration award to the First District Court of Appeal. The PDHP shall initially bear the costs of retaining and hiring the arbitrator. The parties shall bear their own costs and expenses relating to the preparation and presentation of a case in arbitration. The arbitrator shall award to the prevailing party all administrative fees and expenses of the arbitration, including the arbitrator's fee.

70.11 FORCE MAJEURE

The Agency shall not be liable for any excess cost to the PDHP if the Agency's failure to perform the contract arises out of causes beyond the control and without the result of

fault or negligence on the part of the Agency. In all cases, the failure to perform must be beyond the control without the fault or negligence of the Agency. The PDHP shall not be liable for performance of the duties and responsibilities of the contract when its ability to perform is prevented by causes beyond its control. These acts must occur without the fault or negligence of the PDHP. These include destruction to the facilities due to hurricanes, fires, war, riots, and other similar acts. The PDHP shall have an Agency-approved emergency management plan specifying what actions the PDHP shall conduct to ensure the ongoing provisions of health services in a disaster or man-made emergency.

70.12 LEGAL ACTION NOTIFICATION

The PDHP shall give the Agency by certified mail immediate written notification (no later than 30 calendar days after service of process) of any action or suit filed or of any claim made against the PDHP by any subcontractor, vendor, or other party that results in litigation related to this contract for disputes or damages exceeding the amount of \$50,000. In addition, the PDHP shall immediately advise the Agency of the insolvency of a subcontractor or of the filing of a petition in bankruptcy by or against a principal subcontractor.

70.13 LICENSING

All entities that provide Medicaid prepaid dental health care services must be commercially licensed in accordance with the provisions of Chapter 636, F.S., or have a Life and Health Insurance License.

70.14 MISUSE OF SYMBOLS, EMBLEMS, OR NAMES IN REFERENCE TO MEDICAID

No person or PDHP may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet, or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols, or emblems the words "Medicaid," or "Agency for Health Care Administration," except as required in the Agency's core contract, page 2, unless prior written approval is obtained from the Agency. Specific written authorization from the Agency is required to reproduce, reprint, or distribute any Agency form, application, or publication for a fee. State and local governments are exempt from this prohibition. A disclaimer that accompanies the inappropriate use of program or Agency terms does not provide a defense. Each piece of mail or information constitutes a violation.

70.15 RENEWAL

In accordance with Section 287.057(14), Florida Statutes, this Contract may be renewed for a period that may not exceed three (3) years or the term of the original Contract whichever period is longer. Renewal of the contract shall be in writing and subject to the same terms and conditions set forth in the original contract. A renewal Contract may not

include any compensation for costs associated with the renewal. Renewals are contingent upon satisfactory performance evaluations by the Agency, are subject to the availability of funds, and optional to the Agency.

70.16 OFFER OF GRATUITIES

By signing this agreement, the PDHP signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Florida, the General Accounting Office, the Department of Health and Human Services, CMS, or any other federal agency has or shall benefit financially or materially from this contract. The contract may be terminated by the Agency if it is determined that gratuities of any kind were offered to or received by any officials or employees from the offerer, his agent, or employees.

70.17 SANCTIONS

In accordance with 42 CFR 438, and Section 409.912, F.S., the Agency may impose any of the following sanctions against the PDHP if it determines that the PDHP has violated any provision of this contract or the applicable statutes or rules governing Medicaid prepaid dental health plans:

- a. Suspension of the PDHP's enrollments.
- b. Suspension or revocation of payments to the PDHP for Medicaid beneficiaries enrolled during the sanction period. If the PDHP has violated the contract, the Agency may order the PDHP to reimburse the complainant for out-of-pocket medically necessary expenses incurred or order the PDHP to pay non-network PDHP providers who provide medically necessary services.
- c. Imposition of a fine for violation of the contract with the Agency, as described in Section 409.912, F.S.
- d. Termination as described in paragraph III.B.(3) of the Agency core contract and Section 70.19, Termination Procedures. After the Agency notifies the PDHP that it intends to terminate the contract, the Agency may give the PDHP's enrollees written notice of the state's intent to terminate the contract and allow the enrollees to disenroll immediately without cause.
- e. The Agency will conduct an annual audit of outpatient claims. If the audit of emergency department claims reveals an increase (compared to previous state fiscal year or contract period) in Medicaid fee-for-service utilization for dental related services, the Agency may request a corrective action plan. Also, fraud and abuse investigations may be conducted including administrative action and recoupment.

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

70.18 SUBCONTRACTS

The PDHP is responsible for all work performed under this contract, but may, with the written approval of the Agency, enter into subcontracts for the performance of work required under this contract. In all contracts with health care professionals, the PDHP must comply with the requirements specified in 42 CFR 438.214 which includes but is not limited to selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination. All subcontracts and amendments executed by the PDHP must meet the following requirements and must be approved, in writing, by the Agency in advance of implementation. All subcontractors must be eligible for participation in the Medicaid program; however, the subcontractor is not required to participate in the Medicaid program as a provider. The Agency encourages use of minority business enterprise subcontractors. Subcontracts are required with all major providers of services including all primary care sites and management service organizations.

The PDHP shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider that is acting within the scope of the provider's license, or certification under applicable state law, solely on the basis of such license, or certification, in accordance with 42 CFR 438. If the PDHP declines to include individual providers or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

This paragraph shall not be construed to prohibit a PDHP from including providers only to the extent necessary to meet the needs of the PDHP's enrollees, from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or from establishing any measure designed to maintain quality and control costs consistent with the PDHP's responsibilities to the enrollee.

No subcontract that the PDHP enters into with respect to performance under the contract, shall in any way relieve the PDHP of any responsibility for the performance of duties under this contract. The PDHP shall assure that all tasks related to the subcontract are performed in accordance with the terms of this contract.

The PDHP shall identify in its subcontracts any aspect of service and administrative responsibility that may be further subcontracted by the subcontractor.

All model and executed subcontracts and amendments used by the PDHP under this contract must be in writing, signed, and dated by the PDHP and the subcontractor, and meet the following requirements:

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- a. Identification of conditions and method of payment:
1. The PDHP agrees to make payment to all subcontractors pursuant to 42 CFR 447.45, 447.46, and Chapter 636, F.S. If third party liability exists, payment of claims shall be determined in accordance with Section 70.20, Third Party Resources.
 2. Provide for prompt submission of information needed to make payment.
 3. Make full disclosure of the method and amount of compensation or other consideration to be received from the PDHP. The provider shall not charge for any service provided to the member at a rate in excess of the rates established by the PDHP's subcontract with the provider in accordance with Section 1128B(d)(1), Social Security Act (enacted by Section 4704 of the Balanced Budget Act of 1997).
 4. Require an adequate record system be maintained for recording services, charges, dates, and all other commonly accepted information elements for services rendered to beneficiaries under the contract.
 5. Provider incentive plans must comply with 42 CFR 417.479, 422.208, 422.210, and 438.6(h). PDHPs shall make no specific payment, directly or indirectly, under a provider incentive plan to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee. Incentive plans must not contain provisions that provide incentives, monetary or otherwise, for the withholding of medically necessary care.

The PDHP must disclose upon request from either the Agency or Federal agencies information on provider incentive plans and at the times specified in 42 CFR 417.479, 422.208, 422.210, and 438.6(h). All such arrangements must be submitted to the Agency for approval, in writing, prior to use. If any other type of withhold arrangement currently exists, it must be omitted from all subcontracts.
 6. Specify whether the PDHP will assume full responsibility for third party collections in accordance with Section 70.20, Third Party Resources.
 7. The PDHP will include in any contracts, amendments, or addendums with Subcontractor Providers executed after the date of this agreement provisions setting forth the terms of this amendment, eligibility for an incentive payment if preventive service utilization criteria is met, and requiring that distribution of the incentive payment will be made within 30 calendar days of the PDHP's receipt of the incentive payment from the Agency to qualified Subcontractor Providers who have met or exceeded the threshold of 60% utilization rate for the provision of dental prophylaxis, (CDT code D1120 or D1110), among enrolled children ages three through 20 during the six-month reporting period referenced in Section

60.2.3.1 of this contract. Determination of eligibility and structure of incentive shall be in accordance with section 80.6, Incentive Payments For Distribution To Subcontractor Providers.

8. Any Subcontractor Provider that provided services during the reporting period and qualified by meeting or exceeding the 60% threshold for the provision of dental prophylaxis, (CDT code D1120 or D1110), shall be eligible for the incentive payment if the Subcontractor Provider is still a participating provider at the time of distribution. Any incentive payments not distributed in accordance with this paragraph shall be returned to the Agency at the same time that the Incentive Payment Distribution Report is filed with the Agency.
 9. As used in this section and elsewhere in this agreement with regard to incentive payments pursuant to Section 80.6, "Subcontractor Provider(s)" shall mean a sole proprietor or a legal entity which had an enforceable contract with the PDHP to provide primary care dental services during the relevant six (6) month reporting period and to whom the PDHP was contractually bound to tender payment for services during that reporting period. It does not include any individual dentist who is employed by the legal entity. The PDHP shall list on each remittance advice the treating dentists who provided the qualifying services under this amendment to Medicaid beneficiaries. The PDHP shall provide an annual notarized attestation that all Subcontractor Providers are independent of the vendor and independent of any affiliates of this vendor.
- b. Provisions for monitoring and inspections:
1. Provide that the Agency and DHHS may evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed.
 2. Provide for inspections of any records pertinent to the contract by the Agency and DHHS.
 3. Require that records be maintained for a period not less than five years from the close of the contract and retained further if the records are under review or audit until the review or audit is complete. (Prior approval for the disposition of records must be requested and approved by the provider if the subcontract is continuous.)
 4. Provide for monitoring and oversight by the PDHP and the subcontractor to provide assurance that all dental professionals are credentialed in accordance with the PDHP's and the Agency's credentialing requirements as found in Section 20.5.1, Credentialing and Recredentialing Policies and Procedures, if the PDHP has delegated the credentialing to a subcontractor.

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5. Provide for monitoring of subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or state laws and regulations. PDHP must identify deficiencies or areas for improvement and ensure that corrective action is taken.
 6. Provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate
- c. Specification of functions of the subcontractor:
1. Identify the population covered by the subcontract.
 2. Specify the amount, duration, and scope of services to be provided by the subcontractor, including a requirement that the subcontractor continue to provide services through the term of the capitation period for which the Agency has paid the PDHP.
 3. Provide for timely access to dental appointments to comply with the following availability schedule: urgent dental care must be scheduled within one day, sick dental care within two weeks, and routine dental care within one month. Follow-up dental services shall be offered within one month after assessment. Require that the network providers offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries.
 4. Provide for submission of all reports and clinical information required by the PDHP.
 5. Provide for the participation in any internal and external quality improvement, utilization review, peer review, and grievance procedures established by the PDHP.
- d. Protective clauses:
1. Require safeguarding of information about beneficiaries according to 42 CFR Part 438.
 2. Require compliance with HIPAA privacy and security provisions.
 3. Require an exculpatory clause that survives subcontract termination, including breach of subcontract due to insolvency, that assures that beneficiaries or the Agency may not be held liable for any debts of the subcontractor and, in accordance with 42 CFR 447.15, that the beneficiary is not liable to the provider for any services for which the PDHP is liable.

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4. Contain a clause indemnifying, defending, and holding the Agency and the PDHP members harmless from and against all claims, damages, causes of action, costs, or expense, including court costs and reasonable attorney fees to the extent proximately caused by any negligent act or other wrongful conduct arising from the subcontract agreement. This clause must survive the termination of the subcontract, including breach due to insolvency. The Agency may waive this requirement for itself, but not PDHP members, for damages in excess of the statutory cap on damages for public entities if the subcontractor is a public health entity with statutory immunity. All such waivers must be approved in writing by the Agency.
 5. Require that the subcontractor secure and maintain during the life of the subcontractor's worker's compensation insurance for all of its employees connected with the work under this contract unless such employees are covered by the protection afforded by the PDHP. Such insurance shall comply with Florida's Worker's Compensation Law.
 6. Contain no provision that prohibits the physician from providing inpatient services in a hospital to a subscriber if such services are determined by the PDHP to be medically necessary and covered services under the PDHP's contract with the contract holder.
 7. Contain provision for member payment liability protection. The PDHP shall not hold members liable for the following in accordance with Section 1932 (b)(6), Social Security Act (enacted by Section 4704 of the Balanced Budget Act of 1997):
 - a. For debts of the PDHP, in the event of the PDHP's insolvency.
 - b. For payment of covered services provided by the PDHP if the PDHP has not received payment from the Agency for the services, or if the health care provider, under contract or other arrangement with the PDHP, fails to receive payment from the Agency or the PDHP.
 - c. For payments to the health care provider, including referral providers, that furnished covered services under a contract, or other arrangement with the PDHP, that are in excess of the amount that normally would be paid by the member if the service had been received directly from the PDHP.
 8. Contain no provision restricting the provider's ability to communicate information to the provider's patient regarding dental care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient.

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9. Specify that if the subcontractor delegates or subcontracts any functions of the PDHP, that the subcontract or delegation includes all the requirements of this section.
 10. Make provisions for a waiver of those terms of the subcontract that, as they pertain to Medicaid beneficiaries, are in conflict with the specifications of this contract.
 11. Specify procedures and criteria for extension, renegotiation, and termination, and that the provider must give 60 days' advance written notice to the PDHP, and the Department of Financial Services, before canceling the contract with the PDHP for any reason. Non-payment for goods or services rendered by the provider to the PDHP is not a valid reason for avoiding the 60-day advance notice of cancellation. A copy of the notice shall be filed simultaneously with the Agency.
 12. Require that the provider post the following documents, prominently displayed in the reception area of the provider: the Agency's statewide Consumer Call Center's phone number (888-419-3456) including hours of operation and a copy of the summary of Florida Patient's Bill of Rights and Responsibilities, in accordance with Section 381.026, F.S. A complete copy of the Florida Patient's Bill of Rights and Responsibilities shall be available, upon request by a member, at each primary care dentist's offices. The Florida Patient's Bill of Rights is found in Section 110.1, Florida Patient's Bill of Rights and Responsibilities.
 13. Specify that the PDHP will provide 60 days' advance written notice to the provider and the Florida Department of Financial Services (DFS) before canceling, without cause, the contract with the provider, except in a case in which a patient's health is subject to imminent danger or a dentist's ability to practice dentistry is effectively impaired by an action by the Board of Dentistry or other governmental agency, in which case notification shall be provided to the Agency immediately. A copy of the notice submitted to the Florida DFS shall be filed simultaneously with the Agency.

70.19 TERMINATION PROCEDURES

In conjunction with Section III.B., Termination, on page 3 of the Agency's core contract, termination procedures are required. The PDHP agrees to extend the thirty (30) calendar days notice found in Section III.B.1., Termination at Will, on page 3 of the Agency's core contract to ninety (90) calendar days notice. The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery, or by facsimile letter followed by certified mail, return receipt requested. The notice of termination shall specify the nature of the termination, the extent to which performance of work under the contract is terminated, and the date on which such termination shall become effective. In accordance with

1932(e)(4), Social Security Act, the Agency shall provide the PDHP with an opportunity for a hearing prior to termination for cause.

Upon receipt of final notice of termination, on the date and to the extent specified in the notice of termination, the PDHP shall:

- a. Stop work under the contract, but not before the termination date.
- b. Cease enrollment of new beneficiaries under the contract.
- c. Assign to the state those subcontracts as directed by the Agency's contracting officer, including all the rights, title, and interest of the PDHP for performance of those subcontracts.
- d. Take such action as may be necessary, or as the Agency's contracting officer may direct, for the protection of property related to the contract that is in the possession of the PDHP and in which the Agency has been granted or may acquire an interest.
- e. Not accept any payment after the contract ends unless the payment is for the time period covered under the contract. Any payments due under the terms of this contract may be withheld until the Agency receives from the PDHP all written and properly executed documents as required by the written instructions of the Agency.
- f. At least 60 calendar days prior to the termination effective date, provide written notification to all members of the following information: the date on which the PDHP will no longer participate in the state's Medicaid program and instructions on contacting the Agency's local Medicaid office to obtain information on members' enrollment options.

70.20 THIRD PARTY RESOURCES

The PDHP shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to members under this contract. The PDHP has the same rights to recovery of the full value of services as the Agency. (See Section 409.910, F.S.) The following standards govern recovery.

- a. If the PDHP has determined that third party liability exists for part or all of the services provided directly by the PDHP to a member, the PDHP shall make reasonable efforts to recover from third party liable sources the value of services rendered.
- b. If the PDHP has determined that third party liability exists for part or all of the services provided to a member by a subcontractor or referral provider, and the third party is reasonably expected to make payment within 120 calendar days, the PDHP may pay the subcontractor or referral provider only the amount, if any, by which the

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- subcontractor's allowable claim exceeds the amount of the anticipated third party payment; or, the PDHP may assume full responsibility for third party collections for service provided through the subcontractor or referral provider.
- c. The PDHP may not withhold payment for services provided to a member if third party liability or the amount of liability cannot be determined, or if payment shall not be available within a reasonable time, beyond 120 calendar days from the date of receipt.
 - d. When both the Agency and the PDHP have liens against the proceeds of a third party resource, the Agency shall prorate the amount due to Medicaid to satisfy such liens under Section 409.910, F.S., between the Agency and the PDHP. This prorated amount shall satisfy both liens in full.
 - e. The Agency may, at its sole discretion, offer to provide third party recovery services to the PDHP. If the PDHP elects to authorize the Agency to recover on its behalf, the PDHP shall be required to provide the necessary data for recovery in the format prescribed by the Agency. All recoveries, less the Agency's cost to recover, shall be income to the PDHP. The cost to recover shall be expressed as a percentage of recoveries and shall be fixed at the time the PDHP elects to authorize the Agency to recover on its behalf.
 - f. All funds recovered from third parties shall be treated as income for the PDHP.

70.21 WAIVER

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

70.22 WITHDRAWING SERVICES FROM A COUNTY

If the PDHP intends to withdraw services from a county, it shall provide written notice to its members in that county at least 60 calendar days prior to the last day of service. The notice shall contain the same information as required for a notice of termination according to subsection h. of Section 70.19, Termination Procedures. The PDHP shall also provide written notice of the withdrawal to all subcontractors in the county.

70.23 MYFLORIDAMARKETPLACE VENDOR REGISTRATION

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

70.23.1 MYFLORIDAMARKETPLACE TRANSACTION FEE

The State of Florida, through the Department of Management Services, has instituted MyFloridaMarketPlace, a statewide eProcurement system. Pursuant to section 287.057(23), Florida Statutes (2002), all payments for commodities and/or contractual services as defined in Section 287.012, Florida Statutes, shall be assessed a Transaction Fee of one percent (1.0%), which the Vendor shall pay to the State, unless exempt under Rule 60A-1.032, Florida Administrative Code. Notwithstanding the provisions of Rule 60A-1.030, et seq., the assessment of a transaction fee shall be contingent upon Federal approval of the transaction fee assessment program and continued payment of applicable federal matching funds.

For payments within the State accounting system (FLAIR or its successor), the Transaction Fee shall, when possible, be automatically deducted from payments to the Vendor. If automatic deduction is not possible, the Vendor shall pay the Transaction Fee pursuant to Rule 60A-1.031(2), Florida Administrative Code. By submission of these reports and corresponding payments, Vendor certifies their correctness. All such reports and payments shall be subject to audit by the State or its designee.

The Vendor shall receive a credit for any Transaction Fee paid by the Vendor for the purchase of any item(s) if such item(s) are returned to the Vendor through no fault, act, or omission of the Vendor. Notwithstanding the foregoing, a Transaction Fee is non-refundable when an item is rejected or returned, or declined, due to the Vendor's failure to perform or comply with specifications or requirements of the agreement.

Failure to comply with these requirements shall constitute grounds for declaring the Vendor in default and recovering reprocurement costs from the Vendor in addition to all outstanding fees. VENDORS DELINQUENT IN PAYING TRANSACTION FEES MAY BE EXCLUDED FROM CONDUCTING FUTURE BUSINESS WITH THE STATE.

70.23.2 MYFLORIDA MARKETPLACE VENDOR REGISTRATION AND TRANSACTION FEE EXEMPTION

This contract will provide health care services at or below Medicaid rates and are therefore exempt from the Vendor Registration under Rule 60A-1.030(3)(d)i, and the one percent (1.0%) Transaction Fee under Rule 60A-1.032(1)(h) of the Florida Administrative Code.

80.0 METHOD OF PAYMENT**80.1 PAYMENT TO PDHP BY AGENCY**

This is a fixed price unit cost prepaid contract. The Agency or its appointed agent shall make payment to the PDHP on a monthly basis for the PDHP's satisfactory performance of its duties and responsibilities as set forth in this contract. To accommodate payments, the PDHP is enrolled as a PDHP provider with the Medicaid agency. Section 60.2, PDHP Reporting Requirements, details the enrollment report, the monthly payment request processing, and service utilization procedures. Manual adjustments may be made as necessary for state-initiated enrollments or disenrollments.

- a. The Agency shall pay the applicable capitation rate (Section 90.0, Table 2) for each member whose name appears on the ONGOING REPORT for each month, except that the Agency shall not pay for any part of the total enrollment that exceeds the maximum authorized enrollment level(s) expressed in this contract (Section 90.0, Table 1). The payment amount shall depend upon the number of members in each capitation category, at a rate as provided for by this contract, or as adjusted pursuant to the contract when necessary. The PDHP is obligated to provide services pursuant to the terms of this contract for all members for whom the PDHP received capitation payment or for whom the Agency has assured the PDHP that capitation payment is forthcoming.
- b. The capitation rates to be paid are developed using historical rates paid by Medicaid fee-for-service for similar services in the same geographic area, adjusted for inflation, where applicable, and in accordance with 42 CFR 438.6(c). The rates to be paid do not exceed that amount that would have been paid, on an aggregate basis, by Medicaid under fee-for-service for the same services to a demographically similar population of beneficiaries.
- c. The capitation rates to be paid shall be as indicated in Section 90.0, Payment and Maximum Authorized Enrollment Levels, which indicates projected and maximum authorized enrollment levels and capitation rates applicable to each authorized eligibility category, age, and gender.
- d. Unless otherwise specified in this contract, the PDHP shall accept the capitation payment received each month as payment in full by the Agency for all services provided to members covered under this contract and the administrative costs incurred by the PDHP in providing or arranging for such services. Any and all costs incurred by the PDHP in excess of the capitation payment shall be borne in total by the PDHP.

80.2 RATE ADJUSTMENTS

The PDHP and the Agency acknowledge that the capitation rates paid under this contract as specified in Section 90.0, Payment and Maximum Authorized Enrollment Levels, of this contract are subject to approval by the federal government.

- a. Adjustments to funds previously paid and to be paid may be required. Funds previously paid shall be adjusted when capitation rate calculations are determined to have been in error, or when capitation payments have been made for beneficiaries who are determined not to have been eligible for PDHP membership during the period for which the capitation payments were made. In such events, the PDHP agrees to refund any overpayment and the Agency agrees to pay any underpayment.
- b. The Agency agrees to adjust capitation rates to reflect budgetary changes in the Medicaid fee-for-service program. The rate of payment and total dollar amount may be adjusted with a properly executed amendment when Medicaid fee-for-service expenditure changes have been established through the appropriations process and subsequently identified in the Agency's operating budget. Legislatively mandated changes shall take effect on the dates specified in the legislation.

80.3 ERRORS

PDHPs are expected to prepare carefully all reports and monthly payment requests for submission to the Agency. If after preparation and electronic submission, a PDHP error is discovered either by the PDHP or the Agency, the PDHP has 30 business days from its discovery of the error, or 30 business days after receipt of notice by the Agency, to correct the error and re-submit accurate reports and/or invoices. Failure to respond within the 30 business day period may result in a loss of any money due the PDHP for such errors.

80.4 MEMBER PAYMENT LIABILITY PROTECTION

The PDHP shall not hold members liable for the following in accordance with Section 1932 (b)(6), Social Security Act (enacted by Section 4704 of the Balanced Budget Act of 1997):

- a. For debts of the PDHP, in the event of the PDHP's insolvency.
- b. For payment of covered services provided by the PDHP if the PDHP has not received payment from the Agency for the services, or if the health care provider, under contract or other arrangement with the PDHP, fails to receive payment from the Agency or the PDHP.
- c. For payments to the health care provider, including referral providers, that furnished covered services under a contract, or other arrangement with the PDHP, that are in

excess of the amount that normally would be paid by the member if the service had been received directly from the PDHP.

80.5 COPAYMENTS

The PDHP shall not require any copayment or cost sharing for services listed in Section 10.4, Covered Services, and if provided, 10.5, Expanded Services, nor may the PDHP charge members for missed appointments.

80.6 INCENTIVE PAYMENT FOR DISTRIBUTION TO SUBCONTRACTOR PROVIDERS

The PDHP will be eligible to receive an incentive payment for distribution to Subcontractor Providers when the Subcontractor Provider becomes “qualified” by having met or exceeded a 60% participation ratio as reported on the Child Preventive Dental Services Report in accordance with section 60.2.3.1. The Agency will verify Subcontractor Provider participation percentages through reasonable audit procedures. The PDHP shall not have any obligation to make incentive payments to Subcontractor Providers unless and until the PDHP receives the incentive payment from the Agency.

The total amount of all incentive payments payable to the PDHP for any six-month period is subject to the availability of funds, but in no event shall exceed the lesser of \$250,000 or the amount allowed pursuant to 42 CFR 438.6(c)(5)(iii).

The amount of incentive payment due to a qualified Subcontractor Provider for the applicable six-month period shall be calculated as follows:

- The qualified Subcontractor Provider shall receive an incentive payment for each enrolled child identified in the Child Preventive Services Report as having received at least one dental prophylaxis, (CDT code D1120 or D1110) during the six month period.
- The per child incentive will be determined by dividing the total incentive payment authorized by the Agency and payable to the PDHP for each six-month period by the total number of children who received preventive services by all qualified Subcontractor Providers. In no event shall the per-child incentive payment exceed \$7.50 during an incentive period in the first contract year. AHCA shall set caps as needed for other years. For any subsequent contract year, the Agency may change the per-child incentive payment limit referenced above, but may not change the formula set forth above for the per child incentive payment without written consent from PDHP.

Should an incentive payment be made to the PDHP in accordance with the terms of this section, payment shall be made by the PDHP to the Subcontractor Provider within 30 calendar days of the PDHP’s receipt of the incentive payment from the Agency. The

Incentive Payment Distribution Report, as referenced in Section 60.2.3.2, must be completed in full and submitted to the Agency no later than 45 calendar days from the receipt of incentive payment from the Agency. If any disputes regarding payment or reporting arise and consensus cannot be reached between the Agency and the PDHP, the PDHP and the Agency agree to utilize a third party to audit and re-calculate the data. The PDHP shall be responsible for the costs related to any third party audit and data re-calculation.

90.0 PAYMENT AND MAXIMUM AUTHORIZED ENROLLMENT LEVELS

The PDHP is assigned maximum authorized enrollment levels for Miami-Dade County in accordance with the following table. The PDHP shall be paid capitation payments based on the age group, eligibility category, and gender, in accordance with Table 2.

Level 1 is that enrollment level in effect upon written Agency approval of provider networks. The Agency must approve in writing the PDHP's use of a successive enrollment level shown as Level 2. Such approval shall not be unreasonably withheld, and shall be based on the PDHP's satisfactory performance of terms of the contract, approval of the PDHP's provider to enrollee ratio as described in Section 30.6, and administrative and service resources, as specified in this contract, in support of each enrollment level.

The Agency shall amend this contract by September 1, 2007, to reflect changes in capitation rates effective September 1, 2007, and amend this contract by September 1, 2008, to reflect changes in capitation rates effective September 1, 2008, as certified by the Agency's actuary in accordance with 42 CFR 438.6.

Table 1 provides the PDHP's contract enrollment levels. Table 2 provides capitation rates for Miami-Dade County.

**Table 1
Projected PDHP Enrollment**

	Level 1	Level 2
County		
Miami-Dade	250,000	250,000

Table 2
County Wide Age-Banded Capitation Rates for Miami-Dade County.

	Age 3-11 Months	Age 1-5 Yrs	Age 6-13 Yrs	Age 14-20 Yrs, Female	Age 14-20 Yrs, Male
TANF	\$ 0.02	\$ 4.00	\$ 8.52	\$ 9.06	\$ 7.50
SSI	\$ 0.03	\$ 4.34	\$ 7.42	\$ 6.56	\$ 6.56

- a. These capitation rates shall apply to services rendered beginning September 1, 2007.
- b. Notwithstanding the payment amounts that may be computed using the above rate table, the sum of total capitation payments under this contract shall not exceed the total contract amount of \$30,152,115.00.

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100.0 GLOSSARY

The following terms as used in this contract, shall be construed and/or interpreted as follows, unless the contract otherwise expressly requires a different construction and/or interpretation. In the event of a conflict in language between the definitions, attachments, and other sections of the contract, the language in the Contract Core and Attachment I shall govern.

ADM - The Alcohol, Drug Abuse, and Mental Health Program Office of the Florida Department of Children and Families (also referred to as DCF) or DCF's delegate.

Adverse Determination – An adverse determination means a coverage determination by an organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the organization's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated.

Agency – The Florida Agency for Health Care Administration

Agent - A person or entity that has employment or a contract with the PDHP for the provision of items and services that are significant and material to the PDHP's contract with the Agency.

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

Appeal – a request for a “Fair Hearing”, an “Administrative Hearing”, or review of the Agency's action by a court of competent jurisdiction.

Beneficiary or Medicaid Beneficiary - any individual whom the Department of Children and Families (DCF) or DCF's delegate, or the Social Security Administration on behalf of DCF, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods, or services for which the Agency may make payments under the Florida Medicaid or MediKids programs and is enrolled in the Florida Medicaid or MediKids (Title XXI) program. Also see “Member” and “Enrollee”.

Benefits - a schedule of health care services to be delivered to members covered in the PDHP developed under this contract as set forth in Sections 10.4, Covered Services, 10.5, Expanded Services, if provided, and 10.7, Manner of Service Provision, incorporated into and made a part of this contract.

Business Records – are those documents related to the administrative or commercial activities of a provider, as contrasted with medical or professional activities. Business records made available to Medicaid must be dated and legible. Business records include,

as applicable, admission, accident, appointment, assignment, billing, contract, eligibility, financial, insurance, legal, medical release, patient activity, peer review, personnel, procurement, registration, signature authorization, tax, third party correspondence, utilization review documents, all administrative or commercial records that are customarily prepared or acquired and are customarily retained by the provider, and administrative or commercial records that are customarily prepared or acquired and are customarily retained by the provider, and administrative or commercial records that are required by statute or rule to be prepared or acquired and retained by the provider. Records may be on paper, magnetic material, film or other media. Also see “Medical records” and “Medicaid related records.”

Capitation Rate - the monthly fee that is paid by the Agency to a PDHP for each Medicaid beneficiary enrolled under a contract for the provision of Medicaid dental services during the payment period.

Case Management - the manner or practice of planning, directing, and coordinating the health care and utilization of medical, dental, and allied services of beneficiaries.

CDT-4 - the American Dental Association’s *Current Dental Terminology Fourth Edition*. The valid code set for dental procedures.

Certification - the process of determining that a facility, equipment, or an individual meets the requirements of federal or state law, or whether Medicaid payments are appropriate or shall be made in certain situations.

CFR - Code of Federal Regulations.

CHD - County Health Department, previously known as county public health unit (CPHU).

Child Health Check-Up –(CHCUP) The Early and Periodic Screening, Diagnosis and Treatment program administered by the Medicaid program (formerly EPSDT).

Children - Medicaid beneficiaries under the age of 21.

Children/Adolescents - Medicaid beneficiaries under the age of 21.

Clinic - a facility that is organized and operated independent of any institution to furnish preventive, diagnostic, therapeutic, rehabilitative, or palliative Medicaid care, goods, or services to outpatients.

Clinical Peer – a health care professional in the same or similar specialty as typically manages the medical or dental condition, procedure, or treatment under review.

Clinical Review Criteria – the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the organization to determine, for coverage purposes, the necessity and appropriateness of health care services.

CMS - Centers for Medicare and Medicaid Services, the unit of the United States Department of Health and Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and KidCare under Title XXI of the Social Security Act. Formerly known as HCFA.

Complaint - a complaint is any expression of dissatisfaction by a member, including dissatisfaction with the administration, claims practices, or provision of services, that relates to the quality of care provided by a provider pursuant to the PDHP's contract and which is submitted to the PDHP or to a state agency. A complaint is part of the informal steps of a grievance procedure and is not part of the formal steps of a grievance procedure unless it is a grievance as defined in Section 20.11, Grievance System Requirements.

Contracting Officer - the Secretary for the Agency for Health Care Administration or his/her delegate.

Contractor - the organizational entity serving as the primary contractor and with whom this agreement is executed. The term contractor shall include all employees, subcontractors, agents, volunteers, and anyone acting on behalf of, in the interest of, or for a contractor. Also referred to as the PDHP, and as the provider in the Agency's core contract.

Coverage and Limitations Handbook or Provider Manual - a document that provides information to a Medicaid provider regarding Medicaid beneficiary eligibility; claims submission and processing; provider participation; covered care, goods, or services and limitations; procedure codes and fees; and other matters related to Medicaid program participation. May also be referred to as a provider handbook.

Covered Services - see Benefits.

CPT - the Physicians' Current Procedural Terminology, (CPT), which is a systematic listing and coding of procedures and services that is published yearly by the American Medical Association.

DCF - Department of Children and Families or DCF's delegate.

DEA - Drug Enforcement Administration.

Dental or Oral Disease or Condition - a disease or condition of the oral cavity, including but not limited to: dental caries; gingivitis; periodontitis; oral and pharyngeal cancer; salivary and oral mucosal conditions; malocclusion; congenital anomaly; injury or trauma to oral facial structures; and any other dental or oral disease or condition

including manifestation of systemic disease and effect of certain medications and other medical treatments.

Dental Record - those documents corresponding to dental or allied care, goods, or services furnished in any place of service. The records may be on paper, magnetic material, film, or other media. In order to qualify as a basis for reimbursement, the dental records must be dated, signed or otherwise attested to, as appropriate to the media, and legible.

Dental Screening – the dental component of the Child Health Check-Up comprehensive physical examination consisting of an examination to check for obvious abnormalities, such as cavities, inflammation, infection or malocclusion. Dental referrals are required beginning at 3 years of age; earlier as medically indicated (current Medicaid Child Health Check-Up Coverage and Limitations Handbook). Performed by the primary care physician or CHCUP provider.

Dentist – an individual who holds a valid and active license to practice dentistry or dental surgery in full force and effect pursuant to the provisions of Chapter 466, F.S., or the applicable laws of the state in which the service is furnished.

DFS – Department of Financial Services, formerly the Department of Insurance.

DOH - Florida Department of Health.

DHHS - United States Department of Health and Human Services.

Disenrollment – the Agency-approved discontinuance of an enrollee's membership in a contractor's prepaid plan (HMO/PDHP). Also see "Member."

DS - The Developmental Disabilities Program Office of the Florida Department of Children and Families (DCF).

Eligible Beneficiary or Person - see Beneficiary.

Emergency Dental Condition - a dental or oral condition that requires immediate services for relief of symptoms and stabilization of the condition; such conditions include severe pain; hemorrhage; acute infection; traumatic injury to the teeth and surrounding tissue; or unusual swelling of the face or gums.

Emergency Dental Services - those services necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structures (periodontal membrane, gingiva, alveolar bone), jaws, and tissues of the oral cavity.

Emergency Medical Condition – as described in Section 42 CFR 438.114 and 409.901(9), Florida Statutes, an emergency medical condition is: (a) a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson, pursuant to Section 4704 of the 1997 Balanced Budget Act, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) serious jeopardy to the health of a patient, including a pregnant woman or a fetus, (2) serious impairment to bodily functions, (3) serious dysfunction of any bodily organ or part. (b) With respect to a pregnant woman: (1) that there is inadequate time to effect safe transfer to another hospital prior to delivery, (2) that a transfer may pose a threat to the health and safety of the patient or fetus, (3) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes. As further described in 42 CFR 438.114, emergency services means covered inpatient and outpatient services that are as follows: (1) Furnished by a provider that is qualified to furnish these services under this title. (2) Needed to evaluate or stabilize an emergency medical condition.

Emergency Services and Care - medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists, and if it does, the care, treatment, or surgery for a covered service by a physician which is necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

Enrolled Children - Florida Medicaid eligible recipients who are currently enrolled in the PDHP, according to 42 CFR 438.10(a). See also “Member”, “Beneficiary”, and “Enrollee”.

Enrollee - a Florida Medicaid eligible recipient who is currently enrolled in the PDHP, according to 42 CFR 438.10(a). See also “Member”, and “Beneficiary”.

Enrollment - the process by which an eligible beneficiary becomes a member of the PDHP.

EPSDT - the Early and Periodic Screening, Diagnosis and Treatment program administered by the Medicaid program.

Expanded Benefit – a covered service of a PDHP that is either not a Medicaid covered service, or is a Medicaid covered service furnished by a PDHP for which the PDHP receives no capitation payment.

Experimental or Experimental and clinically unproven or Investigational - as related to drugs, devices, medical treatments or procedures as defined in Florida Administrative Code 59G-1.010.

Facility - any premises (a) owned, leased, used or operated directly or indirectly by or for the PDHP or its affiliates for purposes related to this contract; or (b) maintained by a subcontractor to provide services on behalf of the PDHP.

Fair Hearing (DCF)– means the opportunity afforded any Medicaid applicant or recipient, for whom there has been a determination to deny, reduce or terminate benefits or services, except when the determination is due solely to a law or policy requiring an automatic change, to have one or more impartial officials who have not been directly or indirectly involved in the initial determination or the action in question render a final decision based on information submitted for review pursuant to the hearing standards contained in federal regulations.

Fee-for-Service - a method of making payment for health care or allied care, goods, or services based on fees set by the Agency for defined care, goods, or services.

Fiscal Agent - any corporation or other legal entity that has contracted with the Agency to receive, process, and adjudicate claims under the Medicaid program. The current fiscal agent for the Medicaid Program is ACS.

FQHC - Federally Qualified Health Center - A clinic that is receiving a grant from the Public Health Service (PHS) under the PHS Act as defined in Section 1905(1)(2)(B) of the Social Security Act. FQHCs provide primary health care and related diagnostic services. In addition, FQHCs may provide dental, optometric, podiatry, chiropractic, and mental health services. An FQHC employs, contracts, or obtains volunteer services from licensed health care practitioners to provide the above services.

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

FTE - full-time equivalent; means an employee or provider who works a minimum of 40 hours a week in their position in a full year (2,080 hours/year).

Furnished - means supplied, given, prescribed, ordered, provided, or directed to be provided in any manner.

Geographic Area – the county or counties, or an portion of a county or counties, within which the PDHP provides or arranges for dental health care services to be available to its enrollees.

Grievance - a written complaint submitted by or on behalf of a member or a provider to the PDHP or the Agency regarding the: availability, coverage for the delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; claims payment, handling, or reimbursement for health

care services; or matters pertaining to the contractual relationship between a member or provider and the PDHP or Agency.

Grievance Procedure – a written protocol and procedure detailing an organized process by which managed care members or providers may express dissatisfaction with care, goods, services, or benefits received under the program in which they are enrolled and the resolution of these dissatisfactions.

Group or Group Practice – two or more health care practitioners who practice their professions at a common location, whether or not they share common facilities, supporting staff, or equipment, and which organization possesses a federal employer identification (FEI) number.

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

Health Fair - an event conducted in a setting that is open to the public or a segment of the public (such as "school children") at which information about health care services, facilities, research, preventive techniques, or other health care information is disseminated. At least two health-related organizations that are not affiliated under common ownership must actively participate in the health fair.

HIPAA - Health Insurance Portability and Accountability Act.

HMO - Health Maintenance Organization as certified pursuant to Chapter 641, F.S., or in accordance with the Florida Medicaid State Plan definition of an HMO.

Hospital - a facility licensed in accordance with the provisions of Chapter 395, F.S., or the applicable laws of the state in which the service is furnished.

Indirect Ownership Interest – an ownership interest in an entity that has an ownership interest in another entity.

Individuals with Special Health Care Needs - November 6, 2000 Report to Congress - Individuals with special health care needs are adults and children who daily face physical, mental, or environmental challenges that place at risk their health and ability to fully function in society. They include, for example, individuals with mental retardation or related conditions; individuals with serious chronic illnesses such as Human Immunodeficiency Virus (HIV), schizophrenia, or degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis,

individuals with disabilities from many years of chronic illness such as arthritis, emphysema or diabetes; and children and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.

Insolvency - A financial condition when all the assets of the PDHP, if made immediately available, are not sufficient to discharge all of its liabilities or when the PDHP is unable to pay its debts as they become due in the usual course of business.

Licensed – a facility, a piece of equipment, a system, or an individual has formally met and is registered in accordance with all state, county, and local requirements applicable to the particular license, and has authorization from the applicable competent authority to do an act which, without such authorization, would be illegal.

Marketing - any activity conducted by or on behalf of the PDHP where information regarding the services offered by the PDHP is disseminated in order to encourage eligible Medicaid beneficiaries to enroll in the PDHP developed under this contract.

Marketing Materials – materials produced in any medium by or on behalf of the PDHP (PDHP employees, affiliated providers, agents, or contractors) that can reasonably be interpreted as intended to market to potential enrollees.

Market Area - the geographic area in which the PDHP is authorized to market and to conduct pre-enrollment activities.

Medicaid - the medical assistance program authorized by Title XIX of the federal Social Security Act, 42 U.S.C. s.1396 et seq., and regulations there under, as administered in this state by the Agency under Section 409.901 et seq., F.S.

Medicaid-related records – records that relate to the provider’s business or profession and to a Medicaid recipient. Medicaid-related records include records related to non-Medicaid customers, clients, or patients, to the extent that the documentation is shown by the Agency to be necessary to determine a provider’s entitlement to payments under the Medicaid program. See also “Business records” and Medical records.”

Medical Records –means those documents corresponding to medical or allied care, goods, or services furnished in any place of service. The records may be on paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the medical records must be dated, signed or otherwise attested to, as appropriate to the media, and legible and as defined in Section 59G-1.010 (F.A.C.).

Medically Necessary or Medical Necessity - services provided in accordance with 42 CFR Section 438. 210(a)(4) and as defined in Section 59G-1.010(166), F.A.C., to include that medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs.
 3. Be consistent with the generally accepted professional standards as determined by the Medicaid program, and not experimental or investigational.
 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide.
 5. Be furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.
- (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
- (c) The fact that a provider has prescribed, recommended, or approved professional or allied goods or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.

Medicare - the medical assistance program authorized by Title XVIII of the federal Social Security Act, 42 U.S.C. s. 1395 et seq., and regulations there under.

MediKids - a Title XXI health insurance program that provides certain children (ages 0 – 5) who are not Medicaid eligible with Medicaid benefits provided a certain premium is paid and provided the children are enrolled in a Prepaid Dental Health Plan, Medicaid HMO, or MediPass as specified in Section 409.8132, F.S.

MediPass - the primary care case management program administered by the Florida Medicaid Program.

Member - an eligible Medicaid beneficiary who is an enrollee of a PDHP. See also "Enrollee" and "Beneficiary".

Must – for the purpose of this contract, "Must" equals "Shall".

Non-Covered Service - a service that is not a covered service or benefit. (See Covered Services definition and Benefits definition.)

Open Enrollment - the policy wherein Medicaid beneficiaries are enrolled into a managed care option on an annual basis for as long as they retain Medicaid eligibility.

Outpatient - a patient of an organized medical facility or distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

Ownership Interest – the possession of equity in the capital, the stock, or the profits of a business, prepaid health plan contractor or applicant, or other entity. Ownership interest may be direct or indirect. Also see “indirect ownership interest.”

Peer Review - an evaluation of the professional practices of a Medicaid provider by peers of the provider in order to assess the necessity, appropriateness, and quality of care furnished as such care is compared to that customarily furnished by the provider's peers and to recognized health care standards.

PDHP or Prepaid Dental Health Plan - the prepaid ambulatory health plan (PAHP) developed by the Contractor in performance of its duties and responsibilities under this contract; or a contractual arrangement between the Agency and a prepaid ambulatory health plan contractor for the provision of Medicaid care, goods, or services on a prepaid basis to Medicaid beneficiaries for dental services. PDHPs are classified as prepaid ambulatory health plans by 42 CFR 438.

Poststabilization Care Services – as described in 42 CFR 438.114, means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances (described in paragraph (e) of 42 CFR 438.114), to improve or resolve the enrollee's condition.

Potential Enrollee - a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific managed care program, according to 42 CFR 438.10(a).

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

Primary Care Dental Provider/Dentist - a Medicaid PDHP staff or subcontracted dentist practicing as a general or family practitioner, pediatric dentist, or other specialty approved by the Agency, who furnishes primary dental care and dental patient management services to a beneficiary.

Prior Authorization - the act of approving delivery of Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

PDHPs with automated authorization systems may not require paper authorization as a condition of receiving treatment.

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

Provider - a person or entity that has a Medicaid provider agreement in effect with the Agency, or a subcontractual agreement with a subcontractor, and is in good standing with the Agency.

Public Event - an event sponsored for the public or a segment of the public by two or more organizations, one of which may be a health organization.

Public Provider - a county health department or a migrant health center funded under Section 329 of the Public Health Services Act or a community health center funded under Section 330 of the Public Health Services Act.

Quality Improvement - an ongoing process of evaluating the accessibility, quality, appropriateness, and timeliness of the delivery of patient care to achieve positive outcomes, with corrective action when needed.

Receiving Facility - As defined in Part I of Chapter 394, F.S., a facility designated by the Department of Children and Families (DCF) or DCF's delegate that receives patients under emergency conditions or for psychiatric evaluation and provides short-term treatment. The term "receiving facility" does not include a county jail.

Records for Audit – those records, business records, medical/dental records, professional records, documents and files, on whatever media, that the department finds necessary in order to determine the correctness and propriety of cost reports or to determine whether Medicaid payments are or were due and the amounts thereof. Such records must be furnished by providers in accordance with the provisions of ss.1128 (b) and 1902(p) of the federal Social Security Act. Also see "Audit", "Business records," "Medicaid-related records," and "Medical records."

Retrospective Review - means a review, for coverage purposes, of medical necessity conducted after services have been provided to a patient.

Risk - the potential for loss that is assumed by a PDHP and that may arise because the cost of providing care, goods, or services may exceed the capitation or other payment made by the Agency to the PDHP under terms of the contract.

Risk Assessment - the process of collecting information from a person about hereditary, life style, and environmental factors to determine specific diseases or conditions for which the person is at risk.

Routine Dental Care - a well care (non-acute) dental visit for preventive services (e.g. screening, cleaning, check-up, evaluation) or follow up to a previously treated condition and any other routine visit for other than the treatment of a dental illness/condition (e.g. sick care).

Rural Health Clinic (RHC) - a clinic that is located in a rural area that has a health care provider shortage. An RHC provides primary health care and related diagnostic services, and may provide optometric, podiatry, chiropractic, and mental health services. An RHC employs, contracts, or obtains volunteer services from licensed health care practitioners to provide the above services.

Sales Activities - actions performed by an agent, licensed by the Florida Department of Financial Services, of a PDHP for the purpose of enrollment.

Screen or Screening - assessment of a beneficiary's dental/physical condition to determine evidence or indications of problems and need for further evaluation or services.

Service – includes any diagnostic or treatment procedures or other medical or allied care claimed to have been furnished to a recipient and listed in an itemized claims for payment, or in the case of a claim based on costs, any entry in the cost report, books of account, or other documents supporting such claim.

Service Area - the designated geographical area within which the PDHP is authorized by contract to furnish covered services to PDHP members and within which the members reside.

Service Location - any location at which a member obtains any health care service provided by the PDHP under the terms of this contract.

Service Site - the locations designated by the PDHP at which members shall receive primary care physician services.

Shall - indicates a mandatory requirement or a condition to be met.

Sick Care - non-urgent problems, which do not substantially restrict normal activity, but could develop complications if left untreated (e.g., chronic disease).

Specialist – a physician whose practice is limited to a particular branch of medicine or surgery, including one who, by virtue of advanced training, is certified by a specialty board as being qualified to so limit his practice.

State - State of Florida.

Subcontract - an agreement entered into by a PDHP for provision of services on its behalf. Subcontracts include, but are not limited to, the following: agreements with all providers of dental or ancillary services, unless directly employed by the PDHP; management or administrative agreements; third party billing or other indirect administrative/fiscal services, including provision of mailing lists or direct mail services; and any contract that benefits any person with a control interest in the PDHP.

Subcontractor - any person or entity to which a PDHP has contracted or delegated some of its functions, services, or responsibilities for providing dental or allied care, goods, or services, or its claiming or claims preparation or processing functions or responsibilities.

Subscriber - an individual who has contracted, or on whose behalf a contract has been entered into, with the prepaid dental health plan for health care services.

Supervision - directing and being fully legally responsible for the actions of another person. "Direct supervision" means face-to-face supervision during the time the services are being furnished. "Personal supervision" means that the services are furnished while the supervising practitioner is in the building and that the supervising practitioner signs and dates the medical records (chart) within 24 hours of the provision of the service.

Surplus - excess; the extent to which total assets exceed total.

Third Party Resources - an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of dental services related to any dental assistance covered by Medicaid. An example is an individual's auto insurance company, which typically provides payment of some medical and dental expenses related to automobile accidents and injuries.

Title XXI MediKids - a Title XXI health insurance program that provides certain children who are not Medicaid eligible with Medicaid benefits provided a certain premium is paid and provided the children are enrolled in a Medicaid PDHP, HMO, or MediPass as specified in Section 409.8132, F.S.

Transportation - an appropriate means of conveyance furnished to a beneficiary to obtain Medicaid or other authorized services.

Urgent Care - those problems, which, though not life-threatening, could result in serious injury or disability unless attention is received or do substantially restrict a member's activity.

Urgent Grievance - means an adverse determination when the standard time frame of the grievance procedure would seriously jeopardize the dental health of a member or would jeopardize the member's ability to regain maximum function.

Vendor – an individual or entity that engages in the business of selling care, goods, services, or commodities.

Violation - each determination by the Agency that a PDHP failed to act as specified in the contract or in applicable statutes or rules governing Medicaid PDHPs. Each day that an ongoing violation continues may be considered for the purposes of this contract to be a separate violation. In addition, each instance of failing to furnish necessary and/or required dental services or items to beneficiaries is considered for purposes of this contract to be a separate violation.

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110.0 EXHIBITS**110.1 FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES****Section 381.026, F.S.**

(1) **SHORT TITLE.** This section may be cited as the "Florida Patient's Bill of Rights and Responsibilities."

(2) **DEFINITIONS.** As used in this section, the term:

- (a) "Health care facility" means a facility licensed under chapter 395.
- (b) "Health care provider" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, or a podiatrist licensed under chapter 461.
- (c) "Responsible provider" means a health care provider who is primarily responsible for patient care in a health care facility or provider's office.

(3) **PURPOSE.** It is the purpose of this section to promote the interests and well-being of the patients of health care providers and health care facilities and to promote better communication between the patient and the health care provider. It is the intent of the Legislature that health care providers understand their responsibility to give their patients a general understanding of the procedures to be performed on them and to provide information pertaining to their health care so that they may make decisions in an informed manner after considering the information relating to their condition, the available treatment alternatives, and substantial risks and hazards inherent in the treatments. It is the intent of the Legislature that patients have a general understanding of their responsibilities toward health care providers and health care facilities. It is the intent of the Legislature that the provision of such information to a patient eliminate potential misunderstandings between patients and health care providers. It is a public policy of the state that the interests of patients be recognized in a patient's bill of rights and responsibilities and that a health care facility or health care provider may not require a patient to waive his rights as a condition of treatment. This section shall not be used for any purpose in any civil or administrative action and neither expands nor limits any rights or remedies provided under any other law.

(4) **RIGHTS OF PATIENTS.** Each health care facility or provider shall observe the following standards:

- (a) Individual dignity.
 - 1. The individual dignity of a patient must be respected at all times and upon all occasions.
 - 1. Every patient who is provided health care services retains certain rights to privacy, which must be respected without regard to the patient's economic status or source of payment for his care. The patient's rights to privacy must be respected to the extent consistent with providing adequate medical care to the patient and with the efficient administration of the health care facility or provider's office. However, this subparagraph does not preclude necessary and

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- discreet discussion of a patient's case or examination by appropriate medical personnel.
3. A patient has the right to a prompt and reasonable response to a question or request. A health care facility shall respond in a reasonable manner to the request of a patient's health care provider for medical services to the patient. The health care facility shall also respond in a reasonable manner to the patient's request for other services customarily rendered by the health care facility to the extent such services do not require the approval of the patient's health care provider or are not inconsistent with the patient's treatment.
 4. A patient in a health care facility has the right to retain and use personal clothing or possessions as space permits, unless for him to do so would infringe upon the right of another patient or is medically or programmatically contraindicated for documented medical, safety, or programmatic reasons.
- (b) Information.
1. A patient has the right to know the name, function, and qualifications of each health care provider who is providing medical services to the patient. A patient may request such information from his responsible provider or the health care facility in which he is receiving medical services.
 2. A patient in a health care facility has the right to know what patient support services are available in the facility.
 3. A patient has the right to be given by his health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis, unless it is medically inadvisable or impossible to give this information to the patient, in which case the information must be given to the patient's guardian or a person designated as the patient's representative. A patient has the right to refuse this information.
 4. A patient has the right to refuse any treatment based on information required by this paragraph, except as otherwise provided by law. The responsible provider shall document any such refusal.
 5. A patient in a health care facility has the right to know what facility rules and regulations apply to patient conduct.
 6. A patient has the right to express grievances to a health care provider, a health care facility, or the appropriate state licensing agency regarding alleged violations of patients' rights. A patient has the right to know the health care provider's or health care facility's procedures for expressing a grievance.
 7. A patient in a health care facility who does not speak English has the right to be provided an interpreter when receiving medical services if the facility does not have a person readily available who can interpret on behalf of the patient.
- (c) Financial information and disclosure.
1. A patient has the right to be given, upon request, by the responsible provider, his delegate, or a representative of the health care facility full information and necessary counseling on the availability of known financial resources for the patient's health care.

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2. A health care provider or a health care facility shall, upon request, disclose to each patient who is eligible for Medicare, in advance of treatment, whether the health care provider or the health care facility in which the patient is receiving medical services accepts assignment under Medicare reimbursement as payment in full for medical services and treatment rendered in the health care provider's office or health care facility.
 3. A health care provider or a health care facility shall, upon request, furnish a patient, prior to provision of medical services, a reasonable estimate of charges for such services. Such reasonable estimate shall not preclude the health care provider or health care facility from exceeding the estimate or making additional charges based on changes in the patient's condition or treatment needs.
 4. A patient has the right to receive a copy of an itemized bill upon request. A patient has a right to be given an explanation of charges upon request.

(d) Access to health care.

1. A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
2. A patient has the right to treatment for any emergency medical condition that shall deteriorate from failure to provide such treatment.

(e) Experimental research.

In addition to the provisions of Section 766.103, F.S., a patient has the right to know if medical treatment is for purposes of experimental research and to consent prior to participation in such experimental research. For any patient, regardless of ability to pay or source of payment for his care, participation must be a voluntary matter; and a patient has the right to refuse to participate. The patient's consent or refusal must be documented in the patient's care record.

(f) Patient's knowledge of rights and responsibilities.

In receiving health care, patients have the right to know what their rights and responsibilities are.

(5) RESPONSIBILITIES OF PATIENTS. Each patient of a health care provider or health care facility shall respect the health care provider's and health care facility's right to expect behavior on the part of patients that, considering the nature of their illness, is reasonable and responsible. Each patient shall observe the responsibilities described in the following summary.

(6) SUMMARY OF RIGHTS AND RESPONSIBILITIES. Any health care provider who treats a patient in an office or any health care facility that admits and treats a patient shall adopt and make public, in writing, a statement of the rights and responsibilities of patients, including:

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his individual dignity, and with protection of his need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he does not speak English.

A patient has the right to know what rules and regulations apply to his conduct.

A patient has the right to be given by his health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that shall deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him and to the appropriate state licensing agency.

A patient is responsible for providing to his health care provider, to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his health.

A patient is responsible for reporting unexpected changes in his condition to his health care provider.

A patient is responsible for reporting to his health care provider whether he comprehends a contemplated course of action and what is expected of him.

A patient is responsible for following the treatment plan recommended by his health care provider.

A patient is responsible for keeping appointments and, when he is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his actions if he refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

110.3 MEDICAID ORTHODONTIC APPROVAL CRITERIA

The PDHP shall comply with the current Medicaid *Dental Services Coverage and Limitations Handbook*.