DENTAL BENEFIT MANAGEMENT PROGRAM

305PUR-DHHRFP-DENTAL-PAHP-MVA

QUESTON #	SECTION #	SECTION HEADING	PAGE #	QUESTION	ANSWER
1				It appears that two separate sets of response requirements are provided: (1) Section IV, O. Proposal Content and (2) Attachment VI Submission and Evaluation Requirements. In order to allow respondents to appropriately provide item by item responses, will DHH please clarify which response requirements we should follow?	See Addendum 5 for revised proposal format and requirements for submission.
2				I have a question regarding the proposal format for RFP #305PUR-DHHRFP-DENTAL-PAHP-MVA. The format and outline requirements are noted on page 139 of the RFP document. I'd like to verify if my interpretation of the instructions is accurate. **Instructions outlined in RFP** **M. Proposal Format** 1. An item-by-item response to the Request for Proposals is requested. **DentaQuest's interpretation** DentaQuest will respond to the mandatory and technical approach requirements outlined in ATTACHMENT VI item-by-item. **Instructions outlined in RFP** **N. Requested Proposal Outline:** • Introduction/Administrative Data • Work Plan/Project Execution • Relevant Corporate Experience • Personnel Qualifications • Additional Information • Corporate Financial Condition **DentaQuest's interpretation** DentaQuest will respond to the points detailed in O. Proposal Content (O4-O9) on pages 140-143 in sequential order separate from the item-by-item response to the mandatory and technical approach requirements outlined in ATTACHMENT VI. Is this a question that can be answered in advance of 2/1 or should we submit it with other questions we may have by the 1/22 deadline?	See Addendum 5 for revised proposal format and requirements for submission.
3				Is there a timeline document with key dates for the process?	The Schedule of Events (Addendum 3) provides the timeline for the procurement process. Once the contract is awarded, a detailed timeline will be available with dates for implementation activities.
4				DentaQuest submitted a signed Data Use Agreement (Appendix H) on January 13th, 2014. Can you advise us on when we can expect to receive the DentaQuest submitted a signed Data Use Agreement (Appendix H) on January 13th, 2014. Can you advise us on when we can expect to receive the claims data for the procurement #305PUR-DHHRFP-DENTAL-PAHP-MVA?	The Data was mailed out on Tuesday, February 4, 2014.

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5				It appears that two separate sets of response requirements are provided: (1) Section IV, O. Proposal Content and (2) Attachment VI Submission and Evaluation Requirements. In order to allow respondents to appropriately provide item by item responses, will DHH please clarify which response requirements we should follow?	See Addendum 5 for revised proposal format and requirements for submission.
6				The document states that providers would be limited to 3000 Medicaid linkages, later in Appendix G, it states that providers would be limited to 2500 clients. First, the 3000 limit could be very impactful to dentists that primarily serve Medicaid clients. In fact, these providers are increasingly the ones providing access, as the vast majority of dentists have no interest in seeing Medicaid clients. Please tell me that this language means something else and have misconstrued the information. I am interested because NCDR provides administrative support services for Kool Smiles, PC. Kool Smiles is among the largest providers of Medicaid dental access in Louisiana. If I am correct with my assessment, can you please explain why this limit is necessary and why the two different numbers (3000 and 2500)?	The department's interest is access improvement to assure all members have ready access to our enrolled dental providers without limited appointment availability, which harms continuity of care and results in longer wait times. Please see Addendum 3 for the Revised Appendix G correcting the number of Medicaid linkages.
7	III.B.3.10.e.ii, page 36		36	This section of the RFP, Provider Network Requirements, Access to Specialty Providers addresses the requirements regarding accessibility of specialist to Group A members (children under 21), exceptparagraph e.ii, which references "adults and children". Please clarify which members are to have access to specialty providers.	See Addendum 3 (replaced "adults and children" with "members under the age of 21")
8		Appendix E		Certain service categories (e.g., diagnostic and preventive services) are typically not impacted by utilization management (UM). Therefore, a 13.9% reduction in costs due to UM would require greater than a 13.9% reduction due to UM in other service categories. What was the assumed UM savings by service category? What UM Measures were accounted for in Mercer's UM savings adjustment of 13.9%?	Mercer developed a range of utilization management (UM) savings for the entire program which does not vary by service category. When developing the UM assumptions, Mercer considered activities such as reducing unnecessary radiology services, applying frequency limitations to certain oral exams, promoting preventive care and thus reducing high cost dental treatments.
9		Appendix O		What, if any, changes have occurred in provider fees from 2012 to present? Are there any anticipated changes in the near future?	There were rate reductions effective July 1, 2012 and August 1, 2013 to certain Medicaid-covered dental services. At the implementaion of the Dental Benefit Plan, fees from the Fee Schedule effective prior to July 1, 2012 will be reinstated. All dental fee schedules are available at www.LAMedicaid.com.

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10		Appendix H		What are the differences between LaCHIP and Medicaid Children's coverage (benefits, premium contribution, utilization, etc.)?	There are no differences between LaCHIP and Medicaid covered services, and the regular LaCHIP enrollment is included in the Medicaid Children's category. The LaCHIP Affordable Plan (LAP) is listed as a separate category, and reflects only the anticipated utilization/cost of the LAP enrollment. Note that the Medicaid Children rates are based on the experience of both regular LaCHIP and Medicaid children, therefore the PMPM is a composite of the combined experience. Due to these differences, the resulting anticipated utilization and rates are different between the two categories (LAP and Medicaid Children).
11		Appendix E		Rates given by Mercer in Appendix E are only for 12 months. When and how will the rates for contract years 2 and 3 be determined?	Actuaries need to certify dental rates periodically, and we anticipate that being done annually. For contract years 2 and 3, dental rates may need to be updated to incorporate program and legislative changes (if any), trend, changes identified based upon plan experience or other needs that need to be addressed. After dental experience is available and credible, encounter data or plan financial reports may be considered for future dental rates. The types of issues identified will likely influence the timing of future rates, but DHH typically targets release of capitation rates at least 30-45 days prior to their effective date.
12		Appendix H		Will there be a data dictionary provided with the experience data package?	Yes, a data dictonary will be available for the dental claims and eligibility data.There will not be a data dictionary for the Provider Enrollment or Historical Dental Prior Authorizations Data.
13		Appendix E		Based on a review of the claims and enrollment data provided in the previous RFP (07/2010 through 06/2012 data) the claims costs per member per month (PMPM) were higher for CHIP than for Medicaid, whereas for this RFP the premium rates are roughly $4 PMPM lower for CHIP than for Medicaid. In Appendix E, were the LaCHIP and Child Medicaid PMPMs switched in error? If not, what are the drivers of the significant shift in relative costs between the CHIP and Medicaid plans?	No, they were not switched. The dental rates are categorized as LaCHIP Affordable Plan (LAP), Medicaid Children and Medicaid Adult. The Medicaid Children rate category includes both regular LaCHIP and Medicaid Children. The LAP rate category is for LAP eligible children only, not regular LaCHIP eligible children. The base data used to develop the prior rates was FY11 and FY12. Since dental benefits were added to LAP on February 1, 2012, its experience was not long enough to be credible for rate development for the prior rates; instead, regular LaCHIP experience was used as the proxy to develop the LAP rate, and LAP enrollment was combined into the LaCHIP category. In the new rates in this RFP, the base data was updated to FY12 and FY13 and LAP's own experience was used as the base to develop its rate.

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14	RFP Cite II.C, page 21	Schedule of Events	21	Would the Department consider an extension (e.g., 2-4 weeks) for submission of written proposals?	No extension will be given. Written proposals are due March 7, 2014.
15		Appendix E		E One component of the Affordable Care Act (ACA) is the Health Insurer Tax (aka the “HIT Tax” or the “ACA tax”), which must be paid by all insurance carriers. The rating for this program does not appear to include the ACA tax. How will this tax be accounted for?	At the time of this certification, many aspects of the calculation and application of this fee are not yet determined and/or finalized. These fees will be calculated and become payable sometime during the third quarter of 2014. As these fees are not yet defined by insurer and by market place, no adjustment has been made in the rate range development for the dental benefit program. An adjustment and revised certification will be considered when the fee amount and impacted entities are announced in 2014.
16	Attachment VI, Part II.B			Requirement states "Provide the following information (in Excel format) based on each of the financial statements provided in response to item B:31: (1) Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio." This section ends with B.28. Please clarify reference to B:31.	See Addendum 4 for revised Attachment VI, B.31 was corrected to B.27.
17	Attachment VI, Part II.B			There is no B.14. Please confirm this was intentionally left blank.	Letter B.14 was omitted in error. Attachment VI has been renumbered accordingly, see Addendum 4 for the revised attachment.
18	Attachment VI, Part II.I.6			RFP states, "Provide, in Excel format, the proposer’s results for: 1) HEDIS measures specified below for the last three measurement years (2009, 2010, and 2011) for each of your State Medicaid contracts." Please confirm the three measurement years required.	The correct measurement years are 2010, 2011 and 2012. Attachment VI has been corrected accordingly, see Addendum 4 for the revised attachment.

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19	Attachment VI.B.24		24	The Proposal Submission and Evaluation Requirements B.24 state "You are solely responsible for obtaining the fully completed reference check questionnaires." Please confirm that it is acceptable if the State Agency's policy is to provide a contact and contact number only. Please confirm the reference is valid if the State Agency does not complete the questionnaire due to their policy, but provides contact information for purposes of providing an oral reference.	Oral references will not be accepted. The agency is responsible for fully completing the reference check questionnaire.
20	III. B.3.B.11.j.i Page 61 (5th bullet)		61	This section references a "Dental Benefit Program Companion Guide", which is not included in the RFP as an appendix. Please advise where this guide can be obtained.	See Addendum 5 for revised Section III B.3.B.11.j.i
21	RFP CITATION Section J, Page 117-118 (Term of Contract)		117-118	The RFP states “The term of this contract is for the period 3 years. With all proper approvals and concurrence with the successful contractor, agency may also exercise an option to extend for up to twenty-four (24) additional months…” and separately states, “Total contract term, with extensions, shall not exceed five (5) years.” Please clarify how any Transition period relates to the total contract term. For example, may the contract term extend past five (5) years to include Transition?	Due to statutory limitations, the contract may not extend past five (5) years for any reason.
22	RFP III. 3. B. 10. d) i. page 35 and Appendix G		35	The RFP states, "The DBPM shall require that each individual primary care dentist shall not exceed a total of three thousand (3,000) Medicaid linkages in all DBPM’s in which the primary care dentist may be a network provider." Appendix G - Health Plan Subcontract Requirements (last sentence in last section) states, "The subcontract shall also stipulate that by signing the subcontract the PCD confirms that the PCD's total number of Medicaid members for the DBP Program will not exceed 2,500 lives." Please clarify the maximum number of members per PCD.	The correct ratio of members per PCD is 3000:1. The RFP has been amended to correct the conflicting ratios, see Addendum 3 and revised Appendix G.
23	RFP III.3.B.11.j.i. 5th bullet page 61 and RFP B.3.11.j.xiii, 1st bullet, page 68		61 & 68	Please clarify the written interpretation services requirement. The RFP requirement on page 61 states, "…providing enrollees and potential enrollees written information in the prevalent non-English language in the DBPM’s particular service area." The RFP requirement on page 68 states "…and written information is available in Spanish and Vietnamese." Additionally, please provide a list of the prevalent non-English language spoken by the enrollees in the state.	See Addendum 3 for revised section III B.3.11.j.xiii. Currently, the prevalant non-English languages spoken by the enrollees in the state are Vietnamese and Spanish.

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24	RFP III.5.E.18.A.3 and B.5, page 107		107	Please provide a list of all required manuals and clarify any related requirements.	It is recognized that the DBPM will most likely have a system for issuing policies and manuals that cover the requirements specified in this RFP and therefore, we are not dictating exact specifications on individual manuals that need to be published, but do require that all of the requirements are met and are specific to Louisiana Medicaid either through a Louisiana specific policy/manual or through specific reference in corporate wide manuals as to what is and or is not relevant to Louisiana Medicaid. During the Readiness Review, the DBPM will have to provide a cross refreence to the RFP requirements and where the requirements are met in the documents provided. The following is a list of manuals we would expect to find the required components in general. 1. Systems Design and Management Manual should include information such as, but not limited to, documentation and descriscription of all manual and automated system procedures for its information management processes and information systems. More information on Systems information is located in Section Section III 3.E.6 page 104. 2. Systems User Manual should contain information about, and instruction for, using applicable Systems functions and accessing applicable system data. More information on Systems information is located in Section Section III 3.E.6 page 104. 3. Provider Handbook (Provider Manual) requirements can be found in section III 3.11.h.iv page 56. 4. Provider Training Manual should include information such as, but not limited to, polices and prcedures of the DBM, instructions for billing and obtaining member eligibility. 5. The requirements of the Electronic Data Processing (EDP) Manual can be found in Section III 3.E.18 pages 110 - 111.
25	RFP pages 89, 91, 120, 134 and Appendix G		91121134	There are several references to the Quality Companion Guide including a reference to it as an Appendix, however it is not included as an Appendix. Please advise where this quote can be obtained.	See Addendum 5 relevant to the Quality Companion Guide
26	Section 10.b.iii, page 34		34	This section states "Travel distance shall not exceed sixty (60) miles from the member's place of residence for at least 7five percent of members and shall not exceed ninety (90) miles from the member's place of residence for all members." Please clarify "7five".	See Addendum 3 for revised Section III B. 3.10.b.iii

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27	Attaachment VI, Part II: Technical Proposal & Evaluation Guide, Sections D and F		143	In the table on page 143, Evaluation Criteria and Assigned Weights, Section D. indicates 20 points possible, and Section F indicates 100 points possible. The same totals are indicated in the DBP Proposal Evaluation Poionts Summary, however, the totals do not match when adding the listed points for each criteria, i.e., D. 1 and D 2, in that section the total is 30. the total for Section F is 105. Please confirm total poissible points for Sections D and F.	See Addendum 4 for revised Attachment VI.
28	Appendix Z			Appendix Z indicates the Readiness Review is schedule to occcur 90 days prior to go Live Date. If the DBPM satisfactorily completes all requirements of all Readiness Reviews 90 days in advance of Go Live date, what is DHH's expectation regarding activities to occur during the 90 days post Readiness Review?	The 90 day post review period is provided to make any corrections and or adjustments needed based on findings from the readiness review to assure that the DBPM is ready for full operation on the go live date. Once the DBPM is deemed compliant, there may be little or no actions required during this time.
29	Section II Administrative Information	Section II- Administrative Information	Page 21	Could the state please provide an estimated go-live date so that proposers may have an estimated date to use in project planning.	The Go Live date is May 1, 2014
30	Attachment VI DBP Proposal Submission & Requirements	Part II - Technical Approach Question B. 14		Question B.14 is missing from the table of questions. Please confirm that the state would like to keep the question numbering as is.	See Addendum 4 for revised Attachment VI.
31	Attachment VI DBP Proposal Submission & Requirements	Part II - Technical Approach Question B. 19		If an organization does not participate in A.M. Best's interactive rating process, please confirm that it is acceptable to submit ratings from other comparable rating agencies .	Any performance bond furnished shall be written by: (1) a surety or insurance company currently on the U.S. Department of the Treasury Financial Management Service list of approved bonding companies which is published annually in the Federal Register, or (2) by a Louisiana domiciled insurance company with at least an A-rating in the latest printing of the A.M. Best's Key Rating Guide to write individual bonds up to 10 percent of policyholders' surplus as shown in the A.M. Best's Key Rating Guide, or (3) by an insurance company that is either domiciled in Louisiana or owned by Louisiana residents and is licensed to write surety bonds.

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32	Attachment VI DBP Proposal Submission & Requirements	Part II-Technical Approach Question B. 15		Question B.15 requests proposers to provide various financial ratios based on the financial statements provided in response to Question B.31. Please clarify DHH intended for proposers to reference the financial statements requested in Question B.28 as there is not a Question B.31 listed in Attachment VI.	Please reference Addendum 4 for revisions to Attachment VI.
33	RFP Document	Section III- Scope of Work	61-63	The Louisiana RFP references "Dental Benefit Program Companion Guide" in several places in Section III. Scope of Work, B. Deliverables, 3. Operations Requirements, B.(j) Member Education, beginning on page 61. The RFP states this Guide has "the DHH requirements" for items such as processes for member education and orientation, approval processes for all member materials, and requirements for the Provider Directory. However, we are unable to find the Dental Benefit Program Companion Guide in the RFP or its attachments and it is not referenced in any other section of the RFP. Question: Does DHH have a Dental Benefit Program Companion Guide as cited in Member Education (p 61-63) or are these references that should have been deleted from the RFP?	The reference to the Companion Guide is in error and has been omitted from the RFP. See Addendum 5 relevant to the Quality Companion Guide.
34	RFP Document	Section III- Scope of Work E19 Claims Management	Page 108 of the RFP	In Section E 19, Claims Management, the state says" The DBPM shall have procedures approved by DHH, available to providers in written and web form for the acceptance of claim submissions which include: c) The process for prevention of loss of such claims, and " Could the state please clarify what is meant by "loss" of such claims	Prevention of the loss of claims means that every received claim is accounted for, tracked and archived, and that a response is returned to providers for every claim that the Plan receives.
35	RFP Document	Section III- Scope of Work E19 Claims Management	Page 113 of the RFP	In Section E 19, Claims Management, the state says ""Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the DBPMs applicable reimbursement methodology for that service. " Could the state please provide an example of a "discrete service" that supports the definition to which you are referring.	Services are discrete not just to the procedure level, but to the tooth code, or oral cavity designated as required in the Dental Services Provider Manual. The expectation is that Dental encounters be reported in the same manner providers are requested to bill for Medicaid dental benefits and services, as outlined for electronic claims only in the 837 Dental Companion Guide. If the Plan pays at a claim header level, then all lines associated with that claim must also be shown.
36	RFP Document	Section III- Scope of Work E19 Claims Management	Page 108 of the RFP	Could the State please provide the range of actuarially sound capitation rates by rate cell.	This information will be provided after the contract has been awarded.

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37	Appendix E (Mercer Dental Rate Certification)			Could the State please provide a list of covered procedures for each rate cell.	Rates were based upon historical fee-for-service (FFS) information. Covered procedures were those as services defined in the Louisiana Medicaid State Plan, administrative rules and Medicaid Policy and Procedure manuals. Reference Appendix D in the Request for Proposals (RFP) for details. Although historical procedure codes may not represent the full set of covered procedures, Mercer is providing a list of procedure codes identified in the historical claims used for rate Please see tab Historical Dental Codes.
38	Appendix E (Mercer Dental Rate Certification)			Are any services covered for which FFS experience is not available? If so, how were costs for these services incorporated into the rates?	The rates were developed based upon historical FFS experience, and do not explicitly include any services not covered by the Louisiana Medicaid State Plan, administrative rules and Medicaid Policy and Procedure manuals.
39	Appendix E (Mercer Dental Rate Certification)			Are there other payments/settlements made outside of the claims system that will be the responsibility of the plans? If so, will these be built into the rates? Are any of them fixed dollar pass-through amounts or are they all variable based on utilization?	No dental service payments/settlements outside of the claims system have historically been part of the Louisiana Medicaid dental program, and therefore none are the responsibility of the plans.
40	Appendix E (Mercer Dental Rate Certification)			Are any dental services covered as standard Medicaid claims? For example, are emergency dental services or oral surgery covered under the standard medical plan for Medicaid?	Dental services for purposes of rate development were based upon historical FFS claims submitted as dental claims and on dental claim forms; medical claims were not incorporated into the rates.
41	Appendix E (Mercer Dental Rate Certification)			Are there any annual benefit limits, and if so, what are they?	All benefit limits on covered dental services can be found in Appendix O (Dental Services Manual)

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42	Appendix E (Mercer Dental Rate Certification)			Please provide any historical fee schedules that were in force during the experience period.	All Fee Schedule can be found at www.LaMedicaid.com under the fee schedules link.
43	Appendix E (Mercer Dental Rate Certification)			Please itemize a) historical program changes that occurred during the experience period and b) projected program changes that will have occurred between the end of the experience period and the projection period.	The program change is the fee schedule change from the base period to projection period. For EPSDT, the historical program changes include fee schedule change effective July 2012 and fee schedule change effective January 2013. For the Adult Denture Program, the historical program change is the fee schedule change effective July 1, 2012. No projected program change was anticipated. The fee schedules can be found at http://www.lamedicaid.com/provweb1/Fee_Schedules/DentalFeeSChedulesIndex.htm.
44	Appendix E (Mercer Dental Rate Certification)			Please list all adjustments that have been applied to the detailed data to be provided to responders. For example, has the data been completed, trended, adjusted for program changes, or any other adjustments made?	Reference pages 2-5 of the Mercer Dental Rate Certification for a description of the adjustments applied to the data.
45	Appendix E (Mercer Dental Rate Certification)			Please itemize each eligible population included in each rate cell.	The tab 'COA Crosswalk' is included in this file, and details each type case and eligibility category for Medicaid (Medicaid children, Medicaid adults and regular CHIP), LaCHIP Affordable Plan (LAP) and excluded groups. Medicaid Children (both Medicaid and CHIP) and Medicaid Adults are identified by their age(tab 'RC crosswalk').
46	Appendix E (Mercer Dental Rate Certification)			Retroactive eligibility is covered under the DBP. How will managed care plans be compensated for eligibility periods during which they are unable to effectively manage care?	All the claims and eligible member months associated with retroactive eligible members were included in the base data for rate development.
47	Appendix E (Mercer Dental Rate Certification)			Will retroactive claims and membership be identifiable in the data? If so, how are they identified?	Retroactive claims and membership can be identified using field final_retro ="Y".

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48	Appendix E (Mercer Dental Rate Certification)			Please provide lag triangles so we may estimate the impact of IBNR claims.	The claims data provided contains the incurred and paid date information. Dental lag triangles can be developed using the claims data and eligibility data. Please see tab Claims Triangle by RC.
49	Appendix E (Mercer Dental Rate Certification)			Please provide more information on the calculation of the Fraud and Abuse adjustment of -1.67%.	The adjustment is based on a detailed analysis at the recipient and claim level. For certain dental procedures, we looked at the frequency limit in the state plan and compared it to the actual utilization. We then estimated a range of potential Fraud and Abuse adjustment factors.
50	Appendix E (Mercer Dental Rate Certification)			Were trend adjustments developed by dental class or other subcategory, and did they vary by rate cell? Please provide detailed information on the development of the trend rates, including a split between utilization, unit cost and mix trend.	The trend assumption was developed for all populations and does not vary by rate cell. The PMPM trend in the dental rate certification (page 3) is utilization trend. Overall unit cost trend was 0% because the unit cost change was reflected in the fee schedule. No mix change trend was assumed.
51	Appendix E (Mercer Dental Rate Certification)			How were the managed care savings assumptions developed?	Managed care savings assumptions were developed based on savings opportunities discussed with the State (such as promoting preventive care and thus reducing high cost dental procedures).
52	Appendix E (Mercer Dental Rate Certification)			Since one goal outlined in the RFP is enhancing access to enrollees, this will lead to increased utilization. How was this accounted for in the rates development?	Improved geographic access to specialty providers is a goal of the program, but is not assumed to result in increased utilization for these particular services. Historical access to such services was considered reasonable based on current program participation for rate determination.
53	Appendix E (Mercer Dental Rate Certification)			Because these rates are developed by Mercer, is an actuarial certification required with the response?	The actuarial certification letter is provided in Appendix E.

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54	Appendix E (Mercer Dental Rate Certification)			Will there be an opportunity to submit questions about the detailed data files?	DHH has allowed an additional time for questions. Questions received after 2/07/2014 will be responded to in writing on: 02/18/2014
55	Appendix H (Data Use Agreement)			Capitation rates for 5/1/14-3/31/15 are based on the Medicaid Fee Schedule as of July 1, 2013. Are there any anticipated Medicaid Fee Schedule changes between July 1, 2013 and the start of the contract?	No Medicaid fee schedule changes between July 1, 2013 and the start of the contract were anticipated. Dental fee schedule change effective 8/1/2013 was excluded from rate development as that fee cut is restored upon implementation of the prepaid dental program.
56	Appendix E (Mercer Dental Rate Certification)			If there are any Medicaid Fee Schedule changes, how will the rates be adjusted?	Currently, rates reflect July 2013 fee schedule. The August 1, 2013 fee cut was not reflected into the rates as the fee cut will be restored upon the implementation of the Prepaid dental program based on DHH's guidance. If DHH wants to reflect the future fee cuts into the rates, the actuarilly sound rates need to be adjusted.
57	Appendix E (Mercer Dental Rate Certification)			Please define the Rate Floor	The rate floor is defined as the minimum amount of reimbursement that can be reimbursed to providers. Currently the most current dental fee schedule is considered the rate floor
58	Appendix E (Mercer Dental Rate Certification)			Please provide a summary of member months and incurred claims for retroactive membership. Please split by SFY 2012 and SFY 2013, as well as by Rate Cell	As mentioned above, the members months and claims for retroactive members can be identified using field final_retro="Y" in the eligibility and claims data. The summary by retroactive members will not be provided.
59	Appendix E (Mercer Dental Rate Certification)			Since LaCHIP started on 2/1/12, there is only 5 months of experience in SFY 2012. Did Mercer review experience from 2/1/13 through 6/30/13 compared to the total SFY 2013 to determine if a seasonality adjustment was necessary for the incomplete SFY 2012?	For clarification, the LaCHIP Affordable Plan started on 2/1/12. Mercer reviewed the 5 months experience and compared it with SFY2013 experience on a PMPM base. The experience did not vary significantly between the two time periods. No seasonality adjustment was applied. Note that the SFY 2012 data was assigned only 20% credibility.

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60	Appendix E (Mercer Dental Rate Certification)			What is the total administrative load? The Memo says 13.0%, but the individual pieces sum to 13.25%. Please clarify.	The overall administrative load is calculated as 1-(1-9%-2%)*(1-2.25%)=13%.
61	Appendix E (Mercer Dental Rate Certification)			Will Mercer be releasing any data summaries to support their development of the capitation rate? We would like to better understand their process and how the base periods are adjusted to determine the final capitation rates	The actuarial certification letter is provided in Appendix E.
62	Appendix E (Mercer Dental Rate Certification)			The provisions of this RFP do not prohibit the DBPM from limiting provider participation to the extent necessary to meet the needs of the DBPM's members. This provision also does not interfere with measures established by the DBPM to control costs and quality consistent with its responsibilities under this contract nor does it preclude the DBPM from using reimbursement amounts that are less or greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR §438.12(b)(1)].	Please see Addendum 5 for revised language within this section of the RFP
63	Appendix E (Mercer Dental Rate Certification)			In the termination/turnover section on page 92, there is a reference to 22.3.1. There is no section within the RFP of 22.3.1. What is this referring to?	Please see Addendum 5 for revisions.
64	Appendix E (Mercer Dental Rate Certification)			What are the current PPS rates for each FQHC and RHC? How are the current rates account for in the proposed capitation rates?	PPS rates are updated annually in July, therefore the PPS rates will change during contract year one.
65	Appendix E (Mercer Dental Rate Certification)			Will any of the PPS rates change before or during year one of the contract?	PPS rates are updated annually in July.

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QUESTON #	SECTION #	SECTION HEADING	PAGE #	QUESTION	ANSWER
66	Appendix E (Mercer Dental Rate Certification)			How are out of network providers reimbursed?	Please see Section III B.3.B.11.g.iii for information on Reimbursement to out of network providers
67	Appendix E (Mercer Dental Rate Certification)			Will the capitation rates be adjusted annually?	Actuaries need to certify dental rates periodically, and we anticipate that being done annually. For contract years 2 and 3, dental rates may need to be updated to incorporate program and legislative changes (if any), trend, changes identified based upon plan experience or other needs that need to be addressed. After dental experience is available and credible, encounter data or plan financial reports may be considered for future dental rates. The types of issues identified will likely influence the timing of future rates, but DHH typically targets release of capitation rates at least 30-45 days prior to their effective date.
68	Glossary	Glossary	PDF page 5	Clean Claim definition says "It includes a claim with errors originating in a state's claim system." Can the State please clarify this definition? Can an example be provided of this?	A clean claim can come into the state's system, and still deny for some reason. A clean claim means that basic information is contained which allows it to be issued an internal control number, however, during the adjudication process, any number of data elements in the claim can cause the claim to deny. A clean claim can come into the state's system, and still deny for some reason. A clean claim means that basic information is contained which allows it to be issued an internal control number, however, during the adjudication process, any number of data elements in the claim can cause the claim to deny.
69	Copayment and TPL	Copayment and TPL	PDF page 226	Section states "recoveries associated with TPL and subrogation have been removed from claims by selecting only state paid amounts." Could the TPL and subrogation amount also be disclosed as it will affect what proposers can expect to see overall on the claims billed amount side.	After the contract is awarded, these amounts can be made available.
70	Section III B	Section III B	PDF page 30	This section describes how we are to provide TPL information to DHH but can DHH also share TPL information they have captured already? Can this be added to the contract?	Yes,the FI currently provides TPL updates weekly to all existing contracted Health Plans, and the DBPM would be included.

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71	Section III B	Section III B	PDF page 30	Can DHH please provide other coverage information the state has on file be shared with the DBPM?	Coverage information can be provided to the contractor on a regularly scheduled bases.
72	Section III B	Section III B	PDF page 32	Please clarify which providers can be paid below the Medicaid Fee Schedule. Page 32 of the RFP states the following: The provisions of this RFP do not prohibit the DBPM from limiting provider participation to the extent necessary to meet the needs of the DBPM's members. This provision also does not interfere with measures established by the DBPM to control costs and quality consistent with its responsibilities under this contract nor does it preclude the DBPM from using reimbursement amounts that are less or greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR §438.12(b)(1)].	"The words ""less or"" will be deleted from this statement. The language will be revised as follows: ""The provisions of this RFP do not prohibit the DBPM from limiting provider participation to the extent necessary to meet the needs of the DBPM's members. This provision also does not interfere with measures established by the DBPM to control costs and quality consistent with its responsibilities under this contract nor does it preclude the DBPM from using reimbursement amounts that are greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR §438.12(b)(1)]."
73	Section III G	Section III G Insurance Requirements	RFP Page 113	Can the state please clarify the definition of "Special Hazards"	Special hazards as determined by the Department shall be covered by rider or riders in the Commercial General Liability Insurance Policy or policies herein elsewhere required to be furnished by the Contractor, or by separate policies of insurance in the amounts as defined in any Special Conditions of the contract included therewith.
74	Attachment VI DBP Proposal Submission & Requirements	Part II-Technical Approach Question G. 13		G.3 Asks that Proposers "Describe any differences between your UM phone line and your member services line with respect to bullets (2) through (7) in item K.1." Can the State please clarify if they mean "provider services line" where member services line is used.	Member services line will to be changed to Provider services line, please see Addendum 4 for revisions
75		Section III Processing Requirements	RFP Page 50	Regarding Claims processing requirements DHH states " "At a minimum, the DBPM shall run one (1) provider payment cycle per week, on the same day each week, as determined by the DBPM. The DBPM and its subcontractors may, but mutual agreement, establish an alternative payment schedule". Please confirm DHH means "by mutual agreement".	The word 'but' should be replaced with the word 'by.' Please see Addendum 5 for Revised Processing Requirements section.

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76		Section F Section F. 3 significant Traditional Providers (STPs)		Question: In F. 3, there is a reference to G.1. However, it appears the correct reference should have been to Section F.1 as that is the section for provider listings and G.1 relates to utilization management processes. Can DHH confirm which section is the correct one to reference?	The correct section to reference is F.1. Please see Addendum 4 for revisions.
77		Hudson Initiative		we can have clarification as to the specific weights or priority levels attributable to the criteria assigned to the Hudson and Veteran's Initiative evaluation.	Ten percent (10%) of the total evaluation points on this RFP are reserved for proposers who are themselves a certified Veteran or Hudson Initiative small entrepreneurship or who will engage the participation of one or more certified Veteran or Hudson Initiatives small entrepreneurships as subcontractors. Attachment I provides an explanation of the reserved points and how they will be added to the applicable proposers' evaluation score.
78		Section F. 7, second bullet		Section F.7, second bullet states: "Compliance with medical record documentation standards" - Question: Was DHH's intent actually for bidders to describe compliance with dental records versus medical records, given this is a dental benefits management program?	The words "medical records" are in error and have been correct to "dental records". See Addendum 4 for revisions.
79		Section Q Question 2 - regarding enrollment broker		The Department has stated that "The contracted enrollment broker for the CCN Program will be selected through a competitive procurement process." Who/what entity are you referring to as the "Enrollment Broker?"	See Addendum 5 for revised Appendix Q
80		Appendix V		While Appendix V is available in the procurement library, could the state please confirm that the sample spreadsheet referenced in RFP question F.1 is also available?"	The sample spreadsheet is Appendix V.
81				Do members have the opportunity to select a PCD during the enrollment process? If yes, will that information be available to the plan through the enrollment file?	The PCD selection will be through the DBPM

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82				Can the state provide number of members by parish?	This information will be provided in an addendum.
83				In section F.5, can the state please clarify, and/or provide the states standards of "Wait times".	Urgent Care must be provided within 24 hours. Routine or preventative dental services must be available within 6 weeks. Please refer to page 35, subsection ciii and civ.
84				Who is responsible for non-emergency transportation for dental visits.	DHH is responsible for non-emergency medical transportation for dental services.
85		A2 and B.26	RFP Page 21 and 172	Section III A2 states the DBPM must "have a license or certificate of authority issued by the Louisiana Department of Insurance (DOI) to operate as a Medicaid risk bearing “prepaid entity” pursuant to LSA-R.S. Title 22:1016 and submit with the proposal response". Attachment VI, question B.26 states "[p]rovide evidence that the Proposer has applied to Louisiana Department of Insurance for a certificate of authority (COA) to establish and operate a prepaid entity as defined in RS 22:1016 and in accordance with rules and regulations as defined by the Department of Health and Hospitals". Please confirm if it is correct that the Proposer needs to provide evidence that it has a pending application with the Louisiana Department of Insurance at time of proposal submission and a license prior to program go-live.	Yes the proposer needs to provide that it has a pending application with the Louisiana Department of Insurance at the time of proposal submission and a license prior to program go-live.
86	III.B.z.D.3.9. f (TL), page 31			Coorination of Benefits: Does the Department contract with a Third Party such as HMS or Emedeon to preform data matching with matching insurers to discover TPL for Medicaid members? If so, how may this informaiton be passed from the FI to the DBPM?	Yes the Department does curently contract with third party to perform data matching with matching insurers to discover TPL for Mediciad members. This information would be passed to the DBPM by a special request to our FI and TPL vendor.

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87	III.2.C, page 23			RFP states, "2. When making PDP assignments, the DBPM shall take into cnsideraton the enrollee's last PDP (if the PDP is known and available in the DBPM's network), closest PDP to the enrollee's ZIP code locaiton, Keeping children/adolescents within the same family together, and age. 4. The DPBM shall assign all enrollee who are reinstated after a temporary loss of eligibility to the PDP who was treating them prior to loss of eligibility, unless the enrollee specifically requests another PDP, the PDP no longer participates in tyhe DBPM or is at capacity, or the enrolee has hcnaged georgraphic areas." **Will the DBPM be receiving claims history or some other information that ID's who the last PDP was for that member/family?**	Once the contract is awarded, claims history will be provided displaying identifying provider information to allow the contractor to see which provider received reimbursement for services.
88	III.B.3.B.11.i.ii, page 58			o Members, for whom the DBPM is the primary payor, who do not proactively choose a primary care dentist DBPM will be auto-assigned to a primary care dentist by the DBPM. Members, for whom the DBPM is the secondary payor, will not be assigned to a primary care dentist by the DBPM, unless the members request that the DBPM do so." **If the DBPM is secondary payer due to a COB or TPL scenario, why would that preclude the member from being assigned to a primary care dentist? Please clarify what tis meant by secondary payor.**	Medicaid, by law, is intended to be the payer of last resort. Therefore, other available third party resources including private insurance must be used before Medicaid pays for the care of a Medicaid recipient. An assigned primary care dentist may not accept the member's primary insurance causing payment issues, as the DBPM will be the secondary payor.
89	IV.O.7.c, Page 142			Please clarify "the number of personnel" to be included in the Job Description. Does this refer to the number of personnel in this job description or the number of personnel who report to the individual in this job description?	The word “supervised” was omitted from Section O.7.c. (page 142 of the RFP) It should read: “Job descriptions, including the percentage of time allocated to the project and the number of personnel supervised should be included and should indicate minimum education, training, experience, special skills and other qualifications for each staff position as well as specific job duties identified in the proposal. Job descriptions should indicate if the position will be filled by a sub-contractor.
90				what is the Department's [referred method of delivery in the event the weather impacts DHH office hours or facilities being open?	Email notification to point of contact that will be provided during contract negotiations.

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91				1. Please clarify the definition of "Significant Traditional Provider" listed on page 16. For instance, does the "top 80%" mean 80% of the total number of services performed? Or 80% of the total dollar value of all services performed? Also, paragraph g) on page 37 under "10. Provider Network Requirements" only requires that "the DBPM *should* [emphasis added] make a good faith effort to include in its network primary care dentists and specialists who are significant traditional providers (STPs)…" Why is this "should" not "shall?" A "good faith effort" still does not mandate that every STP be included in the network under any circumstances. And using the term "should" here suggests the DBPM really does not have to make much of an effort at all to include STPs in the network. Conversely, the requirement on page 36 in Paragraph 10.f)i that the DBPM "*must* [emphasis added] offer to contract with all FQHCs and RHCs" seems to inappropriately favor one type of provider over another. Yet, there is no evidence that doing so will result in improved quality of care nor efficiency. (Note similar language is contained in Paragraph 11.g)iii on page 50.) Moreover, the language in that paragraph on page 36 seems to suggest that the DBPM must not only offer to contract with FQHCs and RHCs, but "must" include them in its network. At minimum, the words "if contracted" should probably be inserted between "and" and "include" in that paragraph. We strongly feel that obligation for the DBPM to make an effort to contract should be the same for FQHCs and STPs.	The list of STPs provided is based on total number of services performed. The requirement for that the selected DBPM, "should make a good faith effort. . ." is interpreted by DHH to mean that if the provider meets all allowable DBPM specific standard contracts requirements a contract should be offered to the provider, subject to meeting network adequacy requirements. "Allowable" means in compliance with federal and state rules and regulations, the terms of this RFP and the contract between the DBPM and DHH. Contract requirements may included but are not limited to meeting all credentialing requirements as applicable. Furthermore, evidence of a "good faith efforts" requires the DBPM to secure and maintain written documentation of efforts to contract with STPs. The language for the FQHC and RHCs is similar in intent, but also reflects federal requirements that Medicaid recipient MUST have the choices of at least one FQHC if available.
92				2. Page 28, Paragraph 6.a) states that DHH reserves the right to renegotiate the PMPM rates under several circumstances, including "if the rate floor is removed." Though the LDA's position is that any further reduction in reimbursement rates below the "floor" stipulated in the RFP would be detrimental to dentists' participation, we are aware that in an extreme fiscal crisis, there might not be any choice but to lower the rate floor. However, completely removing the rate floor would seem to open up the possibility of the DBPM further cutting reimbursement rates just to improve their bottom line, and not merely in response to fiscal constraints. So, we would like to know under what circumstances would the actual removal of the rate floor be deemed justifiable by DHH.	DHH will not speculate as to reasons the rate floor would be removed.
93				3. On page 32, Paragraph 10.a)vi states that the provisions of the RFP do not "preclude the DBPM from using reimbursement amounts that are *less* [emphasis added] or greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty." If there truly is a rate floor, how can they DBPM be allowed to reimburse a provider *less* than the published Medicaid fee schedule, which the RFP establishes as the rate floor?	"The words ""less or"" need to be deleted from the this statement. The language will be ammended. Please see Addendum % for revised language.

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94				4. Page 32, Paragraph 10.a)ii states that the DBPM "must provide a comprehensive network to ensure its membership has access at least equal to, or better than, community norms." We feel the term "community norms" is ill-defined. If there are some specific criteria that might be applicable (even if they vary from community to community), could DHH share them? Also, to the degree that there may be conflicts between the specific provider network requirements delineated in the RFP and "community norms," to which will the DBPM be obliged to adhere?	Specific Network Criteria can be found under "General Provider Network Requirements" on page 34: Travel distance from member's place of residence to a primary dental provider shall not exceed forty (40) miles for rural areas and twenty (20) miles for urban areas. Travel distance to specialty dental services shall not exceed sixty (60) miles from the member's place of residence for at least 75 percent of members and shall not exceed ninety (90) miles from the member's place of residence for all members. The "community norm" is the level of access to dental services that are available to any non-Medicaid recipient in the same geographical area. For example, if the DBPM is unable to meet the above requirements in a given area because that area is generally underserved by dental providers, the DBPM would need to submit a request for exemption. This written request would need explain the reasons surrounding this lack of access.
95				5. Please clarify what are the "appointment standards" to be addressed in the provider and member education referenced on page 34 in subparagraph c)ii, why DHH feels providers need to be educated on such standards, and what the overall goals of such education would be.	The provisions of this RFP do not prohibit the DBPM from limiting provider participation to the extent necessary to meet the needs of the DBPM's members. This provision also does not interfere with measures established by the DBPM to control costs and quality consistent with its responsibilities under this contract nor does it preclude the DBPM from using reimbursement amounts that are less or greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR §438.12(b)(1)].
96				6. Please clarify whether the distances to dental services delineated on page 34 in Paragraph 10.b)i-iii would restrict patients who choose to travel further to see a particular dentist in the DBPM's network would be prohibited from doing so. If so, what would be the justification?	The requirement is on the DPBM to assure a provider is accessible within the specified distances. It does not restrict patient who choose to travel further to see an in network provider of choice.

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97				7. We can understand the relationship between network adequacy and the requirement on page 35 in Paragraph 10.d)i that the DBPM "shall provide at least one (1) full time equivalent (FTE) primary care dentists per three thousand (3,000) DBP members." This seems a reasonable means of ensuring there are enough dentists in the network to treat all the DBP members. However, we see no corresponding rationale for the requirement in the same paragraph that the "DBPM shall require that each individual primary care dentists shall not exceed a total of three thousand (3,000) Medicaid linkages in all DBPM's in which the primary care dentist may be a network provider." The effect of this provision appears to clearly limit each dentist in the DBPM's network to having no more than 3,000 Medicaid patients of record at any point in time. This does not seem to serve any beneficial purpose. The number of patients in a practice in and of itself is NOT a determinant of quality of care. Myriad factors dictate the patient capacity of a dental practice, including, but not limited to, the number and types of auxiliaries (hygienists, EDDAs and assistants) employed there, modernity of the equipment, efficiency of scheduling systems, characteristics of the patient population, speed at which the dentist works, services provided (e.g., a general dentist who refers out all root canals to an endodontist and complex extractions to an oral surgeon can probably see more patients than one who does not), etc. Moreover, many STPs have long had more than 3,000 patients of record with no history of significant problems. The list of STPs that accompanied the RFP shows that 19 of the top 30 STPs filed claims for more than 3,000 unduplicated recipients in fiscal 2012-13. With so many STPs already with more than 3,000 Medicaid patients in their practice, it begs the question of whether the DBPM is supposed to tell thousands of Medicaid patients that they can no longer see their dentist of choice because of this restriction. And, on what basis would that "culling" of patients be accomplished? Length of a patient's association with that dentist? Geographical proximity to another provider? First-come, first-served? It makes FAR more sense to let the dentists themselves determine how many Medicaid patients they can accept appropriately treat and let the DBPM ensure quality of care through the QAPI program required in the RFP. The provision requiring at least one dentist in network per 3,000 DBP members is sufficient to ensure network adequacy without an accompanying converse requirement that only limits patients' choices and hurts STPs who have been the backbone of dental Medicaid for many years.	Your comments and concerns are noted. This ratio of 3000:1 individual members linked to a provider is based U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) standards for defining provider shortage areas and are considered as evidence of minimum network requirements for network adequacy. We have provisions in the current RFP that allow for exceptions to network adequacy requirements if warranted due to local community norms and can consider making adjustments to this requirement if it is in the best interest of assuring access to appropriate care for Medicaid recipients.
98				8. Pediatric dentists (a.k.a. pedodontists) are accurately listed as part of a recognized dental specialty on page 36 in Paragraph 10.e)iii. However, pediatric dentists may also properly be a primary dental care provider for children. (This situation is somewhat similar to the provision in most health insurance plans that allows for a gynecologist to be listed in network directories as a specialist, but also serve as a female patient's primary care physician.) It is unclear in the RFP whether pediatric dentists would be considered primary dental care providers. We would recommend that this be clearly confirmed in the actual contract language. And, we would strongly urge that it be unequivocally stated that pediatric dentists should be considered primary care dentists for the purpose of auto-assigning patients who are children, as per the system described on page 58 of the RFP.	Pediatric dentist (a.k.a. pedodontist) can serve as a primary care dentist if they have contractually agreed to assume all responsibilities of a primary care dentist including but not limited to hours of availability and performance of all mandatory screenings and treatment services.
99				9. On page 40, in Paragraph 10.k) we believe the terms need clarification. At present, it appears that the RFP does not specifically exclude a dental care provider from being awarded "Major Subcontract." If that were to be allowed, a dental provider who is also participating in the network and receiving remuneration for providing dental care to Medicaid patients could conceivably also subcontract to do any sort of certification, claims adjudication, review or payment function, or anything similar. That would create a considerable conflict of interest and potential for any number of anti-competitive legal issues. We would greatly like to see this language clarified in the final contract, at minimum.	All "Major Contracts" are subject to approval by DHH. An assessment of any potential conflicts of interest will be considered in DHH's approval of "Major Subcontracts."

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100				10. On a related note, we are glad to see that any "Major Subcontracts" would be subject to prior approval by DHH. That said, we would like to reiterate our concern stated in LDA president Dr. Jeff Hooton's letter to then DHH Secretary Bruce Greenstein dated August 3, 2012. At that time, the LDA noted that, should an MCO or other health care organization be selected to administer the dental Medicaid program and opt to subcontract out the dental benefits administration, it would simply add another layer of expense. There is no model like this of which we are aware that has meaningful case management communication between the health plan and dental plan, nor any other significant tangible benefit. And, if there is, as we suspect, simply an added cost to pay administrative expenses for an additional entity, we would be concerned about the potential impact on patients and providers. It is all too easy to envision the additional pressure to minimize costs in other areas leading to decisions that are not in the best interests of the dental Medicaid program overall. Accordingly, we urge DHH to review any such Major Subcontract proposals with rigorous scrutiny.	Your concerns are noted.
101				11. Will the QAPI program described in Section 11, part k) beginning on page 77 replace SURS for dental Medicaid? If not, please describe how QAPI would differ from SURS and the Recovery Audit Contractor (RAC) programs.	No, the QAPI requirements do not replace SURS or RAC program efforts. The QAPI requirements are included for the DPBM to provide DHH with written strategies, efforts and performance measures that they will implement to ensure quality standards are met and quality outcomes improve overtime.