ATTACHMENT B - DEFINITIONS

TERM	DEFINITION
AAPD:	The American Academy of Pediatric Dentistry
Addendum	A detailed description of changes made to clarify or modify part of the bid solicitation and attachments
Administrative Hearing:	A hearing that takes place outside the judicial process before hearing examiners who have been granted judicial authority specifically for the purpose of conducting and such hearings There are two types of Administrative Hearings: a. Provider initiated - conducted by administrative law judges from the AR Department of Health and is governed in part by provisions of the AR Medicaid Fairness Act in addition to CMS and AR State Plan policies and regulations. b. Beneficiary initiated – conducted by administrative law judges from the AR Department of Human Services and governed by CMS and AR State Plan policies and regulations. Administrative hearing and fair hearing have the same meaning and may be used interchangeably throughout the RFP.
AID	The Arkansas Insurance Department
Allowable Expenses	All reasonable expenses related to the Contract between DHS and the Contractor that are incurred during the Contract Term and not reimbursable or recovered from another source
American Indian/ Alaskan Native (AI/AN)	a. Any beneficiary defined at 25 U.S.C 1603(13, 1603(28), or 1679(a), or who has been b. Determined eligible as an American Indian/Alaskan Native, under 42 CFR 136.12. This means the individual: i. Is a member of a Federally recognized Indian tribe; ii. Resides in an urban center and meets one or more of the four criteria: c. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the

	future by the State in which they reside, or who is a descendant, in the first or second-degree, of any such member, d. Is an Eskimo or Aleut or other Alaska Native; e. Is considered by the Secretary of the Interior to be an Indian for any purpose; or f. Is determined to be an Indian under regulations issued by the Secretary; i. Is considered by the Secretary of the Interior to be an Indian for any purpose; or ii. Is considered by the Secretary of Health and Information Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.
Appeal:	The process by which the Contractor reviews an Adverse Benefit Determination
Appellant:	An Enrolled Member, his or her representative, or a provider who challenges an Adverse Benefit Determination of the DMO
Arkansas Department of Human Services (DHS):	The Arkansas Department of Human Services (DHS) is the designated single state agency with responsibilities to administer the Medicaid program, including to oversee the DMO model of care delivery
Arkansas Health and Opportunity for ME (ARHOME)	Medicaid expansion program for adults between the ages of 19 and 64 with an income at or below 138% of the Federal Poverty Level (FPL). The program is operated via an 1115 Demonstration waiver with CMS
Auto Assignment	The process by which DHS assigns a newly eligible Potential Members among the active DMOs
Automated Distribution Call Center System (ADC)	A telephone facility that manages incoming calls and handles them based on the number called and an associated database of handling instructions
Beneficiary	Beneficiary: A person identified by DHS as eligible for Arkansas Medicaid, including for the purposes of this solicitation and resulting contract, a person eligible for Dental Benefits through Arkansas Medicaid.
Benefits or Dental Benefits	A schedule of Dental Services to which Potential Members are entitled to and to be administered by the Contractor pursuant to this RFP.

Bidder's Library	A collection of rules, forms and documents which are included with this RFP for reference purposes. These documents are relevant to the Vendor's preparation of a proposal and/or the Contractor's duties under the Contract. They are specifically referenced in this RFP where applicable.
Business Day	Any day other than a Saturday, Sunday, or a State or federal holiday on which DHS's offices are closed, unless the context clearly indicates otherwise
Capitated Payment	The aggregate amount paid monthly by DHS to the Contractor for the provision of Medically Necessary Covered Services to Enrolled Members, including value-added services, in accordance with the Capitated Rates.
Capitated Rate	A fixed predetermined fee paid by DHS to the Contractor each month in accordance with the Contract, for each Enrolled Member in a defined rate cell, in exchange for the DMO arranging for or providing a defined set of Covered Services, including value-added services, to such an Enrolled Member, regardless of the amount of Medically Necessary Covered Services actually used by the Enrolled Member that are within the defined limits as stated in the Agreement.
Centers for Medicare & Medicaid Services (CMS)	The Centers for Medicare & Medicaid Services (CMS) is the federal agency delegated by the Secretary of the US Department of Health and Human Services to administer the Medicaid program under Title XIX of the Social Security Act and thereby has federal oversight responsibilities for the state and the DMOs.
Children's Health Insurance Program (CHIP) or ARKids B	A program established under Title XXI of the Social Security Act to provide health coverage for children whose family incomes are above Medicaid eligibility limits.
Claim	An itemized statement requesting payment for services rendered by Providers and billed electronically, billed through a web-based portal, or on the American Dental Association Dental claim form.
Clean Claim	A Claim submitted by a Provider for Dental Services rendered to a Beneficiary, with documentation required under the Provider Agreement or otherwise reasonably necessary for the Contractor to adjudicate and pay the Claim.
Co-Payment	A fixed amount that an Enrolled Member must pay for a Covered Service after having satisfied any applicable deductible.
Contract Commencement	The date the Contract is approved/released by OSP after both the Arkansas State Legislature and CMS approvals.
Contract Manager	The State representative for this Contract who is primarily responsible for Contract administration functions, including issuing written direction, invoice approval, monitoring this Contract to ensure compliance with the terms and conditions

	of the Contract, and achieving completion of the Contract on budget, on time, and within scope. The Contract Manager shall be a DHS staff member.
Contract Term	The initial Contract period plus any renewal terms.
Covered Entity	a. A health plan b. A health care clearinghouse c. A health care provider who transmits any health information in electronic form in connection with a transaction covered by 45 CFR Part 160 and Part 164.
Covered Services	Dental Services the Contractor must arrange to provide to Enrolled Members, including all medically necessary services required by the Contract and State and federal law, and all Value-Added Services negotiated by DHS and the Contractor approved by DHS.
Dental Providers	Licensed facilities or professionals providing Dental Services.
Dental Services	All emergency, diagnostic, preventive, restorative, or therapeutic services for oral diseases, as listed on Attachment B (ask to reference attachment or remove)
Dentist	A person licensed by the Arkansas State Board of Dental Examiners as a dentist.
Arkansas Department of Human Services (DHS)	The Arkansas State Agency that administers the Medicaid Program.
Division of Medical Services (DMS)	A Division of DHS and the operating division for Arkansas Medicaid. DMS operates and manages the Healthy Smiles Dental Program.
DMO	Dental managed care organization. Also, for purposes of this RFP and resulting Contract, also referred to as “Vendor” and/or “Contractor”.
Emergency Care	Dental services that are medically necessary to treat acute disorder of oral health that requires dental and/or medical attention, including broken, loose, or avulsed teeth caused by traumas, infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.
Encounter	A Beneficiary interaction with a Provider that involves the provision of Medically Necessary Covered Services or Value-Added Services.
Encounter Data	Data elements from Claims or capitated services proxy claims that are submitted to DHS by the Contractor Services or Value-Added Services.
Enrolled Member	A Medicaid beneficiary who is eligible to be enrolled in the Healthy Smiles program and is either subject to Auto Assignment or chooses to enroll in the DMO during the open enrollment period.
EPSDT	The Early and Periodic Screening, Diagnosis, and Treatment program mandated by 42 U.S.C § 1396d(e) and amended by the Omnibus Budget Reconciliation Act (OBRA) of 1989.
FFS: Fee for Service	The portion of the Arkansas Medicaid Dental program operated under the

	authority of the state plan and paid on a fee for service basis by DHS.
FQHC	Federally Qualified Health Center, as defined in 42 § CFR 405.2401(b), as amended.
Go Live Date	The date when the Contractor must begin providing all services required by this bid Contract. The Go-Live Date is anticipated to be May 18, 2024
Grievance	An expression of dissatisfaction, from or on behalf of a Beneficiary or Provider, about any action taken by the Contractor or Provider, other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Beneficiary's right regardless of whether remedial action is requested. The meaning of "Grievance" includes a Beneficiary's right to dispute an extension of time proposed by the Contractor to make an authorization decision.
Grievance and Appeal System	The processes the Contractor implements to handle Appeals and Grievances, as well as the processes to collect and track information about them.
Healthy Smiles	The Arkansas Dental Managed Care Program, as approved by CMS in AR.0008.
Health Insurance Portability and Accountability Act (HIPAA)	A federal statute (passed in 1996 and amended in 2009) requiring standardization of electronic patient health, administrative, and financial data; unique health identifiers for individuals, employers, health plans, and health care providers; and security standards to protect the confidentiality and integrity of individually identifiable health information.
HRSA	The Health Resources and Services Administration
Indian Health Care Provider (IHCP)	A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization otherwise known as an I/T/U as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).
Insure Kids Now	The Insure Kids Now website is a State locator tool that offers profile information for each oral health care provider participating in Medicaid and Children's Health Insurance Program (CHIP).
Managed Care	Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, medical management, and the coordination of care.

FMCU	Medicaid Fraud Control Unit, the division of the Arkansas Attorney General's Office that investigates and prosecutes cases of Medicaid Fraud.
Medicaid	The medical assistance entitlement program authorized and funded pursuant to Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) and administered by DHS in Arkansas.
Medical Loss Ratio (MLR)	A basic financial measurement used to calculate and categorize costs, profits, and losses of a health insurance plan.
Medicaid Management Information System (MMIS)	The provider enrollment, claims, and payment information system for Arkansas Medicaid.
Medical Necessary	A service or benefit is considered "medically necessary" when it satisfies all the following criteria: a. It directly relates to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition; b. It is consistent with currently accepted standards of good medical practice; c. It is the most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and d. It is not primarily for the convenience of the patient, family, or Provider.
Medical Necessity	All Medicaid benefits are based upon Medical Necessity. A service is "medically necessary" if it is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap or cause physical deformity or malfunction and if there is no other equally effective (although more conservative or less costly) course of treatment available or suitable for the beneficiary requesting the service. For this purpose, a "course of treatment" may include mere observation or (where appropriate) no treatment at all. Final adverse determinations must be made by the Dental Consultant. Coverage may be denied if a service is not medically necessary in accordance with the preceding criteria or is generally regarded by the medical profession as experimental, inappropriate, or ineffective, unless objective clinical

	evidence demonstrates circumstances making the service necessary.
MLR Reporting Year	Means a period of 12 months consistent with the rating period selected by DHS. *Unless otherwise determined by DHS, the "MLR Reporting year" shall be January 1st through December 31st.*
Network	All Dental Providers that have a contract with the Contractor (or a Subcontractor) for the delivery of Covered Services to Beneficiaries under the Contract.
Network Provider	Providers who contract with the DMO to provide services to the DMO's Enrolled Members.
Non-Claims Cost	Means those expenses for administrative services that are not: Incurred claims; expenditures on activities that improve health care quality; or licensing and regulatory fees, or Federal and State taxes. See 42 CFR 438.8.
Non-Compliant Beneficiary	A Beneficiary who refuses or fails to seek Dental Services, habitually misses scheduled dental appointments, or has no history of dental Encounters in MMIS.
Notice to Proceed (NTP)	A written notice from the Contract Monitor, after the Readiness Review described in this RFP that, subject to the conditions of the Contract, work under the Contract is to begin as of a specified date. The start date listed in the NTP is the Go-Live Date and is the official start date for the actual delivery of services as described in the Contract. After Contract Commencement, additional NTPs may be issued by either the Procurement Officer or the Department Contract Monitor regarding the start date for any service included within this solicitation with a delayed or non-specified implementation date.
OMIG	Office of Medicaid Inspector General, which performs the Program Integrity functions for Arkansas Medicaid.
Open Enrollment Period:	A time period established by DHS that will last at least forty-five (45) days. Open enrollment will occur on a yearly basis.
PAHP:	Prepaid Ambulatory Health Plan, an entity that provides services to beneficiaries under contract with a state, and on the basis of capitation payments, or other payment arrangements that do not use state plan payment rates. A PAHP does not provide or arrange for and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its beneficiaries; and a PAHP does not have a comprehensive risk contract. Dental Managed Care Organizations (DMOs) are PAHPs.
Pay for Performance:	A payment model that offers financial incentives to the Contractor upon achievement of specified quality benchmarks.

Potential Member:	A person certified by DHS as eligible for dental benefits through Arkansas Medicaid but is not yet enrolled in a DMO, including through ARKids B and including during any retroactive eligibility period, except individuals who are members of the Spend Down Population, who reside in Human Development Centers, or who are enrolled in the PACE program.
Preauthorization:	An approval required from the Contractor before the provision of a particular Covered Service.
Premium Payment:	The aggregate amount paid by DHS to the Contractor on a monthly basis for the provision of Medically Necessary Covered Services to enrolled Beneficiaries (including associated Administrative Services) in accordance with the Premium Rates in the Contract.
Premium Rate:	A fixed predetermined fee paid by DHS to the Contractor each month in accordance with the Contract, for each enrolled Beneficiary in a defined Rate Cell, in exchange for the Contractor arranging for or providing a defined set of Medically Necessary Covered Services to such a Beneficiary, regardless of the amount of Medically Necessary Covered Services actually used by the enrolled Beneficiary that are within the defined limits as stated in the Medically Necessary Covered Services attachment to the Contract.
Premium Revenue	According to 42 CFR 438.8, premium revenue includes the following for the MLR reporting year: a. State capitation payments, developed in accordance with § 438.4, to the DMO for all members under a risk contract approved under § 438.3(a), excluding payments made under § 438.6(d). b. State-developed one-time payments, for specific life events of members. c. Other payments to the DMO approved under § 438.6(b)(3). d. All changes to unearned premium reserves. e. Net payments or receipts related to risk sharing mechanisms developed in accordance with §438.5 or § 438.6.

Primary Care Dentist (PCD)	A primary care dentist is the principal Dental Services provider for a Beneficiary, responsible for coordinating and integrating the Beneficiary's Dental Services.
Primary Dental Services	Preventive Dental Services as performed by a dentist.
Prohibited Relationships	A DMO may not knowingly have a relationship with an individual or entity as described in 42 CFR 438.600 et seq.
Protected Health Information (PHI)	Individually identifiable information, including demographics, which relates to a person's treatment, payment, or healthcare operations, as further defined under HIPAA.
Provider or Network Provider:	An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a contract with the Contractor for the delivery of Medically Necessary Covered Services to the Beneficiaries enrolled with the Contractor.
Provider Agreement:	An agreement between the Contractor and a Provider that describes the conditions under which the Provider agrees to furnish Covered Services to Beneficiaries.
Provider Incentive Plan:	A compensation arrangement with Network Providers that is designed to increase quality of services provided and decrease waste and overuse of services. Examples of Provider Incentive Plans include, but are not limited to, value-based payments, capitation arrangements, bonus payments, or payment withholds.
Provider Preventable Condition:	A healthcare acquired infection or other preventable condition, as defined by the state, that Medicaid is prohibited from paying for under 42 CFR 438.3(g).
Quality Measures:	The metrics on which the Contractor will be evaluated for the purposes of evaluating whether any portion of the shared savings incentive will be paid to Contractor. Shared savings incentive payments are payments made to a Contractor for delivery of economic, efficient and quality care.
Rating Period:	Means a period of 12 months selected by DHS for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR § 438.7(a). Unless otherwise specified by DHS, the rating period shall be January 1—December 31.
Readiness Review:	Submission of documentation at least 120 days before Go-Live, as required by CMS, to DHS by the Contractor to allow the State to assess the ability and capacity of the Contractor to perform in key operational areas prior to enrollment
Risk Corridor:	Means a risk sharing mechanism in which DHS and the DMO may share in profits and losses

	under the Agreement outside of a predetermined threshold amount.
Risk-Sharing Mechanisms:	All applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with 42 CFR § 438.4, the rate development standards in 42 CFR § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period.
Rural	Geographic area represented by a postal zip code where at least 50% of the total area included in the zip code is outside any Metropolitan Service Area (MSA).
Scope of Work	The set of requirements, services, deliverables, and performance standards outlined within the solicitation and any resulting Contract and any agreed modifications thereto.
Service Location	Any location at which a Beneficiary obtains any oral health care service covered by the Contractor pursuant to the terms of this RFP.
Specialty Services	Dental services that are generally considered outside standard Dental Services because of the specialized knowledge required for service delivery and management, including, but not limited to, pediatric dentistry, oral surgery, endodontics, periodontics, and orthodontics.
Start Up Period	The period of time between Contract Commencement and the Go-Live Date. During the Start-Up Period the Contractor shall perform start-up activities such as are necessary to enable the Contractor to begin the successful performance of Contract activities as of the Go-Live Date. No compensation will be paid to the Contractor for any activities it performs during the Start-Up Period.
State	The State of Arkansas.
Subcontract	An agreement entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to DHS under the terms of this RFP (e.g., claims processing, outreach and education, provider relations) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this RFP. Agreements to provide covered services shall be considered Provider Agreements and not subcontracts.
Subcontractor	An individual or entity that has a contract with an DMO that relates directly or indirectly to the performance of the DMO's obligations under its contract with DHS. A network provider is not a

	subcontractor by virtue of the network provider agreement with the DMO.
Subsidiary	An Entity owned or controlled by the DMO or the entities making up the DMO.
Third Party Liability (TPL)	When any individual, entity, or program is or may be responsible for paying all or a part of the expenditures for Covered Services.
Unearned Premium	Means that portion of the premium (capitation payment) paid in the MLR reporting year that is intended to provide coverage during a period which extends beyond the MLR reporting year.
Unpaid Claim Liabilities	Means reserves and liabilities established to account for claims that were incurred during the MLR reporting year but had not been paid within 3 months of the end of the MLR reporting year.
Urban	A Metropolitan Service Area (MSA), as determined by the US Department of Commerce, which has more than 50,000 residents in the population nucleus and adjacent integrated communities.
Urgent Care	Dental Services that do not constitute Emergency Care but that are needed to treat pain.
Value Added Services (VAS)	Actual Dental Services, Benefits, or positive incentives determined by DHS to promote healthy lifestyles and improve dental outcomes among Beneficiaries. “Best practice” approaches to delivering Medically Necessary Covered Services are not considered VAS.