WRITTEN QUESTIONS AND ANSWERS

ANSWERS ARE IN BLUE

1.	Is it a requirement that the in-state office address for the managed care provider be included in the dental RFP? Answer: No. The in-state office address does not need to be established at the time of the response to the RFP, but would need to be provided by the start of the contract implementation.
2.	RFP Section 3.16.G; Page 57: Attachment A3 Risk Corridor Parameters does not solve to an 85% Loss Ratio. Please confirm the appropriate minimum loss ratio applicable to the program. Answer: See final RFP Section 3.16 (I).
3.	RFP Section 3.16.H; Page 57: Attachment E references benefits and copays. Is Section 3.16.H meant to reference Attachment A3 Risk Corridors Parameters? Answer: See final RFP Section 3.16 (H).
4.	RFP Section 4.1.C; Page 68: DHS has indicated a total possible point value of 10 points per question in each subsection. Can DHS please clarify point allocation further? For example, will bidders receive a score of 1, 2, 3, 4, 5, 6, 7, 8, 9, OR 10 on each question, or will bidders receive a set incremental amount, such as a 0, 1, 5, or 10 depending on the quality and completeness of the answer? Answer: Answers will be scored using 0, 1, 3, 5, 7, or 10 on each question.
5.	Technical Proposal Packet Section E.2.I; Page 3: Can the State please define "non-capitated health care services" in the context of this requirement? Answer: See Technical Proposal Packet Section E.2 (I).
6.	Technical Proposal Packet E.3.G; Page 4: After DHS sends the selected Contractors the provider network data, will the Contractors be required to credential the providers that are already enrolled in the exisiting provider network or will simply obtaining an executed contract from the provider be sufficient until they are due for re-credentialing? Answer: See Technical Proposal Packet Section E.3 (G).
7.	Attachment A2: Will you be providing additional data to support the rating assumptions including detail experience at a dcode level, a claim lag, member access currently and future expectations and membership projections for 2018? Answer: See Attachment A2.1 – Data Book Supplemental Information, Paragraphs 1 and 2.

8.	Attachment B: We located the 2015 fee schedule here: https://www.medicaid.state.ar.us/Download/provider/docs/fees/DENTAL-fees.pdf, however these too do not account for the changes that were made to CDT 2016 coding. Can the state 1) confirm that the 2014 fee schedule is correct, or 2) please provide an updated fee schedule and benefit table that uses CDT 2016 coding? Answer: See Attachment B – Dental Services.
9.	Attachment G: Is the Contractor required to outline these requirements verbatim in its Provider Agreement? Answer: No.
10.	RFP Section 3.15; Page 56: At the Actuarial Rate Vendors Conference it was mentioned the spend down population was considered separate from the rating in the RFP. How many are eligible in the spend down population and what is your proposed rate? Is the spend down population going to be implemented at the same time as the Medicaid managed care program? Answer: The average monthly total eligible for this category is 65. Also see final RFP Section 3.15.
11.	Will beneficiaries be randomly auto-assigned among the two selected contractors initially? Answer: See final RFP Section 3.10.D.
12.	Will there be an open enrollment period or reassignment process? Answer: See final RFP Section 3.10.D.
13.	RFP Section 1.6.A.55 & 3.17.A: In the definitions section #55, it refers to a shared savings incentive that would be settled based upon the quality metrics. Section 3.17.A states that a withhold amount will be settled based on the quality metrics. Is there a shared savings incentive that can be earned in addition to the full return of withhold? If so, would the shared savings payment be included as part of the risk corridor calculation? Answer: The shared savings and the withhold refer to the same thing: a withhold applied to the capitation rate. The risk corridor will use revenue inclusive of any earned withhold amount, and expenses including any earned withhold that was spent.
14.	RFP Section 3.16.A.4: The payments to contractors in this section includes "the administrative fee for the Spend Down Population, as agreed to in the Contract;" are these administrative rates the same as assumed in the development of the capitation rates? If not, how will these be developed? Answer: See final RFP Section 3.16.4.
15.	RFP Section 3.3.C.c: Will the Vendor be responsible for reimbursing the out of network provider up to the allowable amount? Answer: See final RFP Section 3.3.C.3.c.
16.	RFP Section 3.4.A.2.b: Will the Vendor be compelled to accept all previously credentialed Medicaid providers into its network? Answer: See final RFP Section 3.4.A.2.b and 3.4.5.b.i.

17.	RFP Section 3.4.A.2.b: Will the previously credentialed providers be required to contract with the Vendor according to the Vendors provider contract? Answer: See final RFP Section 3.4.A.2.b.ii.
18.	Attachment A3: In the risk corridor settlement, can you confirm whether actual incurred administrative expenses will be used or the expenses assumed in pricing? Answer: Actual incurred administrative expenses will be used in the risk corridor calculation.
19.	Is the Vendor allowed to contract with providers under a capitated payment arrangement? Answer: See final RFP Section 3.4.C.2.c.
20.	Is the Vendor allowed to contract with providers under a bundled payment arrangement? Answer: See final RFP Section 3.4.C.2.c.
21.	Is the Vendor allowed to contract with providers under a non-fee for service arrangement? Answer: See final RFP Section 3.4.C.2.c.
22.	Is the Vendor authorized to enforce a withhold on providers within the Vendors network. Answer: See final RFP Section 3.4.C.2.c.v.
23.	Will the state issue RFP submission instructions (Font Size, Page Size, Acceptable margin, Signatory instructions)? Answer: The State will not issue RFP submission instructions for Font Size, Page Size or Acceptable margin. Signatory instructions are included within the RFP solicitation.
24.	RFP Section 3.7.B.d.iii: Will the Beneficiary PMPM payments to the Vendor continue after the beneficiaries loss of eligibility for the remainder of the orthodontic treatment period? Answer: See final RFP Section 3.7.B.d.iii.
25.	RFP Section 3.7.B.d.iii: Does the state have an estimate on the number of beneficiaries that lose eligibility while orthodontic treatment is ongoing? Answer: A DDS report shows that over the last year, there were approximately 450 Beneficiaries that lost eligibility within twelve (12) months of the date of installation. Also see final RFP Section 3.7.B.d.iii.
26.	RFP Section **3.6.B.2.d.i:** i. indicates 95% of all calls must be answered within 3 rings or 15 seconds. Will the State consider an alternate service level if calls are answered by a live representative rather than a self-service IVR (automated)? For example: 80% of calls answered by a live agent (in the USA) within 30 seconds? Answer: No.

27.	RFP Section **3.6.B.2.d.iii:** **iii.** indicates the number of abandon calls should not exceed 5% of all incoming calls **vi.** indicates the abandoned call rate shall not exceed 3% for any month. We would like clarification as to the expectation for abandon calls. Will it be 3% or 5% monthly? Answer: See final RFP Section 3.6.B.2.d.
28.	RFP Section **3.8.A.b:** On what date does the State wish to see the full-time Dental Director required to be in place and/or how soon before or after the award date? Answer: See final RFP Section 3.8.D.b.
29.	RFP Section **3.16.A.3:** What will the Spend-Down population Administrative Fees be and how will contractor be reimbursed? Answer: See final RFP Section(s) 3.15 and 3.16.
30.	**Updated Attachment A1 – Capitated Rates:** Can you please identify the counties that are in each "Tier" as well as the FY15 MMs by Cohort for each tier? Answer: Please see final RFP Attachment A.2.3 - Rating Region Membership.
31.	RFP Section **2.2 Vendor Qualification**: Regarding NCQA accreditation; Please confirm that NCQA UM/Credentialing and Network accreditation is sufficient. If a different category of accreditation is required, please advice. Answer: NCQA/UM/Credentialing is acceptable.
32.	RFP Section **3.3.A.1.a.i, 3.3.A.1.a.ii, 3.3.A.1.a.iii; Page 22:** Will the State accept either LOIs or LOAs to satisfy network coverage requirements? Answer: See final RFP Section 3.3.A.1.a.
33.	RFP Section **3.6.C-1; Page 36:** What is the state-established time frames for grievance/appeals? Answer: Please see Section 160.000 "Administrative Reconsiderations and Appeals" for all provider manuals. This section can be found at the following web address: https://www.medicaid.state.ar.us/Provider/docs/all.aspx
34.	RFP Section **3.6.C-4.b.i, 3.6.C-4.b.ii; Page 37:** Please confirm the TAT for the investigation and resolution of all Grievances. Non-emergency clinical issues to be completed within 5 days is very short. Answer: Yes. DHS confirms the time frames listed in the RFP.
35.	RFP Section **3.6.C-4.b; Page 37:** Is the TAT days for Grievances in calendar days? Answer: See final RFP Section 3.6.C.4.b.

36.	RFP Section **3.6.C-4f; Page 37:** The RFP states a "dentist" must attend all Administrative Hearings, is the dentist required if the hearing does not involve a clinical decision? Answer: Yes.
37.	RFP Section **3.6.C-4.f; Page 37:** Is it possible to get an annual number of Admin Hearings? Answer: On average, less than 10 provider initiated appeals are filed annually with the AR Department of Health. On average, less than 10 dental appeals are filed per year by beneficiaries with the Fair Hearings Unit of the AR Department of Human Services.
38.	RFP Section **3.6.C-4.f; Page 37:** Are the Administrative Hearings via telephone? If not, where are they held? Answer: See final RFP Section 3.6.C.3.
39.	RFP Section **3.7.B-1.d.iii; Page 40:** Please provide clarification on the requirement to "ensure that orthodontic treatment is completed, despite the loss of eligibility, provided the Beneficiary was eligible on the date the banding occurred" Answer: See final RFP Section 3.7.B.1.d.iii.
40.	**Updated Attachment A2 – Data Book:** **Managed Care Adjustments** > How were these determined? > Why were only the kids affected? I would have expected perhaps more savings on adults for management on non-P&D services, and potential increase to utilization on P&D for kids. The databook shows the opposite. Also, the unit cost is increased for kids and I am not sure why that would be. Answer: See Attachment A2.1 – Data Book Supplemental Information, Paragraphs 3 and 4.
41.	**Updated Attachment A2 – Data Book:** **Historical Trend** What were these trends based on (i.e. what time period(s))? Answer: See Attachment A2.1 – Data Book Supplemental Information, Paragraph 5.

42.	**Updated Attachment A2 – Data Book:** **Prospective Trend** What were these trends based on? Answer: See Attachment A2.1 – Data Book Supplemental Information, Paragraph 6.
43.	**Updated Attachment A2 – Data Book:** **Unit Cost** > What is the underlying unit cost assumption – 100% of State Medicaid? Something else? > Are the same fees assumed for CHIP vs. Medicaid? Answer: See Attachment A2.1 – Data Book Supplemental Information, Paragraph 7.
44.	**Updated Attachment A2 – Data Book:** **Program Changes** Are there any expected program changes that would affect cost of care? Answer: See Attachment A2.1 – Data Book Supplemental Information, Paragraph, 8
45.	**Updated Attachment A2 – Data Book:** **Expansion QHP** This cohort appears to have rates simply set equal to standard Medicaid. Is there no expectation of different utilization patterns on the expansion population? Why or why not? Answer: See Attachment A2.1 – Data Book Supplemental Information, Paragraph 9.
46.	Section 3.3.A.1.d & 3.5.C.1.h; Page(s) 22 & 31: The requirement in 3.3.A.1.d seems to potentially contradict the requirement of 3.5.C.1.h. The latter seems to allow a provider to perhaps not treat individuals with special health care needs or of all ages, while the former seems to require acceptance of all patients. Please clarify. Answer: The AR Medicaid dental unit has generally allowed dental providers to determine and specify what ages, and types of special needs beneficiaries they would accept as patients. This information was also provided on the Insure Kids Now (IKN) website and used by AR Connect Care to assist beneficiaries to find a dentist. The AR Medicaid Dental program is currently evaluating how the provisions of the Affordable Care Act Section 1557 will impact the ability of individual providers to categorically exclude beneficiary groups.
47.	Section 3.5.F.5 & 6; Page 33: For pregnant and non-compliant beneficiaries there must be 2 calls 1 day apart within 10 days of enrollment or within 10 days of notification they are non-compliant or pregnant, if these are not successful within 8 days the beneficiary must be contacted by mail. Will this requirement apply for January 2018 once an initial eligibility file is provided? Answer: See final RFP Section 3.5.F.5.d and 3.5.F.6.c.

48.	Section 3.6.B.2.d.iii & vi; Page 35: Subsection iii requires that the number of abandoned calls cannot exceed 5% of total incoming calls. Subsection vi requires that the abandoned call rate cannot exceed 3% for any month. These seem to potentially be contradictory. Please clarify. Answer: See final RFP Section 3.6.B.2.d.
49.	Section 3.7.B.1.a & b & Attachment B; Page 39: The prior authorization section seems to suggest that a bidder can propose to modify the covered services that require a prior authorization. However, Attachment B ("Dental Services") reflects the services that require a prior authorization in the current environment. Is a bidder permitted to recommend modifications to the list of services that would require a prior authorization? Answer: Yes, the contractor can propose modifications to the schedule of services currently requiring prior authorization.
50.	Section 3.17.A; Page 57: How much will the withhold described in this section be? Answer: See final RFP Section 3.17.A.
51.	"Information for Evaluation" Technical Proposal Packet; Page 2: The initial bullet point states: "Provide a response to each item/question in this section. *Vendor may expand the space under each item/question to provide a complete response* ." 1. Do these instructions require the entire proposed content, including graphics, to be included in the space provided in the table (as expanded)? 2. If the answer to Q1 is "yes", will attachments to the proposal be accepted or rejected? 3. If attachments are accepted, will the contents be read or scored? 4. May an executive summary be included as part of the proposal? Answer: 1. This is preferred, but not required. 2. Attachments will be accepted. 3. Yes. 4. See Technical Proposal Packet: *Submission Requirements* page, bullet point 4; and *Information for Evaluation* page, bullet point 3.
52.	Data Book: In the *0-1 age group* , there are 580 units of endodontics and 1,582 units of restorative listed for CHIP and 22 units of endodontics and 66 units of restorative listed for Medicaid in FY 2015. Can this be explained? Answer: See Attachment A2.1 – Data Book Supplemental Information, Paragraph 10.

53.	Data Book: The quality measures proposed in Attachment D would all serve to increase claims costs to levels higher than the costs implicit in the base data used in rate development. Will any consideration be given to the anticipated increase in utilization in the final rate development? Answer: See Attachment A2.1 – Data Book Supplemental Information, Paragraph, 11.
54.	Benefit limits placed on Beneficiaries run July 1 to June 30. How does this affect, if at all, the application of benefit limits with a January 1, 2018 go live date and the gain/loss calculation? Answer: See the Note at the end of the final RFP Section 3.2.A.
55.	Currently, the $500 annual maximum for adults is administered on a fiscal year basis. Will this annual maximum change to a calendar year basis beginning January 1, 2018? If so, how will claims administered through HP in the period from July 1, 2017 to December 31, 2017 be affected by this annual maximum? How will the change impact benefit limits, accumulators, year-end reporting, and the gain/loss calculation? Are there other considerations Vendor's should consider as a result of this change? Answer: See the Note at the end of the final RFP Section 3.2.A.

56.	What administrative services will DHS (or its vendors) retain for the dental managed care population? Answer: See final RFP Sections 2.1.F and 2.1.G.
57.	What, if any, level of access will the Contractor have to the Medicaid eligibility system(s)? Answer: See final RFP Section 3.10.A.6.
58.	If provider pay-for-performance is part of a bidder's proposal, will that be included in the gain/loss calculation? Answer: See final RFP section 3.16.J.
59.	Can the following operational metrics be provided: 1. Average number of dental calls per month (provider and beneficiary); and 2. Average number of prior authorization requests broken down if possible by service/procedure Answer: In general, dental calls are received by the DHS dental unit staff, Fiscal Agent customer service, and AR Connect Care. The following inbound dental call volume metrics available, include: Dental Unit Provider Support 2500/mo. (estimate by dental unit) Recipient Support 250/mo. (estimate by dental unit) Connect Care Recipient Support 600/mo. (estimate by Connect Care) HP Provider Support 300/mo. (estimate by HP) In SFY 2015, the dental unit received approximately 40,000 prior authorization requests by mail and less than 20,000 via the third party electronic workflow system. (Estimate by dental unit staff).

60.	Will there be finalist presentations? Answer: No.
61.	Is there any restriction to a single subcontractor being identified as a subcontractor in more than one prime contractor's bid submission and ultimately serving as subcontractor to multiple successful bidders? Answer: No, there is no restriction prohibiting this practice.