Washington State Health Care Authority

STATE OF WASHINGTON

HEALTH CARE AUTHORITY

RFP NO. 2516

Amendment #5

PROJECT TITLE: Medicaid Managed Care Dental

PROPOSAL DUE DATE: June 29, 2018 by 2:00 p.m. Pacific Time, Olympia, Washington, USA.

Faxed bids will not be accepted.

ESTIMATED TIME PERIOD FOR CONTRACT: January 1, 2019 to December 31, 2020

The Health Care Authority reserves the right, in its sole discretion, to extend the contract for up to five (5) additional years in increments of one (1). Amendments to extend the period of performance of the contract may require network capacity increases.

The above referenced RFP is amended as follows:

1. HCA's responses to the submitted questions, as attached.

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#	Document	Section	Bidder Questions	HCA Answers
1	RFP	1.2	FQHCs: Will the state consider alternate reimbursement strategies other than encounters?	FQHCs and RHCs are entitled to receive the dental PPS encounter rate for qualifying dental face-to-face visits. At this time, HCA is not considering changing how FQHCs/RHCs are paid for dental services.
2	RFP	1.2	Does Washington State have any FQHC providers that are contracted on a 'per visit' reimbursement method (as opposed to 'Fee For Service' reimbursement method)?	All FQHCs and RHCs currently contracted with HCA are entitled to receive the dental PPS encounter rate for qualifying dental face-to-face visits. Certain services that are not encounter eligible are reimbursed on a "fee for service" method.
3	RFP	1.2	States: 22% of adults, and 50-54% of children utilized services. Can HCA equate these numbers to an approximate "network adequacy" percentage?	HCA cannot provide an exact percentage. One intent of this RFP is to enhance network adequacy.
4	RFP	1.3	Are all eligible enrollees required to have Primary Care Physicians (Dentist)?	Yes.
5	RFP	1.3	How does the state require us to work with Indian Heath Services (I.H.S.) providers? Can we use our current model?	Please refer to RFP, Sections 1.2 (AI/AN), 1.3 (IHCPs) and Attachment 1, Section 14.5 and Section 15.
6	RFP	1.4.17	Preferred Qualifications lists: "Experience with outreach to vulnerable populations, which includes: the economically disadvantaged; racial and ethnic minorities; the uninsured; low-income children; the elderly; the homeless; and those with chronic health conditions, including severe mental illness, who have reduced access to health care services." However RFP does not contain specific requirements/desires/objective for Outreach other than '3 Marketing and Information Requirements' (pages 41-43 of the Contract) and the two programs: ABCD Program and Oral Health Connections Pilot. Are there other Outreach objectives to be identified?	HCA is interested in Bidder's experience in outreach including the programs referenced, and any others Bidder identifies.
7	RFP	1.4.3	Can HCA clarify its definition of 'day-to-day operations' as it relates to the requirement to have an office in state for day to day operations?	HCA expects the Bidder to be able to conduct the business activities, such as customer service, provider outreach, client care coordination, etc. from a Washington state based location.
8	RFP	1.4.8	The 820 file is typically for employers. Please confirm this file format type applies to the dental program.	Yes, this file format type applies to the dental program.
9	RFP	1.5.2	The RFP states "the ASB(s) will be responsible for the costs of implementing the Managed Care Dental Program. This includes the costs incurred by HCA in notifying Clients," How does HCA anticipate allocating its expenses to MCE(s) (population volume, # of regions, etc.)? What is the projected costs (per eligible member) to be incurred by HCA? What is the estimated volume for the notification mailings? What is the method for payment of costs (premium hold back, payment schedule, etc.)? What documentation will be provided to the dental carrier for such costs to be paid back to HCA?	Costs, beyond what was allocated to HCA for notifications, will be divided up among the MCEs based on the Enrollees assigned to them. HCA will provide an itemized invoice of all costs to be reimbursed. HCA is making every effort to make this as cost-effective as possible.
10	RFP	2.14	States: "HCA will expect the ASB(s) to agree to honor and pay for Prior Authorizations that HCA has approved and are non-expired by implementation on January 1, 2019. HCA will provide all applicable approved authorizations to ASB(s) for their respective Enrollees." Will HCA provide reimbursement to ASB(s)? If not, will HCA provide anticipated financial impact prior to submission of Proposal (June 29)?	The information in the data book includes a full year of expenditures which includes costs for services that were authorized in the prior year. Bids based upon the data book will be inclusive of the financial impact of this type of expenditure.

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11	RFP	2.16	Receipt of Insufficient Number of Proposals states: "If HCA receives only one responsive Proposal as a result of this procurement, HCA reserves the right to either: 1) directly negotiate and contract with the Bidder; or 2) not award any contract at all." This indicates that HCA believes that it may refuse to award a contract to a Bidder where the Bidder is the only qualified bidder under the RFP scoring criteria in a Regional Service Area. In creating managed dental care services in SSB 5883, the Washington State Legislature stated, "Except in areas where only a single plan is available, the authority must contract with at least two plans." This statutory budget language adopted by the legislature indicates that HCA will award at least two contracts where there are at least two Bidders successfully bidding, but it also indicates that one can be awarded where only one successful Bidder successfully bids. How does HCA reconcile its decision to not award a contract to a Bidder submitting a successful bid where the Bidder is the only applicant for a Regional Service Area with the legislature's adopted budget language providing that a single ASB will be contracted unless more than one ASB submits a successful application and where in the RFP is that reconciliation found?	HCA appreciates the question, and will comply with all applicable federal and state laws with respect to this RFP and the Medicaid Dental Managed Care Program.
12	RFP	2.5	In addition to the utilization data from 2016 and 2017, will HCA also provide enrollment experience from 2016 and 2017 by month by population?	This information is included in Exhibit F, Dental Data Book.
13	RFP	2.6	How should the redacted version of the response be submitted?	Bidder(s) should not submit a redacted version of their Proposal. Bidder(s) should indicate, as directed in RFP, Section 2.7, which sections are proprietary. HCA will handle all redactions to any public records requests.
14	RFP	3.1	Please clarify the Proposal Format (Mandatory) sections to be included in the response.	The major sections of the Proposal are to be submitted in the order noted below: * Letter of Transmission (includes Exhibit A, Letter of Submittal; Exhibit B Certification of Minimum Requirements; Exhibit C, Certifications and Assurances; and Exhibit H, Completed Diverse Business Inclusion Plan) * Exhibit D, Provider Network Submission, including Section 3.3 (electronically) * Provider Network Questions, Section 3.4 * Exhibit E, Evaluation Questions * Experience, Section 3.6 * References, Section 3.7 * Cost Proposal Template, included in Exhibit F, Dental Data Book (electronically)
15	RFP	3.3	Could HCA explain how the Network Capacity requirements (% of clients in RSA) noted on page 34 of the RFP document, will be calculated?	Only distance standards will be measured, and capacity will be determined by calculating the number of eligible clients in a given service area that can be served by the provider network submitted by Bidder. This will be measured through the GeoCode process outlined in the Bidder's Instructions provided with Exhibit D.
16	RFP	3.3	How is the percent of access requirement tied to the mileage and minute requirement? Is it tied to first mileage, then minutes, and all gens plus specialties must then meet the % of adult and child?	HCA will be scoring based on mileage requirements. See Question 15, and refer to Exhibit D, Provider Network Submission, Bidder's Instructions.
17	RFP	3.3	The RFP is clear that bidders must demonstrate network capacity to cover 18% of children and 7% of adults. With regard to the driving distances/drive times for General Dentists and each specialty, is there a minimum GeoAccess % requirement at the time of the bid?	The percent requirement is 7% of adults and 18% of children at time of Proposal submission.
18	RFP	3.3	Is the network requirement listed on page 34 to be applied to all specialties, or just general and pediatric dentists?	All specialties. However for the purposes of scoring, HCA will only be evaluating General and Pediatric Dentists for distance.

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19	RFP	3.3	There are five provider types, how will time and distance be used to assess network adequacy for each of these? Must all provider types meet time and distance standards as well?	For the first year of the contract, HCA will track time and distance for all provider types, but will use only the data from general and pediatric dentists when we begin using network adequacy for assignment purposes. HCA expects all Managed Care Dental Enrollees to have access to medically necessary services and providers, regardless of location.
20	RFP	3.3	Will General Dentists and Pediatric Dentists be combined since they are both considered Primary Care Dentists? How will they be separate?	They will be measured separately based on Provider's Submissions data, included with Exhibit D, on the "general dentistry" tab. A general dentist can also be a pediatric dentist.
21	RFP	3.3	A point of clarification from the pre-bidders conference: Can General Dentists who also see children be counted in both general dentist and pediatric dentist categories?	Yes, and they should be. In the Provider Submission, there is a column called "PedCare" that should be populated with a "Y" if the dentist serves pediatric patients. Refer to Exhibit D, Provider Network Submission, Bidder's Instructions.
22	RFP	3.3	Can any dentist be considered a "denturist" if they install dentures?	No, they are not considered a "Denturist," as licensed under RCW 18.30; however dentists are qualified to provide denture services.
23	RFP	3.3	Denturists do not meet our credentialing standards and do not have a valid DDS license, thus will not sign a standard participating dentist contract. Will HCA reconsider this requirement and remove denturists for the time and distance requirements and as a requirement for contracting with denturists as a part of our network?	Denturists are not being assessed for network distance scoring. HCA has included denturists due to their importance to the population being served and HCA wants to develop an understanding of the structure of that network.
24	RFP	3.3	Why are denturists listed as one of the five key provider types? They are not licensed like the other 4 providers. Please clarify.	Denturists are credentialed through the Washington State Department of Health, and licensed as described in RCW 18.30.
25	RFP	3.3	When evaluating network coverage, if a plan submits a bid for all 10 regions and HCA determines that the threshold was met in 9 regions, but not the 10th, will the bid be evaluated and scored for the 9 "passing" regions?	Yes.
26	RFP	3.3	If the bidders have a network capacity less than 100%, are the members simply left unassigned to a bidder and remain FFS with HCA? For example, if at the time of Readiness Review all bidders are at a network capacity equal to the requirement of 25% of Adults and 60% of Children, does that mean that 75% of Adults and 40% of Children would remain FFS with HCA?	All eligible Enrollees will be assigned to dental plans, if a sufficient number of MCEs qualify as ASBs and agree to contract terms with HCA.
27	RFP	3.3.1	Requires that the Bidder's network includes enough providers to serve 7% of the adults in each RSA and 18% of the children. To help us understand these requirements more deeply, could HCA provide the provider/patient ratio it's using to determine "enough providers" or define the number of provider (by specialty) needed in each region?	Please refer to: Exhibit D, Provider Network Submission, Bidder's Instructions.
28	RFP	3.3.1	Please clarify if "provider" is access point (belly button + door knob) or unique provider? We would assume it is access points since providers have multiple locations that members can access for the time and distance calculation using GeoAccess. Please clarify.	It is access point. Please refer to Exhibit D, Provider Network Submission, Bidder's Instructions.
29	RFP	3.3.1.1	Can Bidders submit Letters of Intent from providers rather than signed contracts, given that providers are reluctant to contract until they know who the apparent successful bidders are?	No. HCA has experience in previous procurements in which Bidders were allowed to submit Letters of Intent from providers as part of their network adequacy proposal, which never resulted in signed contracts. This created network adequacy shortages. HCA considered and rejected these concerns when setting the minimum required percentages for network adequacy at time of proposal submission.
30	RFP	3.3.1.1	Bidders required to submit the signature pages of current contracts for all provider types: How will the state assess compliance based on signature pages when a particular contract may encompass a group, not just an individual?	If a provider contract encompasses a group, then a list of all providers included in that group should be provided with the signature page. This has been addressed in Amendment #4.

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31	RFP	3.3.2	If a particular county does not have any or enough licensed dentists to meet the mileage requirements, will exceptions for access requirements be considered if a bidder can demonstrate due diligence? For example: Skamania County only has one licensed dentist, thus bidders will not be able to meet the mileage requirements for all members. No bidder will be compliant.	Network Adequacy is based off of distribution of Medicaid Clients compared to location of providers, not simply geographic location. In Regional Service Areas where there are not enough providers serving Medicaid Clients, HCA would review the data to consider an exception to the network standards.
32	RFP	3.3.2	The time and distance standards only include urban and rural classifications. Is membership that GeoAccess will classify as suburban be rolled up into the urban classifications and is the frontier rolled up into rural classification? GeoAccess has 4 separate classifications.	Yes.
33	RFP	3.3.2.1	For Time/Distance standards for provider network: Is this an "either/or" situation? Is it okay to meet either the time OR the distance standard once appropriately measured? Or are both necessary?	Both are necessary per CMS requirements at 42 C.F.R. 438.68. HCA is currently working to develop time standards that correlate with the distance standards, thus will be looking at distance first, and time second.
34	RFP	3.4.1	Can HCA provide an example utilizing specific client by region membership and provider (access point or unique provider) for the calculation for bidders using the percentages by Adult and Children in the table? Is HCA going to provide Bidders with an actual census file by zip code for the membership? Or is HCA only providing the membership by county with no zip code information? We will need this data to load into GeoAccess to plot membership in the appropriate county and roll it up into each RSA to calculate time and distance and the required percentage by Adult and Children in the table. Please advise as to how HCA is intending the calculations to be determined for the carrier's.	Please refer to Exhibit D, Provider Network Submission.
35	RFP	3.8	There are a number of reports related to dental services and costs already on HCA's website. Are they consistent with the data book, and can Bidders use the information in these reports to begin work on rates development?	Bidders should ONLY rely on the information contained in the Dental Data Book to develop their cost proposals. The reports on HCA's websites are generally developed to specifically address a question or concern; for example, legislators or other stakeholders asking specific questions about how services are provided. The reports do not provide the broad information that is needed to develop Bidders cost proposal.
36	RFP	3.8.1	How will ABCD rates be accounted for? Will it be included in the PMPM or will it be an additional calculation? Does HCA plan to handle this as a carve out or will it be embedded in the overall PMPM: ABCD (missing), ABCD expansion, Oral Health pilot?	This information is included in Exhibit F, Dental Data Book.
37	RFP	3.8.1	What is the Dental Access Payments (DAP) program?	Dental Access Payments are supplemental payments included in the capitation rates but paid directly to eligible providers at the PMPM rate specified in the capitation rate development. The funding is intended to assure access for members to specific providers and is not limited to certain services.
38	RFP	3.8.2(A)	How should we demonstrate costs for program items not specifically listed in the RFP (Cost Proposal)	For program cost expected under the model contract but which have not been identified with an adjustment category in the cost proposal, Bidders should use the "Other Adjustment" inputs for benefit costs or "Other Cost" inputs for non-benefit cost. All input assumptions must be documented in the Bidder's accompanying actuarial memorandum, including the data, methodology, and assumptions that were used to develop the rate adjustments. Bidders must absorb all benefit and non-benefit costs which is not covered under the contract. Information regarding such costs may be provided in actuarial memorandum, but will not be considered in rate development.

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39	RFP	3.8.1(B)	"HCA will develop additional monthly payments for these items, which will be included on top of accepted Cost Proposal rates: *ABCD Expansion; Oral Health Connections Pilot Project; and Dental Access Payments (DAP)." What services will be covered for the Dental Access Payments, which will be paid by HCA to dental carriers?	Dental Access Payments are supplemental payments included in the capitation rates but paid directly to eligible providers at the PMPM rate specified in the capitation rate development. The funding is intended to assure access for members to specific providers and is not limited to certain services. HCA makes these payments to contracted plans through the PMPM capitation rates, and the payments are made to providers by the plans. Note that no rate action is required by Bidders for ABCD expansion, Oral Health Connections Pilot Program, or DAP, as is indicated in the Data Book Narrative's instructions for completing the cost proposal.
40	RFP	4	Aside from the Cost Proposal, the Network, and the specific regional question in Section 5.2.3 of Exhibit E, will the RFP be scored from a statewide perspective? Or will there be points designated by region for each question?	The RFP will be scored from a statewide perspective.
41	RFP	4.8	Protest Procedure: The RFP does not contain a requirement for bidders to provide any disclosures of actual or potential conflicts of interest with prior or existing work being performed for the state. The protest procedure in section 4.8 also does not list a successful bidder's potential conflicts of interest as a basis for protest. How does HCA plan to address actual or potential conflicts of interests in the process of evaluating bids?	Please refer to Exhibit A, Letter of Submittal, which includes requirements that Bidders disclose both current and prior contracts with HCA (C), and conflicts of interest (E). HCA will review any potential conflicts of interest during the evaluation period.
42	RFP	General	Who will be on the evaluation team?	HCA does not provide information on specific evaluation team members during the procurement process. However, the team will include a broad array of subject matter experts both internal and external to HCA.
43	RFP	General	Is 11x17 paper permissible for charts and graphs?	HCA will accept 11"x17" for charts and graphs, only. These pages will count towards the page limit, where applicable, for the section. This has been addressed in Amendment #4.
44	RFP	General	Do the attestations require signatures?	Yes.
45	RFP	General	Does the restatement of the questions in 3.4 and 3.5 count against the set page limit?	No.
46	RFP	General	Can we submit the signed contract sheets electronically only?	Please submit the documentation for Provider Network Submission, including contract pages, (Section 3.3) electronically only. This has been addressed in Amendment #4.
47	RFP	General	Are we allowed to include attachments with our response?	Requested documentation, samples, and examples, may be submitted as attachments, referenced in the specific response to the question requesting them. Additional attachments should be within the page limit specified.
48	Exhibit A	(A)(h)	Our firm is a mutual company, which is not one of the legal options listed. Is it acceptable for us to add this as an option in this section? If not, how would you like us to address this?	Yes, please add "Mutual Company" as your Legal Status for this section.
49	Exhibit D		Is there a provider to member ratio that will be used in determining network adequacy?	No.
50	Exhibit D		Will the state be publishing a list of areas that are considered rural versus urban, or must Bidders rely on the GeoAccess tool for those designations?	Rely on the GeoAccess tool for those designations. The designations are incorporated into GeoAccess.
51	Exhibit D		To what extend will time/distance/other GeoAccess characteristics be used to calculate network adequacy percentages?	Geo calculations will be based upon provider distance only.
52	Exhibit E	General	There are no questions that ask bidders to explain their work plan and how they intend to work with the existing (medical) MCOs to coordinate care and share information about clients. Understand collaboration with MCOs is an expectation of MCOs that is outlined in the contract; however, recommendation that HCA ask specific question to Bidders about their experience working with MCOs to coordinate care and their plans on how they plan to coordinate with MCOs to avoid duplication of services, notification with primary care, care coordination, etc., especially with the expectation to reduce costs by reducing ER dental visits.	Thank you for your comment. Attachment 1, Sample PAHP Apple Health Dental Services Contract, is incorporated into the RFP, and specifically referenced throughout the RFP for Bidders to consider when developing their proposals. This coordination is addressed in Section 14, Care Coordination, of Attachment 1.

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53	Exhibit E	General	In the Evaluation questions, how should we discuss / include areas not specifically listed for response?	Please incorporate this information in the answers to the questions they relate to.
54	Exhibit E	2	Will HCA please confirm that Bidders may submit the requested project implementation schedule as an attachment, and that such attachment will not be counted against the limit of three (3) pages for responses to Question 2?	The project schedule may be submitted as an attachment. The attachment will not count against the page limit for this question.
55	Exhibit E	2, 5	Exhibit E, Work Plans are referenced in both Section 2.0 and 5.0. How are they different?	Section 2.0 Work Plan asks for the implementation and day-to-day activities involved in implementing and operationalizing the program - this is milestones and timeframes. Section 5.0 Work Plan relates to how the actual program will run, details about the program, business practices, policies and procedures, and Bidder's ability to meet HCA, state, and federal requirements - this is the detail.
56	Exhibit E	3	Exhibit E, Section 3, Risk Report - Is HCA looking for general risks, or specific to the project and program?	HCA expects the response to include both general risks, and risks specific to the Managed Care Dental Program implementation and administration.
57	Exhibit E	5.1	Collaboration on ABCD. The RFP poses questions regarding how the Contractor(s) will work with WDSF/Arcora Foundation to provide the ABCD program. It should be contemplated that the Contractor(s) could assume administration of the program.	This may be contemplated at a later date.
58	Exhibit E	5.6.4	Asks for provision of sample enrollee materials used in other Quality PI projects - are these materials to be included within the 6 page limit, or can we include with an attachment appendix?	Sample Enrollee materials may be submitted as attachments. The attachments will not count against the page limit for this section.
59	Exhibit E	5.9.2	Asks to provide examples of quarterly reports - are these materials to be included within the 4 page limit, or can we include with an attachment appendix?	Sample reports may be submitted as an attachments The attachments will not count against the page limit for this section.
60	Exhibit E	5.10.2.2	Asks to include documentation to support a Prior Authorization request, and the submission and receipt processes for backup documentation - are these materials to be included within the 10 page limit, or can we include with an attachment appendix?	The documentation to support a Prior Authorization request may be submitted as attachments. The attachments will not count against the page limit for this section.
61	Exhibit E	5.11.3.1	Asks the Bidder to detail the size of the support staff and duties. Please clarify who HCA is including in the definition of "support staff."	Support staff would include the customer service staff themselves, administrative staff, and internal resources used by customer service staff to respond to queries.
62	Exhibit E	5.13.1	Infers HCA uses dental home assignments (or a variation thereof) with FQHCs. Can HCA confirm there is a dental home model in place for FQHCs? Are there any other provider groups or class of enrollees for whom HCA wants dental homes?	HCA expects all Enrollees to be assigned to a PDP.
63	Exhibit E	5.13.3	Asks Bidder to detail their ability to accommodate changes to the FQHC enrollment list submission and enhanced payments. What changes is HCA anticipating? For example, will the State plan to move from a PPS fee plus a wrap fee model to a single PPS fee (enhanced to include the wrap and PPS fee combined)?	HCA anticipates that MCE(s) will pay FQHCs/RHCs their full PPS rate for qualifying face-to-face dental visits. A dental claim for that visit will consist of a CDT code(s) and a T1015 code that represents the FQHC/RHC enhancement portion. T1015 amount is the difference between the contracted amount(s) and the clinic's PPS rate.
64	Exhibit E	5.15 / Attachment 4, 1.4(4)	"Agency IT Security Program must, at a minimum, receive training that addresses the OCIO Security Policy and Standard and the agencies security policies and procedures." Is it HCA's expectation that successful bidder(s) seek out their own training on OCIO Security Policies and Standards, or is HCA going to provide this training?	The expectation is ASB(s) will provide security awareness training for their staff. This training needs to cover subject matter substantively similar to that covered by the OCIO Security Standard, 141.10.
65	Exhibit E	5.15 / Attachment 4, Section 11	"Agencies must comply with the WACIRC incident reporting process(es)." Can Bidders review the WACIRC incident reporting processes?	This process has been superseded by OCIO IT Security Incident Communication policy 143, located here: https://ocio.wa.gov/policy/it-security-incident-communication. HCA will manage reporting as required by the OCIO policy 143. It is expected ASB(s) will notify HCA of any security or breach issues in a timely manner, in accordance with the terms of the contract, and state and federal law.

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66	Exhibit E	5.15 / Attachment 5	As an outside entity contracting with the state of Washington, how will the state's Identity Management and User Authentication Standards impact Bidder's own internal Access Control and User Verification Standards? For example, any portal implementations that must be integrated, access controls for data exchange, etc.?	Any system that processes, stores, or transmits HCA-owned Data must comply with the state's user identity and access management standards. This includes portals and any other form of data exchange.
67	Exhibit E	5.15.1	Will there be further insight and guidance as to the extent of the "Security Design Review" process; and if there is any involvement with the HCA in defining how Bidder's can best participate in the review process (beyond providing documents and artifacts listed in the requirements)? Noted is that we have seen this link: https://designreview.ocs.wa.gov/ but it does not seem to work.	An HCA security engineer will work closely with any ASB(s) to facilitate the security design review process. This process involves reviewing each line item of the OCIO's security standards to document how the proposed solution complies. Areas on non-compliance will need to be mitigated prior to the solution's implementation.
68	Exhibit E	6.2	Regarding other payment methodologies: seems to indicate a preference to move away from this reimbursement model. Is HCA anticipating the successful bidder to transition to an alternate payment model?	HCA is interested in Bidder's experience with alternate payment methods to see potentials for innovation in the Managed Care Dental Program. In the initial contract, HCA is not contemplating an alternate payment methodology, however in future contracts HCA is committed to exploring value-based purchasing.
69	Exhibit E	6	May Bidders rely on the experience of their affiliates and parent company for Bonus questions if those organizations will be involved in the provision of services under this contract?	Yes.
70	Exhibit F	Narrative	Please confirm what specific ABCD, DAP, and OHPP costs HCA will calculate into the final rate. Are these costs considered a pass-through?	Please refer to the Dental Data Book narrative, pages 9-10, and 14.
71	Exhibit F	Narrative	T2035 (Mobile Anesthesia facility fee) is identified in the Dental Databook Narrative as a Claim Payment Enhancement to be paid outside of the risk-based capitation rates. However, per the Cost Model & Cost Template, this cost is included under Class II and thus the total cost included in the Cap rate. Shouldn't this be excluded?	While the mobile anesthesia service does receive a claim payment enhancement, it is included in the risk-based capitation rates. Page 8 of the narrative correctly defines included claims.
72	Exhibit F	Narrative	The Dental Databook Narrative states that bidders are not to supply proposals for Capitation Add-Ons such as the Oral Health Pilot Program (OHPP), however also states that bidders are responsible for evaluating the funding level of OHPP based on expected cost of the program. Is this suggesting that if the bidder believes the $1M in funding for OHPP is insufficient to cover its cost, the bidder should not bid on the regions where it is to be offered? Or will there be subsequent discussion between the HCA and the bidder on the feasibility of implementing the program?	The $1M funding will be included in the capitation rates for affected regions but the allocation has not yet been developed. Bidders are responsible for reviewing historical experience and determine whether to bid in those regions given this funding level compared to expected experience. If a Bidder submits a proposal for a region, but does not think the allocation is adequate after it has been released, the bidder may choose to not accept final proposed rates.
73	Exhibit F	Narrative	The Dental Databook Narrative states under ABCD Expansion that Attachment 2 contains a field for a DD Flag, but that field is not found. Can HCA please clarify the reference made here?	The correct reference is Attachment 3. Attachment 2 does not contain this field.
74	Exhibit F	Narrative	The Dental Databook Narrative states that ABCD providers are paid enhanced fees. Generally enhanced fees have been identified as being covered by HCA outside of the risk-based capitation rate (e.g. Clinic and DECOD SBEs). Is that also the case for ABCD enhanced fees or is the bidder responsible for those payments? If the latter, what are the enhanced fees and how are they determined?	The Bidder will be responsible for the enhanced ABCD fees for children under age 6. These are included in the risk-based monthly capitation rates and in the historical experience provided in the Dental Data Book. For a complete fee schedule and provider billing guide, please refer to the HCA website.
75	Exhibit F	Narrative	The Dental Databook Narrative states that under Network Inputs the expectation is for the utilization rate (and thus the capitation rate) to increase as network capacity increases. However, the capitation rate is on a PMPM basis and is stratified by risk category. Because of this, it does not seem reasonable that increases in membership volume within the same risk category would necessarily increase the rate of utilization and per member cost. For example, if SCHIP members aged 0-2 in Region 1 are expected to cost $7 PMPM, that expectation would not reasonably change whether there are 10,000 members or 40,000 since the risk category is the same. Can HCA please clarify the intent behind the utilization factor input by network capacity level, and why the expectation is for the utilization rate to increase through the 3 different levels?	Please refer to page 12 of the Dental Data Book narrative. The capitation rate adjustment factors are not intended to reflect an increase in membership, but rather an increase in utilization per eligible Enrollee as network capacity increases to provide access for more Enrollees to become utilizers.

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76	Exhibit F	Narrative	Page 14 of the Data Book Narrative says that Milliman/HCA will be responsible for developing population acuity factors that reflect participation of voluntary populations. The only voluntary population described in the Data Book Narrative are AI/AN enrollees, and in that section on page 7 of the Narrative it states "bidders are responsible for developing assumptions to support the development of cost proposals." Can you confirm that Milliman/HCA will develop the utilization and unit cost population acuity adjustments in the Cost Proposal Template?	Milliman/HCA will be responsible for population acuity factors associated with the participation of voluntary populations.
77	Exhibit F	Narrative	The Data Book Narrative states on Page 11 that cost proposals will be evaluated at the composite base rate level for each RSA. This appears to be a different method than the provided "Cost Proposal Scoring Sheet" example, which evaluates at the program level for each RSA. Can you confirm that the method shown in the "Cost Proposal Scoring Sheet" example will be the basis for scoring the Cost Proposal section of the RFP?	The method shown in the "Cost Proposal Scoring Sheet" example will be used to score the base rate proposed by the bidder in each region. Although the example only showed one set of rates being scored, a separate scoring sheet will be completed for each region. Please see the note in row 14 on the Summary tab that says "The base rate for each program for each region will be entered in the highlighted cells on the tables on the remaining tabs."
78	Exhibit F	Attachment 1, Data Dictionary	What type of services fall under the 'Unclassified' procedure class? There appears to be material cost in this category, particularly in lower age groups, so more detail would be necessary to properly evaluate cost expectations.	Please refer to Attachment 1 of the Dental Data Book, the data dictionary. The tab [Class Mapping] fully outlines the services included as "unclassified" procedures. For children under 6, the code D9999, associated with ABCD services, is the majority of unclassified procedures.
79	Exhibit F	Attachment 3	Attachment 3 does not align with the rate groups in the Cost Template. For example the bidder cannot see detail behind the 0-2 age categories since data is grouped at age 0-20. Will the detail be provided so that the bidder can properly evaluate experience?	Additional data will not be provided.
80	Exhibit F	Cost Proposal Template	The Cost Template references a 'Lists' tab for categorizing the different risk categories in the Regional tab into the categories on the Network Inputs tab, however the Lists tab is not visible. Can that please be provided to help follow the formula and mapping correctly? See the Network Adequacy column in any of the regional tabs for an example of where this reference is made.	This tab will not be provided. Please follow-up if you have specific mapping questions that are not addressed in either the narrative or Attachment 1 to the Dental Data Book.
81	Exhibit F	Cost Proposal Template	Cell A44 - Please confirm that this should read "Gray shading with blue black font = respondent input optional, assumptions will be provided by HCA and will be uniform across all bidders	Confirmed. This is a typo in Dental Data Book, Attachment 4.
82	Exhibit F		Can HCA provide an estimated amount for the DAP PMPM add-on? What historical level of supplemental payments have been made to University of Washington School of Dentistry that would be expected to be funded by adjustments to the risk-based monthly capitation rate after January 1, 2019?	This payment has not been made historically. We will not provide additional data at this time regarding DAP.
83	Exhibit F		It is critical that we receive county-level, product-level, and member-level fields for claim utilization in order to meet RFP requests and price effectively by region, product, age-grouping, and service class. We request additional fields	No additional data will be provided.
84	Exhibit F		Why are these two inputs in the data book separate: 1. FFS Fee Schedule: This factor should reflect expected utilization increases related to increased access as a result of increasing provider reimbursement relative to the FFS fee schedule. 2. Network Adequacy: this factor should reflect expected utilization increases related to increased access as a result of expanding dental provider networks.	If Bidder has contracted at rates higher than HCA's FFS fee schedule, Bidder should indicate the rate factor that is related to higher reimbursement amounts. If Bidder expects to have increased utilization levels that result from Bidder's network capacity, Bidder should indicate the resulting factor to be included in the rates here.
85	Exhibit F		Are the clinic rates for each FQHC available?	Yes. Please see: https://www.hca.wa.gov/billers-providers/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules#f FQHC -> Encounter Rates -> April 1, 2018 - present. Filter by "Category of Service" for "Dental Services"
86	Exhibit F		What will the enhanced payment be for the Oral Health Connections Pilot Program?	The enhanced rates for the Oral Health Connections Pilot Program will be a 57% increase from the current fee-for-service schedule, for the enhanced CDT codes.
87	Exhibit F		Is DECOD for both disabled children and adults?	Yes. DECOD is for serving both children and adults.

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88	Exhibit F		Can HCA please confirm that Dental Access Payments (DAP) are excluded from the Cost Model and Template? These are not specifically identified like Clinic and DECOD enhanced payments, so it is unclear where the costs associated with DAP are represented if at all.	We confirm that DAP is excluded from the data book. Payments have not been made for DAP historically, so there is no data to report.
89	Exhibit F		Since it is expected that the bidder meet the Level 1 Readiness Requirements regarding network capacity, does that mean that the starting cost assumptions and capitation rates should reflect that Level (in other words, the Network Inputs for Level 1 should all be 1.00)?	Starting cost assumptions should reflect Level 1 network capacity. Level 1 inputs should not necessarily be 1.0. Rather they should reflect the increase needed to obtain Level 1 network readiness relative to base data network capacity.
90	Exhibit F		If the bidder's network capacity is better than expected at the evaluation period, will the capitation rates be adjusted to reflect that? For example, at Level 1 evaluation the bidder may already be at the Level 2 requirement of 35% adult capacity but the Cost Template reflected an expectation of the Level 1 required 25%. Would the bidder be paid the Level 2 capitation rate to reflect that favorable position?	The Bidder can reflect a higher-than-required network level using the "Other Adjustment" columns in the Cost Proposal Template. This way, the starting capitation rate can reflect estimated cost of the increased network. If this option is taken, please describe these adjustments in detail in the supporting memorandum. Factors input on the [Network Inputs] tab should reflect the standard capacity levels outlined in the data book (and therefore may be more or less than 1.0).
91	Exhibit F		Is it reasonable to assume that the underlying unit cost in the Cost Model & Cost Template reflects a unit cost equal to 100% of the state Medicaid fee schedule?	Yes.
92	Exhibit G	General	How should Bidders handle subcontractors when submitting the Data Share Agreement? The DSA says we must have HCA approval for all subcontractors.	Please include a list of subcontractors to the RFP Coordinator either when you submit your Data Share Agreement, or before sharing Data with such subcontractors. HCA will review and, if appropriate, approve the list in accordance with stated procedures. No HCA Data shall be shared with any third-party until and unless approved in writing by HCA.
93	Exhibit G	General	Requires Bidders to affirm, using the form of page 26, that data used in the preparation of the RFP is destroyed or returned to HCA. Please confirm the timeline by which you seek to receive confirmation that this action has taken place.	Please refer to Exhibit G, Section 8.3. HCA will request Certificate of Disposition upon announcement of ASB(s), or when otherwise deemed appropriate in HCA's sole discretion
94	Attachment 1	1	EPSDT and Medical Necessity definitions In the most recent draft contract changes circulated to advocates, both of these definitions had changes made by HCA that advocates believe are very important. These changes do not appear in the draft dental contract. We ask that HCA replace those definitions with the ones being finalized in the AH MCO contract. Question: Can HCA make the pending changes to the AH contract templates effective for this contract?	HCA will review all definitions to ensure alignment with other managed care contracts and Washington Administrative Code (WAC).

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95	Attachment 1	1	It is unclear if HCA intends for the definition of "subcontractor" to include providers. If the definition of subcontract is intended to refer to providers, then the following comments and questions apply: 1. Subcontractor - the definition apparently includes Participating Providers (1.121). The related definition of Contractor (1.30) extend the definition of "Contractor" to include a subcontractor's owners, employers, etc. It would be appropriate to restrict extension to relevant matters within the performance of the subcontract. The employees of the subcontractor cannot be expected to perform the Contractor's obligations. 2. Financial Records. Section 2.15.1, there is a requirement that "All financial records must follow generally accepted accounting principles." (GAAP). This apparently applies to Participating Providers. It is likely most small practices keep records on modified cash basis, and it would be a burdensome effort to convert such financial records to accrual basis GAAP. In some respects, it may be nearly impossible. If this requirement applies to the providers' financial records, it could discourage participation by dentists. Audit requirements such as Section 9.4.7 should allow for practical limitations of the GAAP covenant. 3. Solvency. Section 2.32, the contract should clarify that the solvency requirements do not extend to the providers as subcontractors. This relates to the Contractor definition as stated above. As an example, a small dentist practice may not retain a positive net worth in excess of two months' operating expenses (Section 2.32.4). Section 9.2 should be clarified. 4. Audits. The audit provision appears in several locations within the contract. These should be reviewed and revised from a provider's perspective so that it is clear what the provider must maintain as records, taking into account the provider's limited role and the GAAP issue discussed above.	Questions will be addressed in the order they were asked. It should be kept in mind that this contract is between HCA and a MCE and that much of the language in the contract is required by state or federal regulations. While some of the requirements in the contract are carried forward to subcontractors, most terms of the contract apply to the contracted MCEs. HCA would expect MCEs to include specific terms in their subcontracts and to ensure compliance by the subcontractor with those requirements. 1. Contractor/Subcontractor: There is no expectation by HCA that a subcontractor would perform the duties of the Contractor, except those detailed in the subcontracting agreement. 2. Financial Records: Subcontractors do not include participating providers; however, HCA would expect providers to keep adequate records to assure the Contractor and any auditors that there is no fraud, waste, or abuse. 3. Subsection 2.32 does not apply to providers or subcontractors. Section 9.2 applies only to those subcontractors at financial risk under this contract, which is unlikely for small providers. 4. This is a risk-based contract governed by federal regulation, between HCA and a MCE. HCA is unable to revise language to reflect a provider's perspective since the contract is between HCA and the MCE(s).
96	Attachment 1	1	1.88, Non-Covered Service definition uses teeth whitening as an example of a benefit "included in a Washington Apple Health Benefits Package." Should it say "not included?" It is vague as written.	Definition 1.88, Non-Covered Service, should read: "Non-Covered Service" is a specific health care service (e.g. teeth whitening), contained with a service category that is not included in a Washington Apple Health benefits package. HCA or HCA's designee requires an approved Exception to Rule (ETR) for payment of a Non-Covered Service. A Non-Covered Service is not an Excluded Service.
97	Attachment 1	1.91	What are the state's plans to update One Health Port to accommodate Dental Benefit Administrators?	HCA is exploring updating OneHealthPort for these purposes, but there are no current timelines, or plans to do so.
98	Attachment 1	2.4.1	Will the contractor be expected to use the most recent updated version of the Current Dental Terminology (CDT) Codes? The use of these codes allow for uniformity, consistency, and specificity in accurately documenting dental treatment.	Yes.
99	Attachment 1	3.1.5.1	Can HCA please clarify about materials in different languages. Is it the top X% of assigned Medicaid membership, or a percentage of the entire state population?	It is determined by Regional Service Area.
100	Attachment 1	3.1.11	Is the contractor allowed to distribute samples and supplies (e.g. toothbrushes) at the community events?	Yes.
101	Attachment 1	3.2.8	How will HCA report the covered members who are eligible to receive Maternity Support Services (MSS) through the HCA First Steps program to dental carriers?	Currently these members are not separately identified on the 834 or by similar mechanism. There is no type of specific indicator in the system that identifies these members. HCA expects MCE(s) to refer known pregnant Enrollees for these services, however HCA does not expect MCE(s) to be the primary source for referral.
102	Attachment 1	3.3.2.1.3	Does the member eligibility file contain information related to the language spoken and language written in order to determine the language for materials?	If it is provided to HCA by the Enrollee, it is provided to Contractor(s) in the 834 file. Since this is self-reported information, Enrollees do not always disclose their preferred language if it is other than English.

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103	Attachment 1	3.5	"Contractor will develop materials to inform all providers and Enrollees that prescriptions will be covered under Apple Health medical." Is this disclosure required to be in the member handbook only?	Contractor(s) may provide this disclosure in the member handbook, or any other Enrollee materials.
104	Attachment 1	4.1	4.10.4.1.1, Involuntary Termination. The long period for consideration of an involuntary termination request, as stated, could jeopardize safety of staff and others. Thirty business days would amount to five or six weeks in total. Additionally, the contract should provide the basic criteria that enables a provider to terminate a contract with either the Contractor or Enrollee. For example, the contract allows for Contractor(s) to terminate Enrollees for specific reasons. Please clarify how the ability of a provider to terminate a patient, such as for missed appointments, will be addressed. Under what circumstances will providers be able to terminate their contracts with Contractor(s)?	Medical providers discharge patients who are enrolled with the Apple Health MCOs when their behavior presents a risk to the provider and their staff, or has missed a number of appointments. Dental providers may want to ensure that requirements around discharging patients and contract termination are addressed in their contract with the MCE. The process of an MCE requesting termination of an Enrollee for cause may start with a provider discharging the Enrollee for threatening or inappropriate behavior.
105	Attachment 1	4.7.2	"HCA will assign the clients who do not select a plan." What method will HCA use to assign members if there are multiple dental carriers available in a given region?	For the first year of the program, HCA will equally distribute new Enrollees amongst Contractor(s). The goal for year two is that HCA will utilize network adequacy information, improvement in achieving quality measures, and percentage of Initial Health Screens to assign new Enrollees.
106	Attachment 1	5	Will the FQHC enhancement payment be included in the 85% HBR calculation?	No. They are not included in either side of the equation.
107	Attachment 1	5.1	This section indicates payment for new enrollees will be denied if it is denied by CMS. Is the contractor still expected to provide dental services for the denied new enrollees?	No. HCA doesn't expect Contractor to provide services to ineligible Clients. Enrollment of these clients will be terminated.
108	Attachment 1	5.4	"The Risk Corridor and Gain Share Settlement (RC&GSS) is defined as the Target Benefit Ratio (TBR) minus the Actual Benefit Ratio (ABR), with the TBR defined as the Benefit Ratio presented in the Contractor's submitted cost proposal." This cost proposal would already include consideration for profit. Please confirm that the RC&GSS would only apply to gains in excess of the included profit in the TBR. For example: assume the TBR is 90% and includes consideration for 2% profit. If the ABR is 86%, this would be 4% favorable to the TBR, and equate to 6% profit. The RC&GSS shares gains equally in the 3-5% range below the TBR. Under this scenario, HCA would recoup half of the 1% of gain in that range, or 0.5%, and the Contractor would be left with a 5.5% gain. Conversely, a 94% ABR would result in the HCA reimbursement to the Contractor of 0.5% (in the first year where downside risk is shared. Please clarify.	The model contract will be updated to reflect a target benefit ratio selected by HCA which is consistent across all contracted plans. The ratio may vary by aid category, in which case the composite target benefit ratio may vary by plan based on the distribution of enrollment.
109	Attachment 1	5.4	5.4.3.1, Payment. Please consider whether fraud prevention activities should be considered an administrative cost rather than a benefit expense.	For purposes of calculating Risk Corridor and Gain Share settlements, benefit cost is defined consistent with 42 CFR 438.8(e), which includes fraud prevention activities as defined in 42 CFR 438.8(e)(4): MCO, PIHP, or PAHP expenditures on activities related to fraud prevention as adopted for the private market at 45 CFR part 158. Expenditures under this paragraph must not include expenses for fraud reduction efforts in paragraph (e)(2)(iii)(B) of this section. For purposes of capitation rate development, all non-benefit cost (such as fraud reduction efforts) should be considered administrative in nature.
110	Attachment 1	5.4	Would tax implications be an incentive for Contractor(s) to be non-profits because there would be more funding for benefits if tax liabilities are lessened?	HCA will not opine on potential tax implication incentives. This question is not relevant to the contract or the risk mitigation settlement calculations.

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111	Attachment 1	5.4.4	"Risk Corridor and Gain Share settlements will be calculated six (6) months following the end of the Contract year, using the financial reports provided by the Contractor." Is there an allowance for IBNR/completion at this time? If so, who determines the appropriate factor (HCA, Contractor and/or HCA's actuary) and what is the process for approval of the final factor to be used? What template is required for the Contractors to use for "financial reports"?	Provision for IBNR/completion will be included in the settlement calculations. The financial report template will be distributed at some point between May and July to collect information from each plan during the previous calendar year. As part of this report, plans will provide claim lag triangles with estimated claims completion by month and population aid category. HCA's actuary will use encounter data to validate submitted benefit cost and completion estimates. As long as the two estimates of ultimate incurred claims are comparable, the settlement calculation will rely upon the plan financial reports. Any adjustments to plan-reported information in the settlement calculation will be documented in the accompanying draft report, and plans will have up to seven days to inquire about draft calculations.
112	Attachment 1	5.4.7	"If the final calculation of risk corridor or gain share settlements results in an adjusted Actual Benefit Ratio below 85%, Contractor will remit the full amount of the difference such that the final adjusted Benefit Ratio is 85%, as authorized under the minimum MLR requirement defined in 42 C.F.R. § 438.8(c)." Please confirm that the MLR calculation is based on the aggregate business for all membership age groups and not by age band and/or region (for example).	Confirmed.
113	Attachment 1	5.5	Will a report be provided to the contractor indicating which enrollees have been retroactively terminated?	HIPAA compliant reports are available to all providers related to enrollments and terminations. See the "834 Benefit Enrollment and Maintenance" companion guide at this link: https://www.hca.wa.gov/billers-providers/prior-authorization-claims-and-billing/hipaa-electronic-data-interchange-edi
114	Attachment 1	5.8.1.2	""Encounter Data" means records of health care services submitted as electronic data files created by the Contractor's system in the standard 837 format and the National Council for Prescription Drug Programs (NCPDP) Batch format." Please explain how the NCPDP format is relevant to this contract	The NCPDP format is one of the standardized formats used by HCA, in addition to the 837 format. This standardization is an agency requirement, regardless of the benefit being provided, and is thus included when referencing any type of encounter data submission to the agency.
115	Attachment 1	5.8.2.2.3	This section mentions ProviderOne System Edits. Where can these be found?	Encounter edits can be found in the Encounter Data Reporting Guide, here: https://www.hca.wa.gov/billers-providers/programs-and-services/resources
116	Attachment 1	5.8.3	Does the contractor have to report the amount paid by other coverage?	Please refer to Attachment 1, Section 18.2 for information on TPL. The HIPAA Implementation Guides are standard and MCE(s) must purchase them. HCA's HIPAA Companion Guides for Encounter Submissions do require Coordination of Benefits (COB) information to be entered, when applicable. HCA's supplemental (state-specific) Encounter Guide(s) are available here: https://www.hca.wa.gov/billers-providers/programs-and-services/resources. Please note these have not been updated to include Dental yet. HCA is currently in process of updating the Encounter Guide(s).
117	Attachment 1	5.17.1	"If the Contractor fails to meet one or more of its obligations under the terms of this Contract or other applicable law, HCA may impose sanctions by withholding from the Contractor up to five percent of its scheduled payments or may suspend or terminate assignments and re-enrollments (defined as connecting an Enrollee who lost eligibility with the Contractor which he or she was enrolled in when he or she lost enrollment)." Will HCA please provide guidance or examples on how the 5% withhold (or subset of 5%) of scheduled payments would be applied for missing one or more of its contract obligations?	HCA would withhold a percentage, up to 5%, of the monthly premium payments until the breach of contract has been cured. Sanctions payments are processed via gross-adjustments to the weekly payment batches to Contractors.

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118	Attachment 1	5.18.2	"Upon receipt and acceptance of an encounter for a qualified service provided at an FQHC, RHC, or IHCP facility, HCA will pay the Contractor a Service Based Enhancement (SBE) payment equal to the difference between the applicable FFS amount for the encounter and the full encounter rate." Does this section mandate that the Contractor must pay the full encounter rate to these providers up front, but ultimately HCA will reimburse the Contractor for the difference between that encounter rate and the applicable FFS amount? When and how will this reimbursement (SBE) be administered? How is the 'applicable FFS amount' calculated - is this according to the State Medicaid fee schedule?	HCA anticipates that MCE(s) will pay FQHCs/RHCs their full PPS rate for qualifying face-to-face dental visits. HCA will reconcile with MCEs for the SBE portion of the claim (T1015 enhancement amount), which is the difference between the contracted amount and the clinic's PPS rate. Reconciliation will be performed regularly, but not less frequently than quarterly. Applicable FFS amount is the contracted payment between the MCE and the FQHC.
119	Attachment 1	6	How does Washington HCA want Managed Care Entity (MCE) to treat Main Dental Home/ First Dental Home?	In accordance with federal regulation, MCEs are required to assign each Enrollee to a primary care (in this case: dental) provider, who is the manager of that Enrollee's care.
120	Attachment 1	6	Network. The Contract should allow for participation by willing providers on a broad basis. Article 6 should encourage that participation.	This contract is between HCA and the MCEs. HCA's managed care contracts comply with the requirements of 42 C.F.R 438.12 and 438.214, which provide detail on provider contracting requirements. Thank you for the suggestion.
121	Attachment 1	6.6	The 24/7 Availability indicates the need to provide services 24/7 by telephone. Is there an option to provide these services via on-line/internet based service? Is an IVR message referring members for emergent care allowable?	24/7 telephonic availability is required. Contractor may provide online/internet based service in addition to the telephone requirement.
122	Attachment 1	6.7	What percent of calls are to be answered within 30 seconds?	Please refer to Attachment 1, Section 6.7.
123	Attachment 1	6.7.2	What are the Quality monitoring requirements for the Contact Center? Does the state have its own score card?	Please refer to Attachment 1, Section 6.7.2.
124	Attachment 1	6.7.2	What are the reporting requirements for the Contact Center, reporting templates were not provided. Are we to provide reports for both enrollees and providers?	Subsection 6.7.2 is about the customer service performance standards, and there is no contractual reference to a "Contact Center." For Subsection 6.7.2, the Contractor is responsible for reporting: 1) provider help desks, 2) authorization lines, and 3) Enrollee Customer Service centers, separately for both the abandonment rate and response time.
125	Attachment 1	6.7.2	What is the turnaround time for written correspondence and email inquiries?	HCA will address this at a later date.
126	Attachment 1	6.7.2	Are there any Performance Guarantees for the Contact Center besides Abandonment Rate and Service Level?	Please refer to Attachment 1, Section 6.7.2
127	Attachment 1	6.8.4	6.1, Acceptance of New Patients. Please clarify whether corresponding appointment standard obligations will be required of the provider, which may be difficult under certain circumstances. For example, in regard to emergency care availability (Section 6.8.4) the contract should clarify how this translates to provider availability; will Contractor(s) have the ability to require their contracted providers to be available 24/7? If so, this could be a deterrent to providers joining the network. Additionally, some providers schedule patients months in advance and may not be able to accommodate a schedule.	MCEs are required to have 24/7 access. HCA does not expect dental providers to be on-call 24/7. Many small medical provider groups and individual providers refer clients to urgent care or the emergency room after hours, or request clients leave information for the provider to return the call the next business day.
128	Attachment 1	6.14.1	This section indicates the contractor shall arrange for necessary services with the nearest qualified specialist outside the contractor's network willing to see an enrollee. Does HCA have to approve the specialist?	No.
129	Attachment 1	6.15	"The Contractor shall contract with an adequate number of Independent Hygienists to ensure Enrollees in health care facilities, senior centers, and schools have access to authorized dental hygiene operations and services without dental supervision." Will the carrier be required to have a separate contract with each Independent Hygienists and pay directly for claims submitted by the Independent Hygienists?	Yes. Independent Hygienists should be contracted with in the same manner as any other dental professional.

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130	Attachment 1	7	Utilization standards It was not clear to us that an increase in utilization over fee-for-service utilization, and an increase in year 2, is required or rewarded during the first 2-year dental managed care contract. We didn't see any assignment changes or payment structure set up to incentivize increases in utilization. The RFP materials also do not indicate that utilization increases would be a factor in decisions to extend contracts. Network adequacy standards are very important to help assure access to care. But a significant objective of this contract (and goal of the legislation) is to increase access, not just to maintain a level of contracted providers. Failing to incentivize utilization increases misses a significant opportunity to pursue and achieve that goal. Worse, in a system in which increased utilization does not increase payment to the plan (because the payments are based on the number of enrollees, not utilization measures), the contract provides a disincentive to increase access. Question: Can HCA address utilization increase as a factor in the scoring, in year 2 assignments or payments, and/or in contract extensions, before the contracts are finalized?	The goal of this RFP is to implement a Dental Managed Care Program. One way of increasing utilization is to increase access to care. HCA fully intends to take increased utilization into account when monitoring Contractor performance.
131	Attachment 1	7.1.1.2	QAPI program structure, indicates (7.1.1.2.1.3) "Contractor staff and practicing provider committee participant titles." Does that mean a joint committee of independent WA Dentists along with Bidder staff? Or could a practicing dentist be a Bidder-employee?	The Contractor must have a QAPI committee with participants that include both staff and external practicing providers. Practicing providers, who are employees, alone are not sufficient to meet this expectation.
132	Attachment 1	7.3	Performance Measures. Please explain who is required to make the risk assessment, Contractor or provider. Please address whether these performance metrics align with the Dental Quality Alliance as well as from which source they were obtained. Additionally, if/when any payments to the Contractor will be increased as a result of the achievement of quality measures, those payments should be passed on to the providers who helped achieve those results.	HCA does not anticipate increased payments to Contractors or providers during the first year of the contract. The first year of the contract will be considered the baseline year for performance measures. Information that enables a Contractor to make the decision as to whether an Enrollee has an "elevated" risk will be provided in the claims data sent to Contractors as part of the contract implementation process.
133	Attachment 1	7.6	Critical Incident Management System, "The Contractor shall establish a Critical Incident Management System consistent with all applicable laws and shall include policies and procedures for identification of incidents, protocols, and oversight responsibilities. The Contractor shall increase intervention for an Enrollee when incident behavior escalates in severity or frequency. The Contractor shall designate a Critical Incident Manager responsible for administering the incident management system and ensuring compliance with the requirements of this section." Under what circumstances would the Dental Insurer be in a position to "increase intervention"? This does not seem to be applicable to the requirements of a dental carrier since we do not handle behavioral or mental issues that may occur with enrollees. Please advise if this should be removed from the dental contract?	HCA is reviewing this language for updates.
134	Attachment 1	7.7	Practice Guidelines. Please explain how these national guidelines were chosen. Please provide clarification of "when applicable" in Section 7.7.2.3.	HCA is reviewing acceptable national guidelines. Subsection 7.7.2.3 "when applicable" is relevant when contract language 7.7.2 applies: "If the Contractor does not adopt guidelines from recognized sources, board-certified practitioners must participate in the development of the guidelines."
135	Attachment 1	9.11	Provider Credentialing. Is the Contractor required to inform providers of the credentialing committee's decision within 15 days of receiving a completed application, or within 15 days of credentialing committee meeting (9.11.4)?	Section 9.11.4 requires the Contractor to notify providers within 15 calendar days of the credentialing committee's decision.

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136	Attachment 1	10.3.2	"The Contractor will allow, to the extent possible and appropriate, each new Enrollee to choose a participating PDP (42 C.F.R. § 438.3(l))." Is the dental home assignment requirements to a PDP applicable to all populations, both children and adult?	Yes. CMS managed care regulations require all managed care Enrollees have a primary care/dental provider.
137	Attachment 1	10.3.2	Enrollee Choice. Please confirm Contractor will not deny payment for services rendered if Enrollee elects to change Contractors.	If the Enrollee changes plans, all services provided prior to the change will be paid for by the original MCE. If the Enrollee changes plans and receives services from a provider who does not have a contract with the new MCE, the new MCE can decline to pay for the service or can offer the provider a contract. Orthodontics will remain the financial responsibility of the original MCE.
138	Attachment 1	11.2	Utilization Management General Requirements. The contract should specify that board-certified specialists shall be a specialist within the same specialty of the licensed dental healthcare professional seeking a determination of medical necessity (11.2.2). The contract should provide more clarity regarding "whenever possible" (11.2.4.4).	Contract and CFR address this concern as UM staff making decisions to deny a service are required to have "appropriate expertise in addressing the Enrollee's oral health needs" (Subsection 11.2.1). Dental healthcare professionals denying services must have appropriate expertise (e.g., highly specialized situations may require a sub-specialty reviewer). The MCE is responsible for ensuring access to a variety of reviewers as the need arises. Thank you for the suggestion to add more clarity. We will take this into consideration.
139	Attachment 1	11.6	Notification of Coverage and Authorization Determinations. When notifying an ordering provider of an adverse benefit determination (11.6.1), the contract should require Contractor(s) to notify the provider in writing.	Thank you for the comment. HCA is currently reviewing all MCE contracts to ensure consistency in these expectations
140	Attachment 1	13.1	Grievance and Appeal System. Within the general requirements it states: "Provider claim disputes initiated by the provider are not subject to this Section." Please then clarify where provider claim disputes are addressed and in what way.	CMS regulations require grievance and appeal systems for clients. MCEs and providers should negotiate provider grievance and appeal process with their contracting arrangement(s). HCA does not determine contractual relationships between MCEs and providers.
141	Attachment 1	18.2	Primary Insurance. Please confirm that the Contractor will pay claims for services not covered by primary insurance that are covered by the Contractor.	Yes.
142	Attachment 1		Will enrollment in the managed care dental program be "earlier enrollment" the same as in the medical managed care programs?	Yes. If, for example, a person becomes eligible for Medicaid managed care programs on May 10, they would be enrolled in the Managed Care Dental Program effective May 1. Eligible Enrollees will be enrolled on the first day of the month in which they become eligible.

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#	Document	Section	Bidder Questions	HCA Answers
143	Attachment 1		Would like to see the following clauses incorporated into the contract - or if HCA believes they have already addressed such items, please clarify as to where in the contract each item is addressed: 1. Allowing any willing provider to participate in the Contractor's network (mentioned above). 2. Allowing all providers currently enrolled in the Medicaid program to participate in the Contractor's network(s). 3. Requiring Contractor(s) to utilize a single, uniform credentialing process. 4. Allowing for an appeal process for providers not credentialed upon initial application. 5. Prohibiting any Contractor(s) that also provide private insurance in Washington state from requiring providers to participate in the Medicaid program in order to remain or join the Contractor's private insurance network. 6. Requiring an annual report of administrative expenses versus expenses spent toward clinical care to allow for transparency to ensure limited state funding is properly spent. 7. Requiring reporting metrics related to program administration on a quarterly basis that includes: network size; average time to make payment of claims; accuracy of paid claims; response time in provider call center; response time in enrollee call center; missed calls in each center; accuracy of provider directory; grievance and appeals resolution; and credentialing times. 8. Requiring Contractor(s) to monitor provider satisfaction through annual assessments of network surveys. 9. Requiring Contractor(s) to develop a method for providers to complete a "self-assessment" using the Contractor(s) database.	Questions will be addressed in the order they were asked. 1. HCA's managed care contracts comply with the requirements of 42 C.F.R 438.12 and 438.214, which provide detail on provider contracting requirements. 2. It is up to the MCEs and the providers to decide to enter into contracts. 3. The state is currently working with medical MCOs to develop and encourage a uniform credentialing process; however HCA cannot require MCOs/MCEs to have a single process. 4. MCEs generally have an appeal process for providers who have been denied credentialing with the MCE. 5. Many MCEs have standard contracts that require providers to participate in all lines of business; however most are willing to negotiate a contract for a single line of business with individual providers. 6. HCA receives a number of reports related to expenditures. Attachment 1, Section 5, describes in detail the process for ensuring at least 85% of funds are spent on direct services. 7. HCA already requires receipt of quarterly network reports, and encounter data (relate to claims and service provision). The other reports referred to are addressed in the annual TEAMonitor process, which is a document review/onsite program audit that reviews the listed documents and reports. 8. MCEs conduct their own provider satisfaction surveys and other provider monitoring activities. 9. Providers would need to discuss with ASB(s) after contract award to gain access to this information, if available. HCA is prohibited by CMS from directing the daily business of MCEs to this level.
144	Attachment 1		FQHC/Essential community providers access The RFP requires offers of contracts to IHCP dental providers, but we found no similar requirement for dental providers in FQHCs, RHCs, or other essential community providers, and no requirement that the contractors offer access to at least one FQHC in the service area. Instead, section 3.4 of the RFP addresses bidder points for provider network issues generally. Of the 480 points awarded in that section, 16 points relate to this question: "How will Bidder's organization ensure Enrollees have access to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for dental services?" We also found in Exhibit E, Work Plan section 5.13, that up to 24 points of a total of 512 could be awarded for coordination/communication planning relating to FQHCs and RHCs. Questions: Does HCA anywhere in the contracting/RFP materials require that contractors ensure access to FQHC services in each service area? • If yes, please identify those requirements. • If no, what is HCA relying on to assure that access and utilization, especially for special populations, will not decrease? • And if no, how does HCA think the contract will avoid dismantling the publicly supported infrastructure for the access we have under fee-for-service?	It would only benefit potential Bidders to contract with FQHCs as they currently provide the bulk of dental services to Medicaid clients. HCA included language in Attachment 1, Section 6.1.2 requiring "sufficient choice and number of FQHCs/RHCs and/or private providers to allow Enrollee choice of service systems or clinics." HCA has no concerns related to a "dismantling" of the FQHC/RHC system based on this managed care dental contract.
145	Attachment 2		Details the available coverage for replacement of complete dentures. Does the current benefit program also include coverage for an initial set of dentures? If yes, please indicate the general policy and other requirements (e.g., prior authorization required).	Yes. One initial maxillary complete denture and one initial mandibular complete denture per client, per the client's lifetime. Prior Authorization is required.

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#	Document	Section	Bidder Questions	HCA Answers
146	Attachment 2		Limitations on silver diamine fluoride treatments. Proposed rule includes some limitations – but they are different from the ones in the spreadsheet attached to the contract. The filing proposed these changes to the rule: (7) Silver diamine fluoride. The agency covers silver diamine fluoride ((per application)), as follows: (a) Allowed only when used ((for stopping the progression of caries only;)): (i) For stopping the progression of caries; or (ii) As a topical preventative agent in lieu of the topical fluoride treatment found in WAC 182-535-1082(2). (b) ((May be provided)) Allowed two times per client, per tooth. Not to exceed six teeth per visit in a twelve-month period((; and)). (c) Cannot be performed and billed with interim therapeutic restoration on the same tooth when arresting caries or as a preventive agent. The spreadsheet suggests even more stringent limitations than those listed in the proposed rule language, limiting the service to six teeth per year instead of 6 teeth per visit. Advocates opposed the new limitations in the rule filing and provided evidence based reasons for the objection. For children, EPSDT bars making such an arbitrary barrier to services and would mean HCA would be required to offer the medically necessary dental services on a fee for service basis to supplement the contract. We object to the restrictions in he proposed rule as well as these more restrictive provisions in the contract as well as this more restrictive iteration found in the dental managed care contract. Question: Is there a way for HCA to revise this standard before the contract is finalized?	After stakeholder comments, HCA adjusted the proposed limitations. The new language reads as follows: Silver Diamine Fluoride The agency covers silver diamine fluoride per application as follows: *When used for stopping the progression of caries and/or as a topical preventive agent; *Two times per client per tooth in a twelve-month period; and *Cannot be billed with interim therapeutic restoration on the same tooth.
147	Attachment 5		Standards in this document are dated 2008. Are these standards still current? As part of this contract, will the winning bidder be working with the State of Washington Security and IT personnel to establish requirements and user roles for developing access privileges?	Yes, the document is still current and enforced. HCA and Washington Technology Solutions (WaTech) security staff will work closely with the ASB(s) during design and implementation.
148	Attachment 6	Appendix A tab	"Please provide information regarding each user type in the environment." Can HCA provide examples of what is considered a "user type?" For example, job role within Bidder's company, providers, members? Will there be access rights review prior to establishing access privileges within this environment?	User type examples include regular users, administrators, service accounts, etc. Requirements may vary depending on whether the user is internal or external to the State Governmental Network (SGN) or the application. User type documentation is one of the more involved aspects of the security design review process. HCA security staff will be available to assist in the documentation and review of all aspects of user access.
149	Attachment 6	Diagram tab	What is the scope and intent of the "Diagram" bidders are supposed to provide? Is this a systems network diagram? Are there requirements for bidders to diagram their infrastructure and how it may interface to the State of Washington's infrastructure?	Network diagrams are required to help demonstrate the security controls used to protect HCA Data. The scope of such documentation is only for those systems that store, process, or transmit HCA/State of Washington information. Documentation is not required (nor desired) for systems unrelated to HCA Data, such as infrastructure used to support other clients, or internal corporate operations.
150	General		Will HCA continue to publish the Medicaid Fee Schedule for dental after 2019?	Yes. HCA will still have a fee-for-service program.
151	General		Does HCA anticipate applying the VBC methodology to dental, with similar requirements for quality improvement, in the near future?	HCA will contemplate Value Based Purchasing when the Managed Care Dental Program contracts are well-established.
152	General		Does HCA have any guidance for MCOs that have risk arrangements? Are there any requirements for risk payments to dental provider networks?	HCA does not determine the contractual relationships between MCEs and providers. With some exceptions, HCA does not direct how MCOs/MCEs pay.

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#	Document	Section	Bidder Questions	HCA Answers
153	General		What will the provider relationship be with ProviderOne after January 1, 2019?	Providers will submit claims and reports to the MCEs for their Enrollees who are enrolled in the Managed Care Dental Program; they will not have the same connection with ProviderOne as under fee-for-service. Providers will continue to look up Enrollee eligibility in ProviderOne.
154	General		If a bidder bids in all 10 RSAs, is it possible that HCA would award a contract to the MCE for fewer than all 10 RSAs (assuming requirements such as network adequacy, etc., are met in each RSA)?	HCA's preference is statewide coverage, however HCA has no way to determine this prior to receiving and evaluating the proposals.
155	General		Will the ABCD members age 6-12 be flagged on the HCA eligibility files so we can pay the ABCD-certified provider(s) the appropriate amount based on the fee schedule?	ABCD eligible clients age 6-12 will be flagged with their DDA flag. That flag, combined with their age will identify them as eligible to receive the ABCD benefits.
156	General		Is the ABCD schedule only for ABCD-certified providers? Do non-ABCD-certified providers receive 20 and younger compensation on the HCA fee schedule when treating patients age 5 and under?	Yes. Only ABCD-certified providers receive the ABCD rates.
157	General		Is there a separate Independent Hygienist fee schedule?	No.
158	General		What ADA codes are the Independent Hygienists allowed to perform?	They are allowed to provide and bill for services within their scope as defined by Department of Health (DOH). Billable codes include: D0190; D0191; D1110; D1120; D1206; D1208; D1330; D1351; D1354; D4341; D4342; D4346; D4355; D4910; D9920.
159	General		Is there a complete list of ABCD providers in Excel format that can be provided?	This is available as part of the provider listing provided by HCA in February 2018, here: https://www.hca.wa.gov/about-hca/apple-health-medicaid/apple-health-dental-moving-managed-care Filter by Column "ABCD_PROVIDER" for "ABCD."
160	General		Is it required for the bidder to contract with providers with enhanced payments (FQHC & Tribal clinics, DECOD providers, Mobile Anesthesia providers, and ABCD providers) at a rate inclusive of the enhanced payment, and then be reimbursed by HCA? Or is that enhanced payment paid directly to the provider? If required to contract at that level, will more detail be provided on the enhanced payments so that the bidder can properly contract with these providers?	For FQHC/Tribes, Bidders must contract with these providers at or above the fee-for-service (FFS) schedule. MCEs should pay at the full FQHC/Tribal encounter rate (https://www.hca.wa.gov/billers-providers/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules#f) for qualifying dental face-to-face services for Medicaid clients. When reporting to HCA, MCEs should include both their contracted rate for the service provided, and the difference between the contracted rate and the full encounter rate in the encounter record. HCA will reimburse the MCE the difference between the contracted amount on each qualified encounter received/accepted and the full encounter rate for the clinic. The FFS dental fee-schedule and FQHC encounter rates are published. For ABCD, the full rate is part of the risk-based capitation payment. Bidders must contract with providers at or above the ABCD rate. The ABCD fee schedule is published. For Mobile Anesthesia, the claim rates are part of the risk-based capitation rate. MCE(s) must contract with providers at or above the current HCA FFS fee-schedule levels. Mobile Anesthesia is not an enhanced rate, but it does qualify for an additional Facility Fee ($312.15), which is paid in addition to the amount for the anesthesia service components of the claim. For DECOD, it is outside the capitation rates. The MCE will pay $154 for a qualifying visit and HCA will pay the MCE via SBE once a qualifying encounter is received/accepted.