DENTAL BENEFIT MANAGEMENT PROGRAM

ADDENDUM # 09 Response To Questions Submitted by 02/14/2014

305PUR-DHHRFP-DENTAL-PAHP-MVA

	SECTION HEADING	PAGE #	QUESTION
QUESTION	Transition Period Requirements "The Transition Period will begin after both Parties sign the Contract. The start date for the DBPM Transition Period is anticipated to be May 2014."		As indicated (on page 21) in the Schedule of Events: Contract Award Announced on 3/21/14, does DHH have dates established for when during the transition period they would expect to conduct the Readiness Review on-site activity? Per Appendix Z stipulation that "DBPMs must have successfully met all Readiness Review requirements established by DHH no later than 90 calendar days prior to the Go-Live Date", can the winning vendor then minimally project an anticipated go-live date for the program approximately 90 days after the provided DHH Readiness Review date for RFP response project planning purposes?
ANSWER			This information will be provided after the contract is awarded.
QUESTION	Transition Period Requirements "DBPMs must have successfully met all Readiness Review		Can DHH provide an estimated 'Go-Live' date?
ANSWER			The "Go-Live" date is 5/1/14
QUESTION	LA Data file detail		Can DHH provide a definiton for the 'clp_serv_prov_spec1', 'clp_serv_prov_type', and 'clc_type_of_service' fields? Each are a 2 character length
ANSWER			The field 'clp_serv_prov_spec1' is from Molina and represents the provider specialty code from the PE 50 (provider enrollment file); the field 'clp_serv_prov_type' is a Molina field which, according to the Molina's data dictionary, is a code which designates the classification of a provider per the Medicaid state plan; and the field 'clc_type_of_serv' is the claim type of service derived in LAM2D060 (claims processing subsystem).
QUESTION	LA Data file detail		Can DHH provide a definiton for the 'clp_bill_prov_id' and 'clp_serv_prov_id' fields? 'Bill' appears to be a location ID while the 'serv' appears to be the actual provider ID.
ANSWER			The field 'clp_bill_prov_id' is a unique identification number assigned by the provider enrollment department of the Bureau of Health Services Financing (BHSF) for a billing or "pay to" provider. A billing provider as a group member uses the professional association/ group ID number as the billing provider ID number on the claim form. The field 'clp_serv_prov_id' is a unique identification number assigned by the provider enrollment department of BHSF for the servicing provider.
QUESTION	LA Data file detail		What does the 'prb_specialty_1' indicate?
ANSWER			The field 'prb_specialty_1' indicates the provider specialty.
QUESTION	LA Data file detail		Can DHH provide more information on the ELB_Parish equal to 26 and 77? What are they?

ANSWER			Regarding the 'ELB_Parish' fields: '26' is Jefferson (West Bank) and '77' is OUT OF STATE.
QUESTION	LA Data file detail		Which procedure codes required a pre payment review?
ANSWER			The Dental Services Manual (Appendix O) list all covered services as well as those that require prior authorization
QUESTION	LA New Data Request		The June 2013 claim detail appears to be incomplete. (Please see table on the right). Would it be possible to send an updated file for 2013 - or a supplemental file containing a complete June dataset?
ANSWER			The file was complete based on the dates of service and paid dates used for the data extract.
QUESTION	Data Files		We noticed a shift in enrollment out of the CHIP program from the 07/2011-06/2012 data to the 07/2012-06/2013 data. Can you explain what caused this shift?
ANSWER			The recent decline in CHIP enrollment is partially offset by increases in the Medicaid Title XIX program, driven in part by recent economic challenges. A reduction in outreach efforts due to funding restrictions may have contributed to this decline as well. Most recent estimates from the 2013 Louisiana Health Insurance Survey show that statewide, only 4.8% of children are eligible for coverage but not enrolled, which limits the potential for enrollment growth.
QUESTION	Data Files		We noticed a drop in per member costs for the CHIP program from the 07/2011-06/2012 data to the 07/2012-06/2013 data. Can you explain what caused this reduction?
ANSWER			It appears that several factors contributed to the PMPM decrease, including the fee cut effective July 1, 2012 and the incomplete SFY 2013 data (i.e. claims still being processed at time of extract). We have not performed any other analysis to identify any other explanations.
QUESTION	Data Files		The claims data that were provided included claims incurred and paid through June 2013, with no additional run-out, and therefore a substantial completion factor (6.75%). Given it is February of 2014 would it be possible to get more recent data, and data with at least one additional month of run-out (for example, claims incurred 2013, with payments through January 31, 2014)? This more current data would give us a better estimate of expected results for the bid period, and would reduce significantly the uncertainty in terms of costs due to having a smaller reserve factor.
ANSWER			The file was complete based on the dates of service and paid dates used for the data extract.
QUESTION	Data Files		The Mercer memo indicates a reserve factor of 6.75%. Can DHH provide the claims triangles used to calculate the reserve to validate it or get the actual claims based on the additional months of run-out that have taken place between June 2013 and today?
ANSWER			Claims Lag Triangles are provided in the Procurement Library and Resources http://www.makingmedicaidbetter.com
QUESTION	III.B.3.B.11.h, page 54 and 55, Provider Handbook	54 and 55	In section iv, Page 54 of RFP states, "The DBPM shall develop and issue a provider handbook within thirty (30) calendar days of the date the DBPM signs the Contract with DHH." However, in the same section, last bullet on Page 55, the RFP states, "The DBPM shall make available to DHH for approval a provider handbook specific to the Louisiana DBP, no later than thirty (30) calendar days from the date the DBPM signs the Contract with DHH, but no later than prior to the Readiness Review." Please confirm which timeframe is the correct one.
ANSWER			At a minimum, a draft of the provider handbook is to be provided no later than 30 days from the date of the signed contract. The final provider manual will need to be submitted as part of the readiness review and must be finalized in order to complete readiness review compliance.
QUESTION	Appendix N		The RFP includes a 13.9% reduction in claims costs due to utilization management. However there is also a requirement to increase the percentage of children who receive dental care. Appendix N explicitly requires increases of 3%, 5% and 7%, respectively, for years 1, 2 and 3. What increase to dental costs is assumed as a result of this increase to overall utilization and therefore overall cost?"

ANSWER			No increase to dental costs is assumed as a result of this requirement. However, the rate certification will be updated to address this requirement prior to contract execution
QUESTION			Due to the significant changes offered in the proposal response structure of Addendum #5, we request a two week extension to the proposal due date.
ANSWER			All proposals are due 3/7/2014
QUESTION			Addendum #3 identifies responses to questions submitted on or before 2/7/2014 will be responded to in writing on 2/12/14. Can DHH please confirm a revised date to respond to written questions submitted on/before 2/7/14 would be issued, as several questions have not yet been answered?
ANSWER			The remaining answers to all questions will be posted on 2/19/14
QUESTION	Attachment II, Page 146 of the RFP		Attachment II found in the Official RFP Document is on legal sized paper (8.5" x 14"). Should proposers print the attachment on legal sized paper for inclusion in the proposal, or can the proposers print the attachment on standard letter paper (8.5" x 11")?
ANSWER			No perference is designated.
QUESTION			The fifth question we submitted was "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 DHH response was "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 section of the RFP we referenced with our question was 10. Provider Requirements, part c) subparagraph ii. This subparagraph does not in any way deal with the DBPM's authority to limit provider participation. It DID deal with policies and procedures for "appointment standards" that the DBPM is supposed to develop and submit to DHH. Our question was intended to get clarification on precisely what is meant by "appointment standards" and what need DHH believes there will be to "educate" providers about the standards. We would appreciate receiving an answer that relates more specifically to the subject matter of our question.
ANSWER			The RFP specifies on page 35 subsection ciii and civ that the DBPM must have a provider network that allows for all members to get an appointment for routine dental services within six weeks, and urgent care within 24 hours. DHH fully expects that dental providers be able to accommodate the members that are linked to them in the above timeframes. The DBPM, therefore, is expected to inform their participating providers of these requirements. The providers should also be informed of what is required and expected of them if accommodations cannot be made for the patients requesting these appointments.

QUESTION			The seventh question we submitted was: "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." *The DHH response was "Your comments and concerns are noted. This ratio of 3000: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."* Please note that the LDA was not expressing any concern over the provision in the RFP requiring the DBPM to provide one full-time primary care dentist per 3,000 DBP members. We are aware of the HRSA standard and understand the rationale for its application here. What we do not comprehend, and would like to have explained, is why the RFP contains a corresponding provision – one that appears to be based on "reverse" logic – that no dentist in the network may exceed 3,000 Medicaid linkages (i.e., can see no more than 3,000 Medicaid patients). We do not feel DHH has adequately answered THIS question. Why is such a provision needed? If the DBPM has met the requirement of at least one dentist per 3,000 Medicaid members, THAT ratio satisfies network adequacy. It should not matter if any particular dentist in the network actually has more than 3,000 Medicaid patients in his/her practice. As noted before, the majority of the current top 30 Medicaid dental providers saw more than 3,000 Medicaid patients in their practices in FY 2012-2013, based on the STP list posted with the RFP. The fact they see more than 3,000 Medicaid patients is indicative of the structure and capacity of those practices, NOT the quality of care delivered. Consider as well that, presumably most of those patients go to those dentists by choice. Should 4,000 DBP members choose the same dentist as their primary dental care provider, is it DHH's position that 1,000 of those members will not be afforded their choice of provider, even if that is the dentist they have seen for years? Moreover, counting on the basis of "linkages" could create distorted pictures of a dentist's patient-load in a group practice situation in which many of the patients may be treated by more than one dentist – and possibly in more than one location – within the same practice. The LDA strongly urges the Department to consider carefully the issues and concerns described herein, and we look forward to receiving the Department's revised responses. Should the Department be interested in exploring with the LDA some of these issues about which we have expressed concern in order to determine appropriate, alternative means of productive resolution, I can state with full confidence that the LDA would STILL be most welcoming of such a dialogue.
ANSWER			DHH agrees that the 3000 patient linkage limit may be too specific and not necessarily applicable in all situation. The RFP will be ammended to remove the language to eliminate specific limits on the number of members that can be linked to an individual dentist. It will be the responsibility of the DBPM to ensure that members have appropriate access within prescribed timeframes,that the quality of care is maintained and health outcomes are achieved.