RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

January 9, 2018

Prospective Vendor(s):

Subject: Solicitation Number: AHCA ITN 012–17/18

Title: Statewide Medicaid Prepaid Dental Health Program

Addendum No. 3

The enclosed information has been provided for consideration in the preparation of your response to the above mentioned solicitation.

All other terms and conditions of the solicitation remain in effect.

To the extent this Addendum gives rise to a protest, failure to file a protest within the time prescribed in Section 120.57(3), Florida Statutes, shall constitute a waiver of proceedings under Chapter 120, Florida Statutes.

Sincerely,
Jennifer Barrett
Jennifer Barrett, Chief
Bureau of Support Services

Enclosures: Addendum No. 2 (5 Pages)
Questions and Answers (37 Pages)

AHCA ITN 012-17/18
ADDENDUM NO. 3

Item #1

Attachment A, Instructions and Special Conditions, **Section D,** Response Evaluation, Negotiations, and Contract Award, **Sub-Section 4.**, Scored Requirements – Evaluation Criteria, **Item b.**, Technical Response Evaluation, **Table 3**, Summary Score Sheet, is hereby deleted in its entirety and replaced as follows:

Table 3 Summary Score Sheet			
	Maximum Raw Score Possible	**Weight Factor**	**Maximum Points Available**
Financial Information	20	10	200
Technical Response			
1. Respondent Background & Experience	60	4	240
2. Agency Goals	305	3	915
3. Recipient Experience	185	5	925
4. Provider Experience	125	5	625
5. Delivery System Coordination	210	3.5	735
6. Oversight & Accountability	325	1	325
Totals	1230		3965

Item #2

Attachment A, Instructions and Special Conditions, **Section E,** Contract Implementation, **Sub-Section 4.**, Transition Enrollment, **Item 4.**, Transition Enrollment, **Sub-Item b.**, Enrollees Who Do Not Make an Active Plan Choice, is hereby deleted in its entirety and replaced as follows:

b. Enrollees Who Do Not Make an Active Plan Choice

1) For the purposes of this Sub-Section, existing plan means a Prepaid Dental Health Plan that was subcontracted as a dental benefits manager for a Managed Care Plan under the SMMC 2014-2019 contracts and was awarded a Contract to provide services under the resulting Contract from this solicitation.

2) For the purposes of this Sub-Section, new plan means a Prepaid Dental Health Plan that was not subcontracted as a dental benefits manager for a Managed Care Plan under the SMMC 2014-2019 contracts, but was awarded a Contract to provide services under the resulting Contract from this solicitation.

3) The Agency will assign Medicaid recipients to a Prepaid Dental Health Plan by giving precedence in the following order:

a) The Agency will assign SMMC enrollees who do not make an active plan choice into their existing plan if that plan was awarded a Contract to provide services under the resulting Contract from this solicitation.

b) The Agency will automatically enroll into a new or existing prepaid dental health plan those Medicaid recipients who do not voluntarily choose a plan. When automatically enrolling recipients in new or existing prepaid dental health plans, the Agency shall automatically enroll based on the following criteria:

- Whether the plan has sufficient network capacity to meet the needs of the recipients.
- Whether the recipient has previously received services from one of the plan's primary dental providers.
- Whether primary dental providers in one plan are more geographically accessible to the recipient's residence than those in other plans.
- A newborn of a mother enrolled in a plan at the time of the child's birth shall be enrolled in the mother's plan. Upon birth, such a newborn is deemed enrolled in the Prepaid Dental Health Plan, regardless of the administrative enrollment procedures, and the managed care plan is responsible for providing Medicaid services to the newborn. The mother may choose another plan for the newborn within 90 days after the child's birth.

Item #3

Attachment A, Instructions and Special Conditions, **Exhibit A-2-a,** Qualification of Plan Eligibility, is hereby deleted in its entirety and replaced with **Exhibit A-2-a,** Qualification of Plan Eligibility **(1-9-18).** An updated version of **Exhibit A-2-a,** Qualification of Plan Eligibility **(1-9-18)** is available for respondents to download at: http://ahca.myflorida.com/Procurements/index.shtml

Item #4

Attachment A, Instructions and Special Conditions, **Exhibit A-4-a**, Submission Requirements and Evaluation Criteria, is hereby deleted in its entirety and replaced with **Exhibit A-4-a,** Submission Requirements and Evaluation Criteria **(1-9-18).** An updated version of **Exhibit A-4-a**, Submission Requirements and Evaluation Criteria **(1-9-18)** is available for respondents to download at: http://ahca.myflorida.com/Procurements/index.shtml

Item #5

Attachment A, Instructions and Special Conditions, **Exhibit A-4-a-1**, SRC# 10 – Dental Quality Measurement Tool, is hereby deleted in its entirety and replaced with **Exhibit A-4-a-1**, SRC# 10 – Dental Quality Measurement Tool **(1-9-18).** **Exhibit A-4-a-1**, SRC# 10 – Dental Quality Measurement Tool **(1-9-18)** is available for Respondents to download at: http://ahca.myflorida.com/Procurements/index.shtml

Item #6

Attachment A, Instructions and Special Conditions, **Exhibit A-4-a-3**, SRC# 36 – Provider Network Agreements Tool, is hereby deleted in its entirety and replaced with **Exhibit A-4-a-3**, SRC# 36 – Provider Network Agreements Tool **(1-9-18)**. **Exhibit A-4-a-3**, SRC# 36 – Provider Network Agreements Tool **(1-9-18)** is available for Respondents to download at: http://ahca.myflorida.com/Procurements/index.shtml

Item #7

Attachment B, Scope of Services – Core Provisions, **Section I.**, Definitions and Acronyms, **Sub-Section A.**, Definitions, is hereby amended to read as follows:

Prepaid Dental Health Plan – As defined in section 409.973(5)(b), F.S.

Item #8

Attachment B, Scope of Services – Core Provisions, **Section III.**, Eligibility and Enrollment, **Sub-Section B.**, Eligibility, **Item 1.**, is hereby amended to read as follows:

1. In accordance with section 409.973(5)(b), F.S., all Medicaid recipients shall receive Medicaid covered dental services through the PDHP, unless otherwise exempted in this sub-section. The Agency will determine eligibility for enrollment under this Contract. The Agency will provide the Prepaid Dental Health Plan a list of recipient aid categories that are eligible to enroll in in the PDHP.

Item #9

Attachment B, Scope of Services – Core Provisions, **Section VI.**, Coverage and Authorization of Services, **Sub-Section B.**, Required Dental Benefits, **Item 1.**, Specific Dental Services to be Provided, **Sub-Item a.**, is hereby amended to read as follows:

a. The Prepaid Dental Health Plan shall provide covered dental services in accordance with Attachment B., Section VI., Coverage and Authorization of Services, the approved federal waiver for the Statewide Medicaid Prepaid Dental Health Program, and the following Medicaid dental rules and services listed on the associated fee schedules and billing codes listings:

Rule No.	Policy Name
59G-4.002	Dental General Fee Schedule Practitioner Fee Schedule* Prescribed Drugs (Not Reviewed by the Pharmaceutical and Therapeutics Committee) Fee Schedule* Prescribed Drug Fee Schedule* Federally Qualified Health Center Billing Codes* County Health Department Billing Codes*
59G-4.055	County Health Department Clinic Services*

59G-4.060	Dental Services Coverage Policy
59G-4-100	Federally Qualified Health Care Services*
59G-4.207	Oral and Maxillofacial Surgery Services Coverage Policy*
59G-4.250	Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook*

**As identified by procedure codes included on the Procedure Code Mapping tab in Appendix I to the Prepaid Dental Health Plan Program Data Book.*

Item #10

Attachment B, Scope of Services – Core Provisions, **Section VI.**, Coverage and Authorization of Services, **Sub-Section D.**, Excluded Services, **Item 1.**, General Provisions, **Sub-Item c.,** is hereby amended to read as follows:

c. The Prepaid Dental Health Plan is not responsible for facility fees associated with the provision of dental services rendered in a hospital, emergency room, urgent care center, or ambulatory surgical center unless otherwise specified in this Contract.

Item #11

Attachment B, Scope of Services – Core Provisions, **Section VI.**, Coverage and Authorization of Services, **Sub-Section E.**, Coverage Provisions, **Item 2.**, Enrollee Screening and Education, **Sub-Item a.,** is hereby amended to read as follows:

a. The Prepaid Dental Health Plan shall use the enrollee's oral health evaluation and/or released dental records to identify enrollees who have not received well-child dental screenings in accordance with the Agency-approved periodicity schedule.

Item #12

Attachment B, Scope of Services – Core Provisions, **Section VI.**, Coverage and Authorization of Services, **Sub-Section H.**, Authorization of Services, **Item 5.**, Clinical Decision-Making, **Sub-Item a.,** is hereby amended to read as follows:

a. Made by a licensed dentist, or other professional as approved by the Agency, who has the appropriate clinical expertise in treating the enrollee's condition or disease (42 CFR 438.210(b)(3)); and

Item #13

Attachment B, Scope of Services – Core Provisions, **Section VII.**, Grievance and Appeal System, **Sub-Section E.**, Notice of Adverse Benefit Determination, **Item 3.b**, **Numbers (7)** and **(8)** are hereby deleted in their entirety.

Item #14

Attachment B, Scope of Services – Core Provisions, **Section VIII.**, Provider Services, **Sub-Section A.**, Network Adequacy Standards, **Item 2.**, Network Capacity and Geographic Access Standards, **Sub-Item c.**, is hereby amended to now read as follows:

c. The Prepaid Dental Health Plan shall provide access in each region for urgent care, routine sick patient care, primary dental care, and follow-up dental services rendered in the dental provider's office, FQHC, or RHC that offers extended office hours (before 8:00 a.m., after 4:30 p.m., and/or on Saturdays).

Item #15

Attachment B, Scope of Services – Core Provisions, **Section IX.**, Quality, **Sub-Section A.**, Quality Improvement, **Item 4.**, Accreditation, is hereby deleted in its entirety and replaced as follows:

4. Accreditation or Certification

A Prepaid Dental Health Plan that holds accreditation or certification by a nationally recognized accrediting body shall authorize its accrediting or certification body to provide the Agency a copy of its most recent accreditation or certification review, including: accreditation or certification status, survey type, and level (as applicable); recommended actions or improvements, CAPs, and summaries of findings; as the expiration date of accreditation or certification.

Item #16

Attachment B, Scope of Services – Core Provisions, **Section XII.**, Financial Requirements, **Sub-Section G.**, Inspection and Audit of Financial Records, the second paragraph is hereby deleted in its entirety.

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ATTACHMENT A

QUESTION NUMBER	VENDOR NAME	SECTION CITE REFERENCE	EXHIBIT REFERENCE (IF APPLICABLE)	SUB-SECTION CITE REFERENCE	ITEM CITE REFERENCE (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
1	MCNA	B. Response Preparation and Content	N/A	2	e	11	Is there a preferred format for the pro forma financial statements respondents are required to provide?	Respondent should use their own template.
2	MCNA	B. Response Preparation and Content	N/A	1	c	8	Attachment A, Subpart B.1.c, states that forms must not be retyped and/or modified. Additionally, Microsoft Word form fields in required Exhibit A-4-a do not allow for section headers, text emphasis, tables, or inline visual aides. In order to minimize the need for a reviewer to go back-and-forth between Exhibit A-4-a and numerous exhibits for each SRC, may a respondent instead simply refer to a single attachment for each SRC that includes a complete response to the respective SRC?	No. See **Attachment A** - Instructions and Special Conditions, **Exhibit A-4**, Submission Requirements and Evaluation Criteria Instructions.
3	Argus Dental & Vision, Inc.	B. Response Preparation and Content	N/A	2	e	12	Does the Agency expect the surplus requirements to be shown as of the application date in 2018 or the contract start date in 2019?	Refer to **Attachment A**, Instructions and Special Conditions **Section B.**, Response Preparation and Content, **Sub-Section 3.**, Additional Response Content. No additional information will be provided.
4	Argus Dental & Vision, Inc.	B. Response Preparation and Content	N/A	2	e	12	Insolvency Protection Account: This section references an Insolvency Protection Account, "as specified below." Please confirm this refers to 5) Prepaid Dental Health Plan.	Yes, the Insolvency Protection Account refers to the calculation for Prepaid Dental Health Plan in number 5.
5	Argus Dental & Vision, Inc.	B. Response Preparation and Content	N/A	2	e	12	Regarding 5) Prepaid Dental Health Plan, does the Agency expect this account to be in place and fully funded as of the application date in 2018, or does it begin in 2019 with the contract?	Refer to **Attachment A**, Instructions and Special Conditions, **Section B.**, Response Preparation and Content, **Sub-Section 2,** Mandatory Response Content, **Item e.**, Financial Information, **Sub-item.5**, page 12. No additional information will be provided.
6	UHC	A. Overview	N/A	2	g	12	This is in reference to Attachment C - Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, Page 13, & Appendix I - Eligibility Data. For the MMA population, there are member months excluded from the data. The narrative states this is because this is due to "inadequate data" and that the member has no associated encounter data. Please clarify - are these members excluded simply because they had no claims in the experience period, or were they excluded because their eligibility for benefits was determined to be erroneous/inaccurate?	To clarify, member months with no associated encounter data are included in the data book/cost proposal if the member is associated with a capitated plan whose claims data was deemed credible. Member months are excluded if the plans corresponding claims data was excluded for one of the following reasons found in **Attachment C**: Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, **Section II**, Dental Data Book, **Sub-Section C**, Dental Book Claims Data. MMA Capitated Plan and CMSN Encounter Data.

QUESTION NUMBER	VENDOR NAME	SECTION CITE REFERENCE	EXHIBIT REFERENCE (IF APPLICABLE)	SUB-SECTION CITE REFERENCE	ITEM CITE REFERENCE (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
7	UHC	A. Overview	N/A	2	g	12	This is in reference to Attachment C - Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, Page 19. Please confirm that the vendor is allowed to reimburse FQHC and RHC at rates below the Agency's established encounter rate, and that the Agency will reimburse the difference between that vendor rate and the established encounter rate to the provider.	In accordance with section 1902(bb)(5) of the Social Security Act (SSA), Florida Medicaid is required to make supplemental payments to FQHC's and RHC's that contract with Medicaid managed care plans representing the difference, if any, between the Medicaid managed care plan's payment to the contracting FQHC/RHC and the payment to which the FQHC/RHC would be entitled for services under the SSA.
8	Delta Dental	A. Overview	N/A	6	N/A	3	Responses are currently due at 9:00 a.m. on January 12, 2018. The Agency's responses to submitted questions are estimated to be posted December 11, 2017. Given the intervening holiday period, in order to allow adequate time for adjustments to responses based the Agency's answers, will the Agency consider an extension of the deadline for receipt of responses?	See Addendum No. 2.
9	Delta Dental	A. Overview	N/A	13	N/A	6	In the "Program Overview", it was specified that more than 3.2 Million Floridians are enrolled in Florida's Statewide Medicaid Managed Care Program. What is the projected growth/decline of this enrollment in the rate years 2018-2023?	Projections for the Statewide Medicaid Managed Care program are handled by the Social Service Estimating Conference which can be found at http://edr.state.fl.us/Content/conferences/medicaid/index.cfm
10	Delta Dental	B. Response Preparation and Content	N/A	2	e	11	The ITN states we must submit Pro Forma financial statements. Please clarify the requirement for Pro Forma financial statements. Are these statements specific to the forecasts for the Florida Medicaid business or should this address all Florida based clients?	Refer to Attachment A, section B.2.e.2:, page 11. 'The respondent shall provide the following pro forma financial statements for the respondent's Florida operation, broken down by line of business.'
11	Delta Dental	B. Response Preparation and Content	N/A	2	e	12	B.2.e.5), Prepaid Dental Health Plan, requires a response in the proposal but the C.1.b.3)b) and C.1.c.3) lists of required "Financial Information" components don't include a "Prepaid Dental Health Plan" tab. Is it correct that the response to B.2.3.5) be included with response to B.2.e.4) Insolvency Protection Account? Or, should there be separate subtab for "Prepaid Dental Health Plan" under the "Financial Information tab?	The Agency has no preference. Respondent can include this item in either the Insolvency Protection tab of the Financial Information section or create a separate subtab for Prepaid Dental Health Plan.
12	Delta Dental	C. Response Submission Requirements	N/A	1	N/A	13	This subsection lists the components for the hard-copy and electronic copy responses, but those lists do not include a table of contents. Will the Agency allow a table of contents to be inserted immediately after the Transmittal Letter in both the hard-copy and electronic responses?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.

QUESTION NUMBER	VENDOR NAME	SECTION CITE REFERENCE	EXHIBIT REFERENCE (IF APPLICABLE)	SUB-SECTION CITE REFERENCE	ITEM CITE REFERENCE (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
13	Delta Dental	C. Response Submission Requirements	N/A	3	b	14	We interpret the ITN instructions as requiring a main tab for "Financial Information" and subtabs for "Financial Statements," "Pro Forma Financial Statements" and "Insolvency Protection." Is our interpretation correct? If not, please clarify the tab requirements for "Financial Information."	Yes.
14	Delta Dental	C. Response Submission Requirements	N/A	1	b	14	We understand that Exhibit A-4-a should be tabbed. Is it acceptable to insert subtabs for the seven major (lettered) categories within Exhibit A-4-a?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
15	Delta Dental	E. Contract Implementation	N/A	4	b	26	E.4.b.3) states the Agency will assign SMMC enrollees who do not make an active dental plan choice into their existing plan, if that plan was awarded a Contract. Please advise: 1. For general comparative purposes, what has the Agency's auto assignment rate been for the past 3 years for medical plans? 2. Since all SMMC enrollees are currently in an existing plan and if existing dental plans are awarded contracts, if the auto-assignment rate is high, it will be difficult for new dental plans to secure adequate enrollment to maintain viability. Also, under this scenario, existing plans' administrative and claims expenses will be less than new plans since they will maintain ongoing enrollees who have had ongoing dental care. How will the Agency ensure that new dental plans are not adversely affected by this policy?	1.) http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/quarterly.shtml 2.) No additional information will be provided at this time.
16	Delta Dental	E. Contract Implementation	N/A	4	b	26	1. Please clarify which ITN provision takes precedence: E.4.b.3) which states current SMMC enrollees who do not make an active plan choice will be assigned to their existing plan (if it is awarded a Contract); or E.4.b.4), which states that enrollees who do not voluntarily choose a plan will be automatically enrolled into a new or existing prepaid dental health plan, subject to the bulleted criteria? 2. If E.4.b.4) takes precedence for all auto-assigned enrollees, please advise the assignment criteria to be applied if more than 1 dental plan (new or existing) has the same provider in its network from whom the enrollee has previously received services.	See Addendum No. 3.

QUESTION NUMBER	VENDOR NAME	SECTION CITE REFERENCE	EXHIBIT REFERENCE (IF APPLICABLE)	SUB-SECTION CITE REFERENCE	ITEM CITE REFERENCE (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
17	Envolve Dental, Inc.	E. Contract Implementation	N/A		N/A	12	For Exhibit A-7-R for Purchasing, can you please provide clarification on the types of services and the scenarios where we are required to use P.R.I.D.E. and RESPECT of Florida? Does this requirement apply to the purchase of services or only to the purchase of commodities? For example, RESPECT of Florida offers Call Center / Call Quality Assurance Monitoring Services. Our expectation is that we would manage call center services internally.	See Chapter 946, Florida Statues and www.pride-enterprises.org/. See Chapter 413, Florida Statutes and www.respectofflorida.org
18	DentaQuest	A. Overview	A-2-b	8	N/A	3	The RFP states that the "Agency may not consider supplemental response narrative for evaluation which is not contained within the Response Sections contained in Exhibit A-4, Submission Requirements and Evaluation Criteria." Please clarify if bidders are permitted to include attachments with information to support their narrative to the SRCs.	See **Attachment A** - Instructions and Special Conditions, **Exhibit A-4**, Submission Requirements and Evaluation Criteria Instructions.
19	DentaQuest	A. Overview	A-2-a	15	N/A	5	Please confirm this certification only applies to contracts directly with State agencies or the Federal government and not contracts with health plans that administer State or Federal programs	Yes.
20	DentaQuest	A. Overview	A-2-a	12	N/A	4	Statute 409.966(3)(e) does not define "business relationship." Should respondents use the definition of "business relationship" cited in statute 409.966(3)(b) or another statute?	See Addendum No. 3.
21	DentaQuest	B. Response Preparation and Content	N/A	1	a	9	a. Transmittal (Cover) Letter 1). Does the state have a form or required format?	No. The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
22	DentaQuest	B. Response Preparation and Content	N/A	2	d	10	d. Original Proposal Guarantee 2). Can the original proposal guarantee be issued by and/or guaranteed by a parent or affiliate of the respondent?	No.
23	DentaQuest	B. Response Preparation and Content	N/A	3	e	12	e. Financial Information 3). Does the state have a form or required format?	Respondent should use their own template.
24	DentaQuest	B. Response Preparation and Content	N/A	3	e	12	e. Financial Information 4). Does the state have a form or required format?	Respondent should use their own template.
25	DentaQuest	B. Response Preparation and Content	N/A	3	e	12	e. Financial Information 5). Does the state have a form or required format?	Respondent should use their own template.

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26	DentaQuest	B. Response Preparation and Content	N/A	2	e	12	Should item number of 5 "States Prepaid Dental Health Plan - five percent of the estimated monthly capitation amount that would be paid to the successful respondent by the Agency each month until a maximum total of two percent of the annualized total Contract amount is funded. Wde a calculation of the five (5%) estimate and indicate the anticipated source and method of funding this requirement" be tabbed separately under the Financial information section of our response? The instructions on page 14 do not account for this component of the financial requirements.	Item number 5 is related to the calculation of Insolvency Protection requirements and as such, can be included in the Insolvency Protection tab of the Financial Information section.
27	DentaQuest	B. Response Preparation and Content	A-3-a		e	1	I. e. The above-listed personnel shall not disclose any information relating to the PDHP ITN Services with any other Milliman personnel. This form does not have an option to add content. Where would you like this information added? And, submitted?	See **Attachment A** - Instructions and Special Conditions, **Section B**., Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item c**., Milliman Organizational Conflict of Interest Mitigation Plan.
28	DentaQuest	B. Response Preparation and Content	A-3-a	2	a	2	II. a. i. Identify itself and its intent to use Milliman. This form does not have the option to add content. Is completing Exhibit A-3-b meeting this requirement?	See **Attachment A** - Instructions and Special Conditions, **Section B**., Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item c.**, Milliman Organizational Conflict of Interest Mitigation Plan.
29	DentaQuest	B. Response Preparation and Content	A-3-a	2	a	2	II. a. ii. Identify the specific Milliman personnel that will be assisting the respondent in the procurement. This form does not have the option to add content. Is completing Exhibit A-3-b meeting this requirement?	See **Attachment A** - Instructions and Special Conditions, **Section B**., Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item c**., Milliman Organizational Conflict of Interest Mitigation Plan.
30	DentaQuest	B. Response Preparation and Content	N/A	5	d	10	Section B.2 d (5) Would the respondent be required to forfeit the proposal guarantee if respondent failed to execute a Contract within 10 consecutive days after a Contract had been presented to respondent for signature if such proposed Contract included terms that had not been agreed to or offered by respondent in the RFP or in the course of negotiations?	Negotiations will occur prior to contract award. See **Attachment A** - Instructions and Special Conditions, **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item d.**, Original Proposal Guarantee, **Sub-Item 5**).
31	DentaQuest		A-7		N/A	11	Exhibit A-7 O. Assignments and Subcontracts- Please provide how this approval process will work with current and or new subcontractors?	See **Attachment B** - Scope of Service - Core Provisions, **Section X**., Administration and Management, **Sub-Section C**., Performance Improvement Projects, for the process.

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32	DentaQuest	B. Response Preparation and Content	N/A	2	e	12	Section B.2.e (5) It appears that this section is asking respondent to create a fund (possibly a reserve fund) equal to 2% of the annual contract value. Is this correct? If so, where and by whom will this fund be held? Are there restrictions on what it can be used for? How will it ultimately be dispersed? Is there reporting that will be required with respect to such fund?	Refer to **Attachment B** - Scope of Service - Core Provisions, **Section XII.**, Financial Requirements, **Sub-Section A.**, Insolvency Protection, **Item 1.**, Insolvency Protection Requirements, **Sub-Items a-e**.
33	DentaQuest	D. Response Evaluation, Negotiations, and Contract Award	N/A	9	f	24	Will the agency limit its right to unilaterally amend the Contract to the extent that such changes would result in material additional costs or other adverse consequences to respondent/Vendor?	There will be no change to this specification of the ITN.
34	DentaQuest		A-7		N/A	7	Section I K.: It appears that the background check requirements in this section are similar to those set forth in Attachment B, Section XV.C.7. Therefore, it is clear that such information must be provided for management and ownership of the respondent. However, please clarify which background information, if any, would be required for ALL of respondent's employees that have access to PII, PHI or "financial information," which could include hundreds of individuals and impose a tremendous burden on the respondent to compile such information and on the Agency to review it.	All principals of the Managed Care Plan, and all persons with five percent (5%) or more ownership interest in the Managed Care Plan, or who have executive management responsibility for the Managed Care Plan, or have the ability to exercise effective control of the Managed Care Plan. (s. 435.04, F.S.) are required to have a criminal history record check due to their percentage of ownership or control of the Managed Care Plan. However, all Vendor employees including managing employees that have direct access to personally identifiable information (PII), protected health information (PHI), or financial information shall have a County, State, and Federal criminal background screening comparable to a level 2 background screening as describe in Section 435.04, F.S.
35	DentaQuest		A-7		N/A	12	Section I Q: In a case where the Agency asserts overpayment and respondent/Vendor has a good faith dispute with regard to such asserted overpayment amount, when does the noted 40 day period begin?	See, A-7 Standard Contract, Section I. THE VENDOR HEREBY AGREES, Sub-section Q, Return of Funds - The Vendor shall return any overpayment to the Agency within forty (40) calendar days after either discovery by the Vendor, its independent auditor, or notification by the Agency, of the overpayment.

QUESTION NUMBER	VENDOR NAME	SECTION CITE REFERENCE	EXHIBIT REFERENCE (IF APPLICABLE)	SUB-SECTION CITE REFERENCE	ITEM CITE REFERENCE (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
36	DentaQuest		A-7		N/A	14	Section I.W.9.g. and i.: Does this language mean that when respondent configures its internal systems to adjudicate claims in accordance with the program requirements, the Agency can require respondent to deliver source code and other proprietary or confidential processes and information, and thereafter be free to share the same with respondent's competitors? If so, is this true even if nearly all of such proprietary information would be applicable to the adjudication of claims for any health plan and only contains a few customizations for the Agency's program? It is not clear why proprietary trade secrets that would be protected from public disclosure and remain the property of the respondent if delivered to the Agency as part of the RFP process should lose that protection either during or upon termination of the Contract.	There will be no change to this specification of the ITN.
37	DentaQuest		A-7		N/A	22	Section III.C.2; Is the intent of the provision to give the Agency the authority to retroactively impose a rate reduction?	There will be no change to this specification of the ITN.
38	DentaQuest		A-2-b	11		4	11. Names of Operation: Please define "organization."	The organization is the respondent replying to the ITN.
39	Scion Dental	B. Response Preparation and Content	A-2-a	2	b	9	How should respondents complete Exhibit A-2-a, Qualification of Plan Eligibility, when they've submitted application materials to receive a Certificate of Authority to act as a Prepaid Limited Health Service Organization, but due to State timelines, have not yet received the Certificate of Authority?	There will be no change to this specification of the ITN. The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
40	Scion Dental	B. Response Preparation and Content	N/A	2	e	10	Can respondents submit cost proposals on both an Administrative Services Only (ASO) basis and a risk basis?	There will be no change to this specification of the ITN.
41	Poms & Associates Insurance Brokers, LLC						I am the surety broker for a client that will be submitting a response to the subject RFP. I will be providing them a bond for the Proposal Guarantee. Is there a bond form that your agency will provide or can I use the standard AIA Bid Bond Form (see attached). If you have a bond form that you would like us to use, please email me a copy.	The Agency will not provide a bond form. See **Attachment A.**, Instructions and Special Conditions, **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item d.**, Original Proposal Guarantee.

ATTACHMENT B

QUESTION NUMBER	VENDOR NAME	SECTION CITE REFERENCE	SUB-SECTION CITE REFERENCE	PAGE NUMBER	QUESTION	ANSWER
42	MCNA	I. Definitions and Acronyms	A.	14	The definition of the term "Plan Factor" seems to indicate budget-neutral, diagnosis-based risk adjustment. However, we could not find any other references to risk adjustment. Will the capitation rates be risk-adjusted? If so, can you provide additional details on how the risk adjustment will work?	The Agency does not anticipate risk adjusting the Prepaid Dental Rates at this time.
43	MCNA	XI. Method of Payment	C.	158	Please confirm if the following is correct: PDHPs will initially be paid 99% of the agreed upon capitation rates, with the potential to earn the remaining 1% if the performance measure rates in sub-section C.1.f.(1) are achieved.	No additional information will be provided.
44	MCNA	XII. Financial Requirements	F.	171	How does the MLR requirement of 85% beginning on 1/1/2019 interact with the Achieved Savings Rebates that PDHPs are subject to (described in Section XI.)? Are PDHP refunds considered either a reduction to revenue or increase to plan expenses for purposes of the MLR requirement?	Refer to **Attachment B.**, Scope of Service - Core Provisions, **Section XII.**, Financial Requirements, **Section F.**, Financial Reporting, **Sub-Section 2.**, Medical Loss Ratio, **Items a. and b.** No additional information will be provided.
45	MCNA	IX. Quality	A.	103	In the cited statute, the reference to a treatment or service plan is for enrollees who require long-term services and supports that, as defined under 42 CFR 438.2, have the primary purpose of supporting the ability of the individual to live or work in the setting of their choice. This does not appear to be pertinent to dental plans of care. Please explain the Agency's expectations and goals for plans of care for dental services.	There will be no change to this specification of the ITN. See 42 CFR 438.208(c), Additional Services for enrollees with special health care needs or who need LTSS.
46	Argus Dental & Vision, Inc.	II. General Overview	A.	25	Item 1. refers the reader to a definition of a Prepaid Dental Health Plan in Section I, however Section I does not appear to include a definition.	See Addendum No. 3.
47	Argus Dental & Vision, Inc.	III. Eligibility and Enrollment	C.	27	Will the Agency's Enrollment Broker interaction with the Potential Enrollee for Prepaid Dental Health Plan selection include selection of the Primary Dental Provider?	See **Attachment B.,** Scope of Service - Core Provisions, **Section III.**, Eligibility and Enrollment, **Sub-Section C.**, Enrollment, **Item 1.**, General Provisions, **Sub-Item c.**
48	Argus Dental & Vision, Inc.	X. Administration and Management	D.	133	Please expand on the member-specific information that the Agency will provide to the Prepaid Dental Health Plan for assigned members. For example, will the Agency's enrollment file include each member's assigned Statewide Medicaid Managed Care Plan and PCP in addition to his/her identifying information? Similarly, will the Agency share the member's initial Health Risk Assessment results (when available) with the Prepaid Dental Health Plan in order to help inform our outreach/work with the member?	The plan will receive demographic, enrollment, and health information indicators via Panel Roster and 834 reports.
49	UHC	XII. Financial Requirements	F.	2	Medical Loss Ratio - if plan runs below MLR minimum of 85%, is there are rebate mechanism? Contract does not specify, only that "CMS will determine corrective action…"	No additional information will be provided.

QUESTION NUMBER	VENDOR NAME	SECTION CITE REFERENCE	SUB-SECTION CITE REFERENCE	PAGE NUMBER	QUESTION	ANSWER
50	UHC	XI. Method of Payment	C.	158	Interpretation of Achieved Savings Rebate (section f., pages 158-163). The provisions indicate that the Prepaid Dental Health Plans retain 100% of net operating income (NOI) up to and including 5% of premium revenue; 50% of NOI above 5% and up to 10%; 100% of NOI above 10% of revenue is refunded to the state. In addition f1 and f5 indicate the Dental Plans are able to "..retain an additional 1% of revenue" based on meeting metrics identified on page 158. Please confirm that the Prepaid Dental Health Plans are able to retain the 1% in addition to the initial 5% of NOI.	No additional information will be provided.
51	Delta Dental	VI. Coverage and Authorization of Services	B.	52	Please confirm that the "Unit" column In the current Dental Fee Schedule, effective January 1st 2017, represents the benefit coverage limitation (i.e., per month/year/lifetime). If the "Unit" column does not represent the benefit coverage limitation, please provide the current list of benefit coverage limitation for all required benefits.	See **Rule 59G-4.060, F.A.C.**, Dental Services Coverage Policy, **Section 4.2**, Specific Criteria
52	Delta Dental	VI: Coverage and Authorization of Services	E.2.a	55	Can the state provide clarity around it's expectation for the beneficiaries Health Risk Assessment? Is it the state's intent that the HRA be holistic (i.e., medical and dental), or dental only?	See Addendum No. 3.
53	Delta Dental	VI. Coverage and Authorization of Services	E.3	56	What is the time period for an enrollee to make an initial PDP selection before the dental plan auto-assigns a PDP?	The Prepaid Dental Health Plan must notify the enrollee of the name, telephone number, and address of the enrollee's assigned PDP within five (5) days following the receipt of the X12-834 enrollment file from the Agency or its designee. See **Attachment B.**, Scope of Service, **Section V.**, Enrollee Services, **Sub-Section B.**, Enrollee Material, **Item 4.**, Enrollee Procedures and Materials.
54	Delta Dental	VI: Coverage and Authorization of Services	E.4	56	Are there limitations to the reimbursement requirements for providers participating in telemedicine?	The Prepaid Dental Health Plan may use telemedicine in accordance with **Rule 59G-1.057, F.A.C.**, and as specified in this Prepaid Dental Health Plan ITN. The Prepaid Dental Health Plan has the flexibility to negotiate mutually agreed upon rates with its providers.
55	Delta Dental	VI: Coverage and Authorization of Services	F	58	Is the State planning to fund the dental plan development of treatment plans (instead of the dentist) as part of the ITN award?	No.

QUESTION NUMBER	VENDOR NAME	SECTION CITE REFERENCE	SUB-SECTION CITE REFERENCE	PAGE NUMBER	QUESTION	ANSWER
56	Delta Dental	VI: Coverage and Authorization of Services	F.2.b.(1)	58	Paragraph F.2.b.(1) asks about procedures for identifying enrollees with complex needs: is the State making available the previous three (3) years of medical and dental claims data to allow identification of enrollees with co-morbid conditions and specifically co-morbid medical conditions? If not, what other data does the State plan to provide to obtain this information?	The plan will receive demographic, enrollment, and health information indicators via its Panel Roster and 834 reports.
57	Delta Dental	VI: Coverage and Authorization of Services	F.4.a.(4)	58	Please define "progress of case management" in this context, does it mean dental case management or medical case management?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
58	Delta Dental	VI: Coverage and Authorization of Services	F.4.a.(4)	59	Does the State plan to provide the dental plan a continuous feed of medical claims data to allow "monitoring of enrollees with…complex medical conditions and coordination of services for high utilizers…"	No.
59	Delta Dental	VI: Coverage and Authorization of Services	F.5	61	Is it the state's intent that vendors will establish, or assist in establishing, Flexible Spending Accounts for beneficiaries?	No.
60	Delta Dental	VI. Coverage and Authorization of Services	H.	62	Do authorizations for children under 21 expire at their 21st birthday, the end of the month of their birth month, end of established authorization period or do they continue until treatment is completed? Please address orthodontics specifically.	No additional information will be provided.
61	Delta Dental	VI: Coverage and Authorization of Services	H.6	64	Does AHCA define clinical documentation or prior authorization requirements?	The plain meaning of the terms clinical documentation or prior authorization requirements should be used in preparing a response for this Prepaid Dental Health Plan ITN.
62	Delta Dental	VIII. Provider Services	A.	77	In the Provider Network Standards Table in A. 2. d., under the Urban and Rural County headings, there is a sub-heading entitled "Maximum Distance (miles)." Does that mean driving distance miles as opposed to "as the crow flies" miles?	"Maximum distance" refers to driving miles.

QUESTION NUMBER	VENDOR NAME	SECTION CITE REFERENCE	SUB-SECTION CITE REFERENCE	PAGE NUMBER	QUESTION	ANSWER
63	Delta Dental	IX. Quality	H.	118	Would the Agency please release a current list of the provider network to ensure continuity of care for the current enrollment, by ensuring the current providers are contracted for the program?	There will be no change to this specification of the ITN.
64	Wakely	I. Definitions and Acronyms	A.	9	The definition of the term "Expanded Benefit" indicates that Prepaid Dental Health Plans will receive no direct payment from the Agency for these benefits. The data book information shows that the expanded coverage represents a material portion of total costs. Are Prepaid Dental Health Plans expected to fund these benefits via reduced profits?	See Attachment C: II.C MMA Capitated Plan and CMSN Encounter Data.
65	Envolve Dental, Inc.	VI. Coverage and Authorization of Services	H.	64	Standard authorization requirements presented in 3.f.1, 3.f.2, and 6.b.1 seem to be contradictory. If 6.b.1 and 3.f.2 are met, there seems to be no need for 3.f.1. Please provide your thoughts.	For standard authorization decisions, 42 CFR 438.210(d)(1) requires managed care organizations to provide notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service. The seven-day timeframe provided in **Attachment B.**, Scope of Service - Core Provisions, **Section VI.**, Coverage and Authorization of Services, **Sub-Section H.**, Authorization of Services, **Item 6.**, Service Authorization Standards for Decisions, **Sub-Item b.** represents the Agency's minimum standard, which is within the 14 days permitted by the CFR. For expedited authorization decisions, 42 CFR 438.210(d)(2) requires managed care organizations to provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service. **Attachment B.**, Scope of Service - Core Provisions, **Section VI.**, Coverage and Authorization of Services, **Sub-Section H.**, Authorization of Services, **Item 3.**, Service Authorization System, **Sub-Item f.** represents the Agency's proposed service level agreement.
66	Envolve Dental, Inc.	VI. Coverage and Authorization of Services	E.	56	For new enrollee procedures, if the member's dental benefits were managed by the Prepaid Dental Health Plan as a subcontractor under the Statewide Medicaid Managed Care Program can the member screening be waived?	There will be no change to this specification of the ITN.
67	Envolve Dental, Inc.	IX. Quality	B.	108	For Well-Child Visit Performance Measures, there is an escalating schedule for dental treatment services (TDENT) similar to the escalating scheduling for preventive dental services (PDENT). As preventive dental services increase, the ideal result is that restorative services decrease so the use of an escalating schedule for TDENT utilization seems counterintuitive to the goal of increasing PDENT utilization. Is it possible that this is an error in the ITN?	This is not an error.

QUESTION NUMBER	VENDOR NAME	SECTION CITE REFERENCE	SUB-SECTION CITE REFERENCE	PAGE NUMBER	QUESTION	ANSWER
68	DentaQuest	VI. Coverage and Authorization of Services	G.	62	Please define and provide examples of what the Agency views as "Children's Wellness Programs."	See **Attachment B.**, Scope of Services - Core Provisions, **Section VI.**, Coverage and Authorization of Services, **Sub-Section G.**, Quality Enhancements, **Item 2.**
69	DentaQuest	IX. Quality	A.	103	Regarding individuals with special health care needs - will the Agency provide an indicator on the eligibility file to flag individuals with special health care needs?	The plan will receive demographic, enrollment, and health information indicators via its Panel Roster and 834 reports.
70	DentaQuest	VI. Coverage and Authorization of Services	G.	61	We understand the definition of "Quality Enhancements" is certain health-related, community-based services to which the PDHP must offer and coordinate access to its enrollees. PDHP are not reimbursed by the Agency for these types of services." Can the Agency please provide examples of "certain health-related, community-based services" that would fall under this definition?	See **Attachment B.**, Scope of Services - Core Provisions, **Section I.**, Definitions and Acronyms, **Sub-Section A.**, Definitions; and **Section VI.**, Coverage and Authorization of Services, **Sub-Section G.**, Quality Enhancements, **Item 1**.
71	DentaQuest	V. Enrollee Services	B.	46	B.9.a.(9) requires the PDHP to include "specific performance indicators" on the printed provider directory. Please define what "specific performance indicators" the Agency expects the PDHPs report.	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
72	DentaQuest	VI. Coverage and Authorization of Services	E.	54	Section 2.a. references "the Agency-approved periodicity schedule." Can the Agency please provide the Agency-approved dental periodicity schedule?	Refer to the Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care and the American Academy of Pediatric Dentistry (AAPD) periodicity schedules.
73	DentaQuest	V. Enrollee Services	B.	43	Section V.B.4.a states that the PDHP must notify each person who is to be newly enrolled or reinstated with the PDHP. If there is more than one newly enrolled or reinstated individual at the same address, may the PDHP send one packet that includes a single enrollment notice, a single current enrollee handbook, a single current provider directory, and individual ID cards for each enrollee?	See **Attachment B.**, Scope of Service, **Section V.**, Enrollee Services, **Sub-Section B.**, Enrollee Material, **Item 4.**, Enrollee Procedures and Materials.
74	DentaQuest	V. Enrollee Services	B.	44	Section V.B.5.e requires the PDHP to provide a postage-paid, pre-addressed return envelope. May the PDHP not include this in the initial mailing, and instead advise the enrollee to contact the PDHP should they require one?	There will be no change to this specification of the ITN.
75	DentaQuest	V. Enrollee Services	B.	44	Section V.B.5.d - is it the Agency's expectation that the PDHP would make updates to enrollee information in its system? Or is the Agency expecting the PDHP to forward the updated enrollee information to DCF and/or the Social Security Administration?	The PDHP shall provide enrollees with information on how to update enrollee information as required in **Attachment B.**, Scope of Service - Core Provisions, **Section V.**, Enrollee Services, **Sub-Section B.**, Enrollee Material, **Item 5.**, Required Enrollment Notice, **Sub-Item d.**

QUESTION NUMBER	VENDOR NAME	SECTION CITE REFERENCE	SUB-SECTION CITE REFERENCE	PAGE NUMBER	QUESTION	ANSWER
76	DentaQuest	VI. Coverage and Authorization of Services	H.	64	Section VI.H.3.f(4) states that the turnaround time for expedited authorization requests shall not exceed two business days. This conflicts with the requirement in H.6.b(2), which states the PDHP shall provide expedited authorization decisions no later than 48 hours after receipt of the request for service.	There will be no change to this specification of the ITN. For standard authorization decisions, 42 CFR 438.210(d)(1) requires managed care organizations to provide notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service. The seven-day timeframe provided in Attachment B., Scope of Service - Core Provisions, Section VI., Coverage and Authorization of Services, Sub-Section H., Authorization of Services, Item 6., Service Authorization Standards for Decisions, Sub-Item b. represents the Agency's minimum standard, which is within the 14 days permitted by the CFR. For expedited authorization decisions, 42 CFR 438.210(d)(2) requires managed care organizations to provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service. Attachment B., Scope of Service - Core Provisions, Section VI., Coverage and Authorization of Services, Sub-Section H., Authorization of Services, Item 3., Service Authorization System, Sub-Item f. represents the Agency's proposed service level agreement.
77	DentaQuest	XIV. Liquidated Damages	B.	190	For items #107 and #108: How do the Damages in the Liquidated Damages relate when the damages talk of per occurrence and the Core Program Issue is a rate - the Ambulatory Care Sensitive ED Visits for Dental Caries is a rate?	The rate is calculated by dividing the numerator by the denominator per the measure specifications. Each case in the numerator is an occurrence.
78	DentaQuest	XIV. Liquidated Damages	B.	190	For item #107: Is the $250 per occurrence LD limited or capped at all? There are reasons members may present at an ED that are beyond a PDHP's control.	No.
79	DentaQuest	XIV. Liquidated Damages	B.	190	For item #108: Is the $100 per occurrence LD limited or capped at all? There are reasons members may present at an ED that are beyond a PDHP's control. For example we have heard that adults go to EDs in order to avoid a 5% copay for scripts that they would have to pay if they filled same script in an outpatient pharmacy.	No.
80	DentaQuest	XIV. Liquidated Damages	B.	190	For items #107 and 108: does the Agency intend to simultaneously place responsibility on the health plans and hospitals to coordinate with the PDHPs, since the PDHPs cannot independently control ED utilization?	There will be no change to this specification of the ITN.
81	DentaQuest	VI. Coverage and Authorization of Services	B.	52	Section VI.B.1.a. Please clarify whether the Oral and Maxillofacial Surgery Program (and associated services and fees) is the responsibility of the member's health plan or the member's PDHP?	See Addendum No. 3.

QUESTION NUMBER	VENDOR NAME	SECTION CITE REFERENCE	SUB-SECTION CITE REFERENCE	PAGE NUMBER	QUESTION	ANSWER
82	DentaQuest	VIII. Provider Services	E.	100	The contract language for Timely Claims Payment includes time limits of 15 days for electronic claims and 20 days for paper claims. Florida Statute 641.3155 at (3)b and (4)b indicate 20 and 40 days for the same process. Additionally, 641.3155(9) states "The provisions of this section may not be waived, voided, or nullified by contract." Please provide confirmation of the timely claims payment requirements.	There will be no change to this specification of the ITN.
83	DentaQuest	VIII. Provider Services	E.	100	If the contract language requiring the 15 and 20 days is allowable, what is the time requirement for when interest accrues? The contract language does not mention interest only the time frame for payment. Only the Statute talks of interest (not the contract) and the statute indicates interest on an overdue payment for a claim or for any portion of a claim begins to accrue when the claim should have been paid, denied, or contested and the Statute indicates 20 and 40 days as to the time payment should have been made, denied or contested. Thus, since the contract is silent on interest, does interest accrued at 20 and 40 days as per statute?	The contract provisions do not alter the provisions of the statutes regarding interest.
84	DentaQuest	XIII. Sanctions	C.	174	The contract language states the state may sanction the PDHP $10,000 when the percentage rate of the listed performance measures falls 2% compared to the previous year. One of the performance measures listed is dental treatment services. Ideally the more preventive services being performed would reduce the number of dental treatment services. Would the Agency consider removing this sanction?	There will be no change to this specification of the ITN.
85	DentaQuest	XVI. Reporting Requirements	A.	213	In the chart in Section A.3, the last line lists "Well Child visit (CMS 416) and FL 80% screening" report. Additionally, the Scope of Services (Enrollee Screening and Education section) requires the PDHP to outreach to members who have not received a "well-child dental screening." It is our understanding that the well-child screening and the 80% dental screening rate are medical measures, as they are part of the physician-performed EPSDT well-child visits. Is it the Agency's intent to require PDHPs be accountable for a measurement that is specific to physicians?	Prepaid Dental Plans will be reporting solely on numbers of eligible children and the dental service-related lines.

QUESTION NUMBER	VENDOR NAME	SECTION CITE REFERENCE	SUB-SECTION CITE REFERENCE	PAGE NUMBER	QUESTION	ANSWER
86	DentaQuest	IX. Quality	B.	107	Section IX.B.2.a. The contract indicates targets for the HEDIS Annual Dental Visit (ADV), the Preventive Dental Visit (PDENT), and Treatment Dental Visit (TDENT) for each measurement year. Since the Prepaid Dental Health Program will start rolling out in October of 2018 and will not be complete until January of 2019, this rollout will cause a transition of data at least for the CMS-416 measures (PDENT and TDENT) and possibly for the HEDIS ADV measure. Will the Agency account for this and adjust the targets for the first year as well as adjust the sanctions and achieved savings rebate?	The Agency will address transition with successful bidders once contracts are awarded.
87	DentaQuest	X. Administration and Management	D.	128	What are the requirements for network connectivity?	See **Attachment B. - Scope of Service - Core Provisions**, **Section X**. Administration and Management, **Sub-Section D.**, Information and Management Systems, **Item 1.**, General Provisions, **Sub-Item h.**
88	DentaQuest	IX. Quality	D.	112	Is the PDHP permitted to conduct enrollee satisfaction and experience surveys using inside resources, or must the PDHP use an outside NCQA-certified survey vendor?	There will be no change to this specification of the ITN.
89	DentaQuest	XVI. Reporting Requirements	A.	213	Please provide information on the expected information that should be in the report "ER Visits for Enrollees without a PDP appointment"	See The Statewide Medicaid Managed Care Report Guide (Effective 10-1-17), Chapter 32: ER Visits for Enrollees without PCP Appointment Report. The ER Visits for Enrollees without a PDP appointment report will collect similar data.
90	DentaQuest	II. General Overview	K.	7	Does the background screening requirement (which includes fingerprinting) apply to every employee within an organization that may have access to PII, PHI or financial information?	All principals of the Managed Care Plan, and all persons with five percent (5%) or more ownership interest in the Managed Care Plan, or who have executive management responsibility for the Managed Care Plan, or have the ability to exercise effective control of the Managed Care Plan. (s. 435.04, F.S.) are required to have a criminal history record check due to their percentage of ownership or control of the Managed Care Plan. However, all Vendor employees including managing employees that have direct access to personally identifiable information (PII), protected health information (PHI), or financial information shall have a County, State, and Federal criminal background screening comparable to a level 2 background screening as describe in Section 435.04, F.S.
91	DentaQuest	IV. Marketing	F.	32	As a component of marketing to members for open enrollment purposes, enrollees may be contacted via phone. How is permission obtained by enrollees in order for a PDHP to contact them? Is this information received by the Agency and shared with the PDHPs?	No. See **Attachment B.**, Scope of Service - Core Provisions, **Section IV.**, Marketing, **Sub-Section F.**, Telephonic Activities and Scripts.

QUESTION NUMBER	VENDOR NAME	SECTION CITE REFERENCE	SUB-SECTION CITE REFERENCE	PAGE NUMBER	QUESTION	ANSWER
92	DentaQuest	V. Enrollee Services	F.	49	The language in this particular section appears to conflict with Section V.3.b, which notes the PDHP shall staff the enrollee help line 24/7. As such, is a voice mail option acceptable to replace a team member staff 24/7 help line?	No. There will be no change to this specification of the ITN.
93	DentaQuest	VI. Coverage and Authorization of Services	B.	52	Should respondents assume the prescribed drug fee schedules are not applicable to PDHP?	See **Attachment B.**, Scope of Service - Core Provisions, **Section VI.**, Coverage and Authorization of Services, **Sub-Section B.**, Required Dental Benefits, **Item 1.**, Specific Dental Services to be Provided, **Sub-Item a.**
94	DentaQuest	VI. Coverage and Authorization of Services	D.	54	It is noted that PDHP is not responsible for the provision of dental services provided in a hospital, emergency room or urgent care place of service. Is this language implying that the PDHP will be responsible for reimbursing for the dental services and the health plans will be responsible for covering the facility charges? Or will even the dental services be covered by the health plans if administered in one of the specified places of service?	See Addendum No. 3.
95	DentaQuest	VI. Coverage and Authorization of Services	F.	57	Are there any Agency-required experience and educational requirements for case managers?	There are no Agency-required education and experience requirements for case managers and case management support staff beyond what is established in **Attachment B .,** Scope of Service - Core Provisions. See **Attachment B.**, Scope of Service - Core Provisions, **Section VI.**, Coverage and Authorization of Services, **Sub-Section F.**, Care Coordination/Case Management, **Item 2.**, Additional Care Coordination/Case Management Requirements, **Sub-Items b.(4)** and **b.(5)**.
96	DentaQuest	VIII. Provider Services	A.	76	May a waiver be submitted for certain regions that simply do not have access to urgent care to dentists that offer extended office hours?	The respondent should utilize the form of response that it believes best responds to the requirement of the ITN. See Attachment B., Scope of Service - Core Provisions, Section VIII., Provider Services, Sub-Section A., Network Adequacy Standards, Item 9., Waiver, Sub-Item a.
97	DentaQuest	VIII. Provider Services	A.	77	If the PDHP determines it can increase the dentist ratio by 500 enrollees for each licensed dental hygienist affiliated with a PDHP providing dental services, must the dental hygienist obtain a Medicaid ID and complete the full credentialing process?	See **Attachment B - Scope of Services - Core Provisions**, **Section VIII**., Provider Services, **Sub-section C.**, Provider Credentialing and Contracting, **Item 2.**, Credentialing and Recredentialing.
98	DentaQuest	VIII. Provider Services	A.	81	Does the waiver process also apply to obtaining relief from requiring a specific percentage of participating PDPs by region offer after hours appointment availability to Medicaid enrollees since this may not be feasible in certain regions?	The respondent should utilize the form of response that it believes best responds to the requirement of the ITN. See Attachment B., Scope of Service - Core Provisions, Section VIII., Provider Services, Sub-Section A., Network Adequacy Standards, Item 9. ,Waiver, Sub-Item a.
99	DentaQuest	VIII. Provider Services	D.	95	For the provider training requirement noted within section VIII.D.3.c; must this occur in person or are webinars and other communications acceptable?	The respondent should respond in the manner that it believes best responds to the requirements of the ITN.

QUESTION NUMBER	VENDOR NAME	SECTION CITE REFERENCE	SUB-SECTION CITE REFERENCE	PAGE NUMBER	QUESTION	ANSWER
100	DentaQuest	VIII. Provider Services	D.	96	In section VIII.D.4.c, does the staffing requirement only apply to prior authorization needs and not other inquiries?	Yes.
101	DentaQuest	VIII. Provider Services	E.	99	Is the requirement in section VIII.E.1.h fully applicable to dental, since majority of codes are CDT compared to HCPCS/CPT?	This section is applicable to all services the PDHP provides.
102	DentaQuest	IX. Quality	A.	103	Would the Agency permit payment to providers for missed appointment code submission and accept via encounters in order to track missed and cancelled appointments for member outreach purposes (section IX.A.2.c)?	There will be no change to this specification of the ITN. Services must be medically necessary.
103	DentaQuest	IX. Quality	A.	105	Must the Dental Director acting as the chair or co-chair for the PDHP QI Program Committee be located in FL or simply possess a FL license?	Refer to **Attachment B.**, Scope of Service - Core Provisions, **Section X.**, Administration and Management, **Sub-Section B.**, Organizational Governance and Staffing, **Item 2.**, Minimum Staffing, **Sub-Item b.**
104	DentaQuest	IX. Quality	B.	107	Section IX.B.2.c - will the Agency provide data related to ambulatory care sensitive emergency department visits for dental caries in children and adults to the PDHPs?	This will be discussed as a part of the transition process with successful bidders.
105	DentaQuest	XII. Financial Requirements	G.	171	Section XII.G notes financial terms between PDHP and Pharmacy Benefits Manager. Please explain the applicability of this as it relates to the Scope of Services.	See Addendum No. 3.
106	Scion Dental	VIII. Provider Services	C.	84	Is the State aiming to consolidate credentialing services under a single entity for the entire State of Florida, even if there are multiple winners?	See **Attachment B.**, Scope of Service - Core Provisions, **Section VIII.**, Provider Services, **Sub-Section C.**, Provider Credentialing and Contracting, **Item 1.**, General Provisions, **Sub-Item c.**
107	Scion Dental	VIII. Provider Services	C.	85	Are respondents required to perform the level II background check for all providers, or is this background check performed by a different entity?	See **Attachment B.**, Scope of Service - Core Provisions, **Section VIII.**, Provider Services, **Sub-Section C.**, Provider Credentialing and Contracting, **Item 2.**, Credentialing and Recredentialing, **Sub-Item d.**
108	Scion Dental	VIII. Provider Services	C.	86	Are respondents required to perform in-person site visits for every provider in network, or throughout the entire State?	See **Attachment B.**, Scope of Service - Core Provisions, **Section VIII.**, Provider Services, **Sub-Section C.**, Provider Credentialing and Contracting, **Item 2.**, Credentialing and Recredentialing, **Sub-Item I.(2)**

ATTACHMENT C

QUESTION NUMBER	VENDOR NAME	APPENDIX REFERENCE	EXHIBIT REFERENCE (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
109	LIBERTY Dental Plan of Florida, Inc.		7	121	Attachment B, Page 121 of 214: The ITN specifies that selected plans "shall designate a full-time Dental Director who is a dentist licensed in the State of Florida with experience providing services to the populations served under this Contract." The pool of highly qualified dentists willing to entirely give up treating patients to become a Dental Director is small, and even if willing to do so will lose the perspective of a dentist actively serving Medicaid recipients in Florida. Will the Agency permit selected plans to hire two Dental Directors (a Chief and an Associate) – both of whom meet all of the criteria for a Dental Director in the ITN, and equal 1 or more FTEs in the aggregate – so that the Chief Dental Director may also maintain a part time dental practice serving Medicaid recipient patients?	There will be no change to this specification of the ITN.
110	LIBERTY Dental Plan of Florida, Inc.		4	2	Attachment A, Page 2 of 57: SRC#2 Do references to "respondent" used throughout the ITN apply only to the legal entity seeking to contract directly with AHCA and not its parent company, subsidiaries, or affiliates?	Please see the definition of respondent in Section 15 of Attachment A to the ITN and at section 1(c) in form PUR 1001.
111	LIBERTY Dental Plan of Florida, Inc.		2	2	Attachment A, Exhibit A-2-b Page 2 of 8: Also, pursuant to the ITN, a Prepaid Dental respondent may not "directly or indirectly, collude, consult, communicate or agree with any other respondent, as to any matter related to the response each is submitting [to the Florida Prepaid Dental ITN]." Do these prohibitions apply to a Prepaid Dental ITN respondent that wishes to collaborate with an MMA ITN respondent if the MMA ITN respondent has a parent or sister subsidiary company that intends to respond to the Prepaid Dental ITN?	Yes. A respondent to the Prepaid Dental ITN may not collude with any other person, persons, organization, or parties in submitting a response.
112	LIBERTY Dental Plan of Florida, Inc.		4	3	Attachment A, Exhibit A-4, pg 3 of 57 : SRC #2 evaluation item 1 appears to award no points if a respondent's headquarters is in Florida if its parent company is located elsewhere. It is not feasible for a respondent subsidiary to disassociate from its parent company in order to respond to an ITN. Please consider awarding 3 points to a respondent that currently has its headquarters in Florida but that has a parent with a headquarters located outside Florida, and 0 points only if both the parent and the subsidiary's headquarters are located outside Florida.	There will be no change to this specification of the ITN.

QUESTION NUMBER	VENDOR NAME	APPENDIX REFERENCE	EXHIBIT REFERENCE (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
113	LIBERTY Dental Plan of Florida, Inc.				To assist prospective MMA plans in the development of their responses to the MMA ITN, the Agency held a public meeting on April 12, 2017 to allow the Agency's employees and actuaries to present the MMA data book and collect MMA respondents' (and other stakeholder's) questions. Will the Agency please consider holding, as soon as feasibly possible, a similar public meeting for Agency staff and its actuaries to present the Prepaid Dental data book and collect Prepaid Dental respondents' questions?	The Agency does not plan on holding a public meeting regarding the Prepaid Dental data book.
114	LIBERTY Dental Plan of Florida, Inc.		4	25	Attachment A, Exhibit A-4, pg 25 of 57: "SRC# 15 – Expanded Benefits" contemplates that Prepaid Dental ITN respondents may propose to offer expanded benefits that duplicate expanded dental benefits for adults that are also included in the currently pending MMA Plan ITN (AHCA ITN [001-011]-17/18; SRC#9 "Dental benefits for adults"). It does not appear to be specified in either ITN (MMA or Dental) which plan would be the primary payor in the event that a particular enrollee's MMA plan and Dental plan both proposed to offer expanded benefits which are overlapping and duplicative yet were included in each plan's respective contract with AHCA. Please clarify whether the MMA plan or the prepaid dental plan is the primary payor for expanded benefits if both plans offer overlapping expended benefit coverage for the same enrollee. Alternatively, please consider addressing this issue at a public meeting as discussed in question 5, supra.	Coordination of expanded benefits will be subject to additional discussion during negotiations. The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
115	LIBERTY Dental Plan of Florida, Inc.		4	25	Attachment A, Exhibit A-4, pg 25 of 57 : "SRC# 15 – Expanded Benefits" contemplates that Prepaid Dental ITN respondents may propose to offer "Adjunctive general dental services for adults" yet does not appear to award points for doing so. Please clarify whether the omission of a stated point award for offering such benefits was an oversight and, if so, please clarify what if any points the Agency will award for proposing to offer those benefits.	See Addendum No. 3.

QUESTION NUMBER	VENDOR NAME	APPENDIX REFERENCE	EXHIBIT REFERENCE (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
116	LIBERTY Dental Plan of Florida, Inc			26	1. Attachment B, Pages 26-27 of 214: The "Excluded Populations" specified in the prepaid dental ITN does not include: children receiving services in a prescribed pediatric extended care center (PPEC); children with chronic conditions enrolled in the Children's Medical Services Network; or, other populations currently excluded from enrollment in an MMA plan. Does the Agency intend, based on this omission, to make enrollment in a prepaid dental plan mandatory for those previously excluded populations? Similarly, unlike existing MMA plan contracts, the prepaid dental ITN does not include a proposed contractual provision specifying the "Voluntary Populations" set forth in section 409.972, Fla. Stat., such as "Medicaid recipients enrolled in the home and community based services waiver pursuant to chapter 393, and Medicaid recipients waiting for waiver services." By this omission does the Agency intend to make enrollment of these previously voluntary populations mandatory for prepaid dental plans?	See Addendum No. 3.
117	LIBERTY Dental Plan of Florida, Inc		4	3	2. Attachment A, Exhibit A-4, pgs. 3-4 of 57: SRC #1 instructs respondents to provide "a list of all current and/or recent (since October 16, 2012) contracts for managed dental health care services," which could be interpreted to require a response which lists all contracts, including commercial contract. However, SRC #1 can also be interpreted to require only a list of Medicaid contracts based on: subpart a. which specifies that the respondent shall identify the "Medicaid population served" for each identified contract; and Evaluation Criteria 5 which awards points based on the "extent to which the respondent's Medicaid populations served are similar to the populations served by the Statewide Medicaid Prepaid Dental Health Program." Because the scope of the list provided includes the contracts of the "respondent's parent, affiliate(s), and subsidiary(ies)," the lists of national plans with extensive commercial lines of business could include thousands of commercial contracts (some for small private employers) for which the populations served, and services provided, would have little to no relevance to this procurement. Please clarify whether respondents must include in their list non-Medicaid contracts and, if so, whether the response may be limited in some way to eliminate non-relevant information (e.g., by limiting to only those contracts which involve populations similar to the Florida Medicaid population, or by excluding commercial contracts). If all contracts must be listed, please clarify whether information must be provided which is responsive to subparts a-n for all contracts listed, or only the Medicaid contracts.	There will be no change to this specification of the ITN.

QUESTION NUMBER	VENDOR NAME	APPENDIX REFERENCE	EXHIBIT REFERENCE (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
118	LIBERTY Dental Plan of Florida, Inc		4	3	3. Attachment A, Exhibit A-4, pgs. 3-4 of 57: SRC #1, Evaluation Criteria 2, awards points based on the "extent of experience of the respondent's subcontractor(s) in coordinating or providing services to Medicaid recipients." Please clarify whether "subcontractor(s)" as used in this Evaluation Criteria includes dental providers or only subcontractors to which a respondent delegates plan level duties? If the latter, will respondents that don't use subcontractors to coordinate or provide services to recipients get reduced points for this Evaluation Criteria even if they don't plan to use subcontractors to provide recipient services in Florida?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
119	Liberty Dental	Appendix I			Please provide a description of any program changes made to either benefits or eligibility between the base period in the data book and the rate year 18/19. Additionally, please provide the rating factors used to adjust for these program changes.	There will be no change to this specification of the ITN.
120	Liberty Dental			21	Section III.A.4 indicates that the PDHP proposal is to be quoted assuming the SFY 15/16 databook disctribution of members by rate cell for the 3 delivery systems in the base data. However, Section III.C (page 23) indicates that the cost proposal should reflect the anticipated enrollment in RY 18/19 in the delivery system distribution. Could the Agency please clarify? Additionally, can the Agency provide the most recent information available regarding the percentage blend for each delivery system for each rate cell?	There will be no change to this specification of the ITN. Respondents are to assume the SFY 15/16 data book distribution of members by rate cell for the three delivery systems in the base data included in the cost proposal. Respondents using data other than the data book are expected to normalize the data for differences in their starting base data relative to the data book base data to reflect a similar distribution in the cost proposal.
121	Liberty Dental			27	The cost proposal requires an actuarial certification to state that the rates in the cost proposal are actuarially sound and complies with ASOP 49 - Medicaid Managed Care Capitation Rate Development and Certification and that the rates are projected to provide for all reasonable, appropriate, and attainable costs during the time period for which they are intended. Section III.F lists specific items that are to be excluded from the cost proposal. By explicitly excluding certain items - namely program changes - the proposed rates cannot "provide for all reasonable, appropriate, and attainable costs". Can the agency please address this discrepancy between requiring the rates to be actuarially sound yet also requiring specific items to be excluded from the cost proposal?	Respondents should write the certification to indicate that rates are actuarially sound for the base rate for the applicable program and period before the application of items in Attachment C: III.F
122	Liberty Dental	Appendix III			Please provide the FFS Fee Schedule by procedure code so that PDHPs can assess any adjustments necessary for fee schedule differences.	http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml

QUESTION NUMBER	VENDOR NAME	APPENDIX REFERENCE	EXHIBIT REFERENCE (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
123	MCNA			6	What unit cost basis is reflected in the databook and base data for the Cost Proposal template? Is it the actual reimbursement to providers, or has the data been repriced to the current State Dental fee schedule?	The data was not repriced, see Attachment C: II.A.
124	MCNA			15	In our experience, not only do dental costs vary significantly between the adult and child populations, but also for children of different ages - particularly in the first few years of life and as they approach adulthood. Can the Agency share a distribution of ages for the children constituting the "Medicaid Only / Dual Eligible 0 to 20 Years" rate cell?	There will be no change to this specification of the ITN.
125	MCNA			15	Does the Agency expect that the age distribution of child (age 0 to 20) beneficiaries during the first year of the contract period will be approximately the same as the distribution that the data book is based upon?	There will be no change to this specification of the ITN.
126	MCNA			15	Does the fact that there are not distinct rate groups for the various eligibility categories (like TANF, SSI, HIV/AIDS, Child Welfare) included in the recent SMMC MMA indicate that the Agency did not see significant cost differences between eligibility categories?	There will be no change to this specification of the ITN.
127	MCNA			17	It was unclear to us if dental claims with a hospital, emergency room, or urgent care place of service are included in the data book, or excluded. Can you clarify?	Any dental claim with a hospital, emergency room, or urgent care place of service is excluded from the data book. See Attachment C: II.C MMA Capitated Plan and CMSN Encounter Data.
128	MCNA			N/A	Will the State mandate that PDHPs charge members copays for any covered benefits, such as complete dentures and partial dentures?	There will be no change to this specification of the ITN.

QUESTION NUMBER	VENDOR NAME	APPENDIX REFERENCE	EXHIBIT REFERENCE (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
129	Delta Dental	Appendix I	N/A	1	In Appendix I "Data Book Database", the claims and encounters are summarized at service category level by 6-month service period. Will AHCA provide detailed claim level data with membership and date of service information? If so, when will this information be available?	There will be no change to this specification of the ITN.
130	Delta Dental	Appendix I	N/A	1	Would the Agency please provide claim utilization data for the last 3 years?	There will be no change to this specification of the ITN.
131	Delta Dental	Appendix IV	N/A	1	In Appendix IV "Cost Proposal Template", it is specified that the rate is for October 2018-September 2019 rate year. However, no instructions were provided regarding rate year 2019-2023. How are the rates in future rate years developed? Please provide detailed information on the future rating process.	See **Attachment B.**, Scope of Service - Core Provisions, **Section XI.**, Method of Payment, **Sub-Section C.**, Payment Provisions, **Item 1.**, Prepaid Dental Health Plans, **Sub-Item a.**, Capitation Rates.
132	Envolve Dental, Inc.	Appendix I	2	1	Expanded benefit flags appear to be reversed (i.e. all child benefits are flagged 1 while all adult are flagged 0). Please confirm that this is incorrect.	Expanded benefits are flagged as intended. For all codes marked with a "1," all claims for these procedure codes outside the age range covered by Medicaid are considered expanded benefits. See **Attachment C**: Data Book, Cost Proposal Instructions, and Rate Methodology Narrative, **Section II.**, Dental Data Book, **Sub-Section C.**, Dental Data Book Claims Data MMA Capitated Plan and CMSN Encounter Data.
133	Envolve Dental, Inc.	Appendix I	N/A	10	On the "Procedure Code Mapping" tab of the Excel file "0121718_CI.xlsx", there are CPT and HCPCS "J codes" listed in addition to the expected CDT codes. These non-CDT codes comprise the "Other" service category. Please clarify under what conditions the PDHP covers physician services and J-code medications.	The PDHP shall be responsible for such codes when provided within the dental provider's scope of practice.
134	Envolve Dental, Inc.	Appendix I	N/A	10	The [Procedure Code Mapping] worksheet in Appendix 1 includes an "Expanded Benefit" column. It is unclear from the description in Attachment C whether services with the "Expanded Benefit" column flag set to 1 were historically expanded benefits that are now covered under the core PDHP benefit package, or whether they are considered as expanded benefits under the PDHP. Please clarify whether these services are considered core or expanded under the PDHP.	The expanded benefit procedure codes listed in Attachment C: II.A Data Book Structure, Procedure Code Mapping, are considered expanded benefits under the PDHP and are included for informational purposes only. Claims falling outside of the maximum age listed in column D and with an expanded benefit flag of "1" in column F are considered expanded. Expanded benefits should not be included in the final PDHP cost proposals.
135	Envolve Dental, Inc.	Appendix I	N/A	12	Please provide information on the demographic composition by gender and detailed age band of each rate group / rate cell in the data book.	There will be no change to this specification of the ITN.
136	Envolve Dental, Inc.	Appendix I	N/A	12	In the recent State of Florida MMA ITN (ITN 001-17/18 through ITN 011-17/18), "Adult Dental Services" was one of the expanded benefits that MCOs were encouraged to offer. If there is overlap in covered populations and benefits between the MMA "Adult Dental Services" benefit and the PDHP, please clarify how overlapping benefits will be coordinated between the two sources of dental coverage.	Coordination of expanded benefits will be subject to additional discussion during negotiations. **Attachment A** - Instructions and Special Conditions, **Section D.**, Response Evaluation, Negotiations, and Contract Award, **Sub-Section 5.**, Negotiation Process, **Item c.** The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.

QUESTION NUMBER	VENDOR NAME	APPENDIX REFERENCE	EXHIBIT REFERENCE (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
137	Envolve Dental, Inc.	Appendix I	N/A	12	In the recent State of Florida MMA ITN (ITN 001-17/18 through ITN 011-17/18), “Adult Dental Services” was one of the expanded benefits that MCOs were encouraged to offer. If there is no overlap between the MMA “Adult Dental Services” benefit and the PDHP, please clarify how dual coverage is avoided for members enrolled in an MMA plan with the "Adult Dental Services" benefit who are also in a PDHP-eligible population.	Coordination of expanded benefits will be subject to additional discussion during negotiations. **Attachment A** - Instructions and Special Conditions, **Section D.**, Response Evaluation, Negotiations, and Contract Award, **Sub-Section 5.**, Negotiation Process, **Item c.** The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
138	Envolve Dental, Inc.	Appendix I	N/A	17	Please provide information on reimbursement levels relative to the FFS dental fee schedule, as reflected in capitated plan experience in the data book.	There will be no change to this specification of the ITN.
139	Envolve Dental, Inc.	Appendix I	N/A	N/A	Please provide HEDIS rates for the historical periods presented in the data book.	HEDIS Annual Dental Visit rates for Florida Medicaid managed care plans are available on the Agency's website at: http://ahca.myflorida.com/Medicaid/quality_mc/submission.shtml
140	Envolve Dental, Inc.	Appendix I	N/A	N/A	What are we required to reimburse out-of-network providers for services rendered when an in-network provider is not available?	See Attachment B - Scope of Services - Core Provisions, Section VIII. Provider Services, Sub-section A. Network Adequacy Standards, Item 1. General Provisions, Sub-item d., p. 75/214
141	Envolve Dental, Inc.	Appendix I	N/A	N/A	Are we required to reimburse a contracted provider 100% of the State’s current fee schedule?	The Prepaid Dental Health Plan has the flexibility to negotiate mutually agreed upon rates with its providers.
142	Envolve Dental, Inc.	Appendix I	N/A	N/A	How does teledentistry services impact benefit limitations? For example, if a member receives an oral exam via teledentistry, will it impact the person's benefit limit for the year?	Telemedicine services do not impact benefit limitations. Telemedicine dentistry is a mode of delivery in which health care is delivered by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment. See **Attachment B.**, Scope of Service - Core Provisions, **Section VI.**, Coverage and Authorization of Services, **Sub-Section E.**, Coverage Provisions, **Item 4.**, Telemedicine Coverage Provisions.
143	Envolve Dental, Inc.	Appendix I	N/A	N/A	Are site visits required during the recredentialing process?	No.

EXHIBIT A-4-a

QUESTION NUMBER	VENDOR NAME	SUB-EXHIBIT REFERENCE	SECTION (IF APPLICABLE)	SRC # (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
144	MCNA	A-4-a-2	C. Recipient Experience	15	25	The list of expanded benefits in Exhibit A-4-a-2 for "Adult Dental Services" is identical to the Adult Dental Expanded benefit that was included in the recent SMMC reprocurement ITN. In the event that an adult Medicaid recipient is enrolled with a Managed Care Plan and PDHP who both offer the adult dental expanded benefit, how would services be coordinated between the Managed Care Plan and the PDHP? Specifically, would the PDHP still have primary responsibility for providing services listed under the Adult Dental Services expanded benefit in SRC #15?	Coordination of expanded benefits will be subject to additional discussion during negotiations. The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
145	MCNA	A-4-a-2	C. Recipient Experience	15	25	The expanded "Pregnancy-related" Dental benefits for adults in SRC #15 and Exhibit A-4-a-2 appears to be a subset of the expanded Adult Dental Services (both in the population and services covered). Wouldn't any PDHP opting to provide all the expanded Adult Dental Services also by definition be providing the "Pregnancy-related" expanded dental benefits? Or are the expanded benefits for adults explicitly for non-pregnant adults?	Enrollees may utilize each expanded benefit selected by the respondent, subject to population eligibility and medical necessity. For example, a pregnant-adult may access both the expanded dental benefits for adults and the expanded pregnancy-related dental services.
146	MCNA	A-4-a-2	C. Recipient Experience	15	25	For the "Over-the-counter" expanded benefit in SRC #15 and Exhibit A-4-a-2, can PDHPs have dollar or quantity limits, or are the benefits intended to be unlimited?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN. See Attachment B - Scope of Service - Core Provisions, Section VI. Coverage and Authorization of Services, Sub-Section C. Expanded Benefits.
147	MCNA	A-4-a-2	C. Recipient Experience	15	25	How will the Agency determine a score between 0 and 10 points for the "Other Dental benefits for adults" in SRC #15 and Exhibit A-4-a-2?	All 10 points will be given to respondents electing to offer "Other Dental benefits for adults".
148	MCNA		F. Oversight And Accountability	34	52	Evaluation Criteria #4 requests the extent to which the respondent uses innovative technology for the purposes of verifying home-based visits and services. Please confirm that this was a hold-over from another RFP and is not applicable to dental.	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
149	MCNA		B. Agency Goals	11	20	Please explain the criteria for scoring a responsive answer. Will plans who have not had "any instances of failure to meet contractually-required quality standards" automatically receive all points for this question? If so, the question would give an unfair advantage to inexperienced plans and plans who have never had to perform on a high volume full-risk statewide level and meet such rigorous goals. Additionally, if a plan had an instance or instances of failure to meet contractually-required standards, yet gave a thorough response about how they improved, how would points be allocated to the respondent?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.

QUESTION NUMBER	VENDOR NAME	SUB-EXHIBIT REFERENCE	SECTION (IF APPLICABLE)	SRC # (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
150	MCNA		C. Recipient Experience	16	26	Bullet c of this SRC requires a list of performance indicators in the provider directory results and Evaluation Criteria #3 scores the bidder based on the extent and relevance of the performance indicators available in the respondent's provider directory for each provider type listed. Please confirm that this was a hold-over from another RFP and is not applicable to dental. In reviewing the AHCA Comprehensive Quality Strategy, this appears to relate closely to indicators such as attainment of patient-centered medical home designation, which are not yet applicable to dental home providers.	There will be no change to this specification of the ITN. The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
151	MCNA		B. Agency Goals	7	12	Evaluation Criteria #3b requests the percentage of type of authorized providers that provided dental services through telemedicine during the 2016 calendar year. The CDT code to enable dentists to use telemedicine and report it on their claims/encounters will not become effective until January 1, 2018, per the American Dental Association. Please confirm that this was a hold-over from another RFP and is not applicable to dental.	There will be no change to this specification of the ITN.
152	Argus Dental & Vision, Inc.	A-4-a	B. Agency Goals	5	9	Please provide historical data on use of emergency departments for potentially preventable dental visits by region.	There will be no change to this specification of the ITN.
153	Argus Dental & Vision, Inc.	A-4-a	B. Agency Goals	10	18	Please confirm that respondents may use their experience as a Florida Healthy Kids vendor for responses to SRC 10 and Exhibit A-4-a-1 - Dental Quality Measurement Tool.	See SRC# 10. There will be no change to this specification of the ITN.
154	Argus Dental & Vision, Inc.	A-4-a	C. Recipient Experience	14	24	Please confirm that vendors are not limited to providing mobile dental services through the providers specified in s. 409.906(6), F.S., (county health department- or federally qualified health center-affiliated, serving adults in a nursing facility, or dental educational institution-affiliated), either as a covered service modality or as an in lieu of service.	The requirements of s. 409.906, F.S. apply to this ITN.
155	Argus Dental & Vision, Inc.	A-4-a	C. Recipient Experience	15	25	Please confirm that vendors may propose additional dental benefits not already included in the Dental and OTC lists on the "other" tab.	**See Attachment B** - Scope of Service - Core Provisions, **Section VI.** Coverage and Authorization of Services, **Sub-Section C.** Expanded Benefits.
156	Argus Dental & Vision, Inc.	A-4-a	E. Delivery System Coordination	22	33	This SRC suggests that transportation, outpatient prescribed drugs, and facility-based services are provided FFS, not through a Managed Care Plan. Please clarify.	See **Attachment B** - Scope of Services- Core Provisions, **Section VI.** Coverage and Limitation, **Sub-section E.** Enrollee Screening and Education, **Item 2**. and **Sub-section F.** Additional Care Coordination/ Case Management, **Item 2**.
157	Argus Dental & Vision, Inc.	A-4-a	E. Delivery System Coordination	26	40	Regarding evaluation criteria 5: "The extent to which the respondent's overall outreach approach identifies opportunities to improve upon the level of transparency for external stakeholders," does external stakeholders refer to members and their families, advocacy groups, stakeholders working in the EPSDT arena in Florida, or something else?	The respondent should utilize the form of response it determines best meets the requirements of the ITN.

QUESTION NUMBER	VENDOR NAME	SUB-EXHIBIT REFERENCE	SECTION (IF APPLICABLE)	SRC # (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
158	UHC	A-4-a	A. Respondent Background/Experience	1	3	SRC 1 requests the bidder to provide contract information for the respondent, parent, affiliate or subsidiary. Please confirm that the Agency's interest is in contracts limited to providing dental health care services as insurer or subcontractor for Medicaid contracts, only.	There will be no change to this specification of the ITN.
159	UHC	A-4-a	A. Respondent Background/Experience	3	6	SRC 3 requests the bidder to identify voluntary and involuntary contract terminations for the respondent, parent, affiliate, or subsidiary. Please confirm that the Agency's interest is in contracts limited to providing dental health care services as insurer or subcontractor for Medicaid contracts, only.	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
160	UHC	A-4-a	B. Agency Goals	9	15	Item a. refers to a Health Risk Assessment. Health risk assessment is also referenced in the Contract, Attachment B, Section VI (E)(2)(a) Enrollee Screening and Education, page 55, but is not defined. Please clarify which assessment this is in relation to dental services. Is it the Health Assessment as defined in the Contract, the comprehensive assessment referenced in Section XIV of the Contract, page 182, or some other assessment?	See Addendum No. 3.
161	UHC	A-4-a	C. Recipient Experience	15	25	Please explain who will be responsible for providing expanded dental benefits to adults when both a SMMC plan and dental plan elects to provide these benefits.	Coordination of expanded benefits will be subject to additional discussion during negotiations. The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
162	UHC	A-4-a	E. Delivery System Coordination	25	38	Will the dental plan have access to an enrollee's medical claims including BH claims data, for the purpose of coordination of care? If so, how will the dental plan access this data?	This will be discussed as a part of the transition process with successful bidders.

QUESTION NUMBER	VENDOR NAME	SUB-EXHIBIT REFERENCE	SECTION (IF APPLICABLE)	SRC # (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
163	UHC	A-4-a	C. Recipient Experience	14	24	The Provider Network Development Plan (SRC 14) refers to 3 types of services (emergency dental, preventive dental and mobile dental) on page 24 to demonstrate timely access in the plan; But in the Attachment B Scope of Services, Section VIII under B. Network Management, subsection 2c (page 82) and subsection subsection 2i (page 83) regarding the Network Development Plan requirements expect descriptions of certain elements of the network by "each covered service at all levels". Please clarify specifically the meaning of "each covered service" for these areas of the requirements for the draft Network Development plan, and its annual updates, and what is meant by "at all levels"?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
164	Delta Dental	A-4	N/A		1	Exhibit A-4, p. 1 of 1 states that the SRCs "may not be retyped and/or modified and must be submitted in the original format." The "Response" form fields in Exhibit A-4-a do not allow for any text formatting or insertion of tables. To improve readability and clear presentation of responses, will the AHCA consider unlocking the styles in the form-fillable "Response" section of each SRC so the responses can include basic formatting (e.g., bolded subheads, indents and bullet lists)?	There will be no change to this specification of the ITN.
165	Delta Dental	A-4	N/A		1	Exhibit A-4, p. 1 of 1 states that the SRCs "may not be retyped and/or modified and must be submitted in the original format." We are unclear about how to comply with that requirement while also complying with the requirement to locate SRC attachments behind their respective SRC responses. Please provide us with additional instructions on how to insert formatted SRC attachments into the Exhibit A-4-a file, including Exhibit A-4-a-1, Exhibit A-4-a-2 and Exhibit A-4-a-3.	See Attachment A, Instructions and Special Conditions, Section C. Response Submission Requirements.
166	Delta Dental	A-4-a	A. Respondent Background/Experience	1	3	Florida State regulations refer to State managed care plans as being paid on a “prepaid per capita and prepaid aggregate fixed-sum basis.” Therefore, it appears that contracts under which members pay a percentage of expenses and deductibles should be considered “traditional” and not “managed care” contracts. Therefore, we assume that Florida does not consider such contracts to be "contracts for managed dental health care services" and, as a result, we should not include those contracts as a part of our response to SRC# 1. Please confirm that this assumption is correct.	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.

QUESTION NUMBER	VENDOR NAME	SUB-EXHIBIT REFERENCE	SECTION (IF APPLICABLE)	SRC # (IF APPLICABLE)	PAGE NUMBER	QUESTION	ANSWER
167	Delta Dental	A-4-a	A. Respondent Background/Experience	1	3	With inclusion of all affiliates, subsidiaries, etc., a bidder may have hundreds or even thousands of managed dental health care services contracts. Would the Agency consider putting an upper limit on the number of contracts to be listed?	SRC# 1 states that respondent only need list current and/or recent contracts since October 16, 2012. There will be no change to this specification of the ITN.
168	Delta Dental	A-4-a-1	A. Respondent Background/Experience	3	6	What is the definition of "voluntary" versus "involuntary" termination?	The plain meanings of "voluntary" and "involuntary" should be used in preparing a response.
169	Delta Dental	A-4-a	B. Agency Goals	5	9	Please confirm the Agency's Event Notification System referenced in SRC# 5 is the same as the Event Notification Service referenced in Attachment B, Definitions (page 9 of 214). Please provide additional information on the Event Notification System (e.g., how it is currently used, what types of data it contains).	See Addendum No. 3.
170	Delta Dental	A-4-a	A. Respondent Background/Experience	5	9	Can you please breakout how the 40 maximum points for this section are allocated over evaluation criteria 1 through 7, as 7 x 5=35? Please specify if criteria (7)(a) is worth 5 points and criteria (7)(b) is worth 5 points.	Criteria (7)(a) and (7)(b) are worth 5 points each.
171	Delta Dental	A-4-a	A. Respondent Background/Experience	6	11	Can you please breakout how the 20 maximum points for this section are allocated over evaluation criteria 1 through 2, as 2 x 5=10? Please specify if criteria (1)(a), (1)(b), and (1)(c.) are worth 5 points each and criteria (2) is worth 5 points. These are just some examples. Please clarify where points to be awarded match the criteria and sub-criteria for all SRCs.	Criteria (1)(a), (1)(b) and (1)(c) are worth 5 points each; and criteria (2) is worth 5 points.
172	Delta Dental	A-4-a	N/A	9	15	Does the HRA mentioned in the ITN mean a dental HRA or a medical HRA? If medical, Is the State planning to make available medical claims data to the dental plan?	See Addendum No. 3.
173	Delta Dental	A-4-a	N/A	9	15	Is the Agency looking to build an entirely new kind of dental care coordination/case management? Is the Agency anticipating the dental plan get involved with medical plan matters (which might be out of scope for state insurance license purposes)?	See **Attachment B** - Scope of Service - Core Provisions, **Section V**I. Coverage and Authorization of Services, **Sub-Section F**. Care Coordination/Case Management.
174	Delta Dental	A-4-a	N/A	9	15	Would the Agency please define “Service Planning?”	See **Attachment B** - Scope of Service - Core Provisions, **Section IX**. Quality, **Sub-Section A**. Quality Improvement, **Item 3**. Individuals with Special Health Care Needs.
175	Delta Dental	A-4-a	N/A	9	15	Is the Agency anticipating funding a dental case management service focused on dental case management, or is the Agency interested in the dental plan assisting with an existing medical case management capability?	See **Attachment B** - Scope of Service - Core Provisions, **Section VI**. Coverage and Authorization of Services, **Sub-Section F**. Care Coordination/Case Management.
176	Delta Dental	A-4-a	N/A	9	15	Is the State looking for medical risk stratification or dental risk stratification?	See **Attachment B** - Scope of Service - Core Provisions, **Section VI**. Coverage and Authorization of Services, **Sub-Section F**. Care Coordination/Case Management, **Item 1**. General Provisions.

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177	Delta Dental	A-4-a	N/A	9	15	Would the Agency please define “plan of care,” in other words does it refer to the dental care plan or the medical care plan? Does the Agency anticipate the dental plan coordinating and intervening on the dental plan of care, or the provider coordinating and intervening appropriately on the dental plan of care?	See **Attachment B** - Scope of Service - Core Provisions, **Section IX**. Quality, **Sub-Section A**. Quality Improvement, **Item 3**. Individuals with Special Health Care Needs.
178	Delta Dental	A-4-a-2	N/A	15	25	Does the Agency expect to include the cost of expanded benefits in the claims cost based on the experience provided or may bidders price for expanded benefits based on anticipated utilization?	See **Attachment C - Appendix III**, Prepaid Dental Health Program Data book Supplemental Information. Note that expanded benefits should not be included in the final PDHP cost proposals since the cost of these services will not be included as part of the final capitation rate.
179	Delta Dental	A-4-a	D. Provider Experience	20	30	Evaluation Criteria #5 for SRC 20 references respondent's participation in the Agency's claims dispute resolution program under Section 408.7057, Florida Statutes. ITN Attachment B, Section VIII.D.5.d(5), page 98, states that the PDHP 'shall utilize the Agency's contracted dispute resolution vendor...' Does AHCA (or the vendor, MAXIMUS) have a written procedure PDHP's are required to follow to comply with this program? If so, can you please provide a copy or website location?	For more information on the Agency's Statewide Provider and Health Plan Claim Dispute Resolution Program go to http://ahca.myflorida.com/Medicaid/dispute_resolution.shtml or contact Maximus at 1-866-763-6395.
180	Delta Dental	A-4-a	E. Delivery System Coordination	22	33	Please specify what are the non-dental, SMMC plans' responsibilities for coordinating carved-out services?	See **Attachment B**. - Scope of Services - Core Provisions, **Section VI**. Coverage and Limitation, **Sub-section E**. Enrollee Screening and Education, **Item 2**. and **Sub-Section F**.Additional Care Coordination/ Case Management Requirements, **Item 2**.
181	Delta Dental	A-4-a	N/A	25	38	Does the Agency anticipate delivering at least the past three years of claims data (dental and medical) to the dental plan awarded the ITN, in order to allow understanding of "complex medical and/or behavioral health needs" and allow for stratification?	There will be no change to this specification of the ITN.
182	Delta Dental	A-4-a	N/A	25	38	Would the Agency please define "coordination of care" in this context, as it mirrors medical coordination of care language but is not usually applicable in a dental setting? Is the Agency interested in funding interventions outside the dentist-patient relationship (such as having the dental plan intervene) to address "enrollee engagement" and "treatment adherence?" Would the Agency please define "enrollee engagement?"	See "Care Coordination" definition in **Attachment B** - Scope of Service - Core Provisions, **Section I**. Definitions and Acronyms, **Sub-Section A**. Definitions. Also see **Attachment B** - Scope of Service - Core Provisions, **Section VI**. Coverage and Authorization of Services, Sub-**Section F**. Care Coordination/Case Management. The plain meaning of "engagement" should be used in preparing a response. The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.

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183	Delta Dental	A-4-a	E. Delivery System Coordination	27	42	Please specify what are the non-dental SMMC plans' responsibilities for providing and coordinating transportation services?	See **Attachment B**. Scope of Services- Core Provisions, **Section VI**. Coverage and Limitation, **Sub-section F**. Additional Care Coordination/ Case Management Requirements, **Item 2**.
184	Delta Dental	A-4-a	E. Delivery System Coordination	28	44	Does the Florida Medicaid enrollment application/process include identification of enrollees with special health care needs or circumstances?	The prepaid dental health plan will receive demographic, enrollment, and health information indicators via its Panel Roster and 834 reports.
185	Delta Dental	A-4-a	F. Oversight And Accountability	34	52	Since there are no other requirements or references to home-based visits or services, could the Agency please provide additional direction in regards to expectations, restrictions and limitations?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
186	Delta Dental	A-4-a-3	F. Oversight And Accountability	36	55	SRC 36 requires submittal of a completed Exhibit A-4-a-3, Provider Network Agreements, demonstrating the number of Provider Agreements the respondent has executed by the time the ITN response is submitted. However, ITN Section B.VIII.A.1.a. and B.VIII.C.5 require dental plans to submit a model provider agreement/templates for Agency review for compliance with Contract requirements. If respondents must obtain Agency approval of the provider agreement templates it will execute prior to proposal submission, please clarify the process. Or, should respondents use a provisional agreement, such as a Letter of Intent (LOI), for ITN response purposes?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
187	Delta Dental	A-4-a-3	F. Oversight And Accountability	36	55	In order to ensure that we secure participation agreements with dental providers in the appropriate locations, numbers and specialties to comply with access standards, please provide a file of enrollee counts of current SMMC enrollees by residence address or ZIP Code.	The Agency posts enrollments reports available to the public on the external website: http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml
188	Delta Dental	A-4-a-3	F. Oversight And Accountability	36	55	Please provide a listing of providers currently serving SMMC enrollees (or an encounter/claim file with at least 12 months of recent data) to enable respondents to minimize disruption to current patient/dentist relationships.	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
189	Delta Dental	A-4-a	F. Oversight And Accountability	38	57	Will the Agency for Health Care Administration consider full accreditation to the internationally recognized ISO-9001:2015 standard as a valid health plan accreditation alternative in lieu of NCQA?	See Addendum No. 3.
190	Envolve Dental, Inc.	A-4-a	B. Agency Goals	7	12	Will diagnostic services provided through teledentistry have a separate benefit limitation?	No. Refer to **Attachment B**. Scope of Service-Core Provisions, **Section VI**. Coverage and Authorization of Services, **Sub-Section E**. Coverage Provisions, **Item 4**. Telemedicine Coverage Provisions, **Sub-Item 1**.

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191	Envolve Dental, Inc.	A-4-a	B. Agency Goals	7	12	Will the State be adding the 2018 ADA CDT codes D9995 - teledentistry - synchronous; real time encounter and D9996 - teledentistry - synchronous; information stored and forwarded to dentist for subsequent review to the 2019 fee schedule to cover and reimburse for teledentistry services?	The respondent should utilize the current fee schedules and other relevant regulations in developing its response to the ITN.
192	Envolve Dental, Inc.	A-4-a	B. Agency Goals	8	13	Would you consider changing policy to allow mobile and portable dental service providers to render services when they do not have a brick and mortar location to provide more access?	There will be no change to this specification of the ITN.
193	Envolve Dental, Inc.	A-4-a	B. Agency Goals	10	18	Will the State be adding the 2018 ADA CDT codes D0601 - caries risk assessment and documentation with a finding of low risk, D0602 - caries risk assessment and documentation with a finding of medium risk, and D0603 caries risk assessment and documentation with a finding of high risk to the 2019 fee schedule to cover and reimburse dental providers to aid in caries risk assessment and group stratification?	There will be no change to this specification of the ITN.
194	Envolve Dental, Inc.	A-4-a	B. Agency Goals	10	18	The bid states the respondent will be measured against the extent to which a respondent exceeds the national mean. How does the national mean correlate with the State mean as FL has historically used State mean measurements from a contracting/measurement standpoint?	There will be no change to this specification of the ITN.
195	Envolve Dental, Inc.	A-4-a	D. Provider Experience	20	30	When referring to a Dispute Resolution process, is it agreeable to include this in our Complaints and Grievances process?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
196	Envolve Dental, Inc.	A-4-a	E. Delivery System Coordination	25	38	How does AHCA define risk as it pertains to AHCA's request for risk stratification?	See **Attachment B** - Scope of Service - Core Provisions, **Section VI**. Coverage and Limitation, **Sub-Section E**. Enrollee Screening and Education, **Item 2**. and **Sub-Section F**.Additional Care Coordination/ Case Management Responsibilities, **Item 2.b.**
197	Envolve Dental, Inc.	A-4-a	E. Delivery System Coordination	25	38	How will AHCA oversee and facilitate coordination between stand alone dental plans and the health plans?	See **Attachment B** - Scope of Service - Core Provisions, **Section X**. Administration and Management, **Sub-Section A**. General Provisions.
198	Envolve Dental, Inc.	A-4-a	E. Delivery System Coordination	25	38	Will the state facilitate a process between Health and Dental suppliers to share and identify those with complex health and dental needs?	Negotiation sessions for this ITN will include discussion of the scope of services to be provided by the respondent. **Attachment A** - Instructions and Special Conditions, **Section D**. Response Evaluation, Negotiations, and Contract Award, **Sub-section 5**. Negotiation Process, Item c.

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199	DentaQuest	A-4-a	C. Recipient Experience	15	25	In the MMA ITN, health plans had the option of offering an expanded adult dental benefit that mirrors the elected adult dental benefits (diagnostic, preventive, restorative, periodontics, and oral and maxillofacial surgery) in the dental ITN. If both a health plan and a PDHP offer the exact same expanded dental benefits, which entity would be the primary payer?	Coordination of expanded benefits will be subject to additional discussion during negotiations. The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
200	DentaQuest	A-4-a	C. Recipient Experience	15	25	For the MMA ITN, health plans had the option of offering an expanded adult dental benefit. Can the Agency please disclose which health plans committed to offering the adult expanded dental benefit?	Due to the competitive procurements for the Statewide Medicaid Managed Care Contracts, we are in a statutorily imposed “Blackout Period” until 72 hours after the award and cannot provide interpretation or additional information not included in the solicitation documents.
201	DentaQuest	A-4-a	F. Oversight And Accountability	29	45	Please define "third party payers."	See **Attachment B** - Scope of Service - Core Provisions, **Section XII**. Financial Requirements, **Section D**. Third Party Resources, **Item 1**. Covered Third Party Collections, **Sub-Item a**.
202	DentaQuest	A-4-a	C. Recipient Experience	15	25	Are PDHPs allowed to have limitations on the over-the-counter benefit?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
203	DentaQuest	A-4-a	C. Recipient Experience	15	25	Are PDHPs allowed to use system edits and require evidence of medical necessity for certain expanded benefits?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN. See Attachment B - Scope of Service - Core Provisions, Section VI. Coverage and Authorization of Services, Sub-Section C. Expanded Benefits, Item 1., General Provisions, Sub-Item c.
204	DentaQuest	A-4-a	A. Respondent Background/Experience	1	3	Please confirm the Agency is requiring respondents to disclose all contracts for managed dental care services inclusive of Medicaid, CHIP, Medicare Advantage, and commercial and under all financial arrangements (capitated or ASO).	The respondent should utilize the form of response it determines best meets the requirements of the ITN.
205	DentaQuest	A-4-a	A. Respondent Background/Experience	2	5	For evaluation criteria item #1, would the state consider awarding partial points for respondents that have corporate headquarters in Florida, but with the parent organization outside of Florida? A respondent may have a significant positive impact to the state's economy based on the number of individuals it employs in Florida.	There will be no change to this specification of the ITN.
206	DentaQuest	A-4-a	A. Respondent Background/Experience	3	6	Please define "termination" in the context of "voluntary termination."	The plain meaning of "termination" and the plain meaning of "voluntary" should be used in preparing a response.
207	DentaQuest	A-4-a	A. Respondent Background/Experience	3	6	Please define "involuntary termination."	The plain meanings of "termination" and "involuntary" should be used in preparing a response.

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208	DentaQuest	A-4-a	A. Respondent Background/Experience	3	6	In the normal course of business, we may need to voluntarily end a contract with a client. For example, we may end a contract if we cannot agree on a price point that supports an influx in service utilization. Continuing on with the contract would represent a financial loss to our organization. Therefore, we would end that relationship. Is this considered a "voluntary termination"?	Yes
209	DentaQuest	A-4-a	A. Respondent Background/Experience	3	6	The majority of our contracts are evergreen with no end date. If we end our contract with a health plan as their subcontractor voluntarily, would this be considered a voluntary termination?	Yes
210	DentaQuest	A-4-a	B. Agency Goals	5	9	Please provide detail as to what constitutes a "super-utilizer" of emergency departments for dental services. Will all PDHPs we held to the same definition?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
211	DentaQuest	A-4-a	B. Agency Goals	10	18	Respondents are required to use their three largest Medicaid contracts (measured by number of enrollees). Should respondents only consider child enrollees when measuring their "largest" Medicaid contracts?	No. The respondent should provide the three largest Medicaid contracts measured by the total number of enrollees, not just child enrollees.
212	DentaQuest	A-4-a	F. Oversight And Accountability	29	45	Are the respondents' provider networks considered subcontracts?	No. See **Attachment B** - Scope of Service - Core Provisions, **Section II**. Definitions and Acronyms, **Sub-Section A**. Definitions, Subcontract.
213	DentaQuest	A-4-a	F. Oversight And Accountability	29	45	Please define "third party payers."	See **Attachment B** - Scope of Service - Core Provisions, **Section XII**. Financial Requirements, **Section D**. Third Party Resources, **Sub-Section 1**. Covered Third Party Collections, **Sub-Item a**.
214	DentaQuest	A-4-a	A. Respondent Background/Experience	3	6	This SRC has an all or nothing point value. One respondent may have 150 clients, whereas another respondent may have only 10. In contrast, SRC 1 allows for other respondents with some experience to still gain points (it's not all or nothing). We respectfully ask the Agency to reconsider the scoring methodology for this question to at least account for the differences in the size and numbers of contracts (and thus exposure) a PDHP may have in the past and currently.	There will be no change to this specification of the ITN.
215	DentaQuest	A-4-a	B. Agency Goals	8	14	The last sentence of sentence of this SRC states an additional 5 points will be awarded to respondents who demonstrate that providers shall have real time access to "their" progress in achieving quality and/or performance metrics. Who or what is meant by the term "their" - the PDPH or the provider? And what specific quality and/or performance metrics must be available in order to earn the extra 5 points.	See Exhibit A-4-a, Submission Requirements and Evaluation Criteria, Section B. Agency Goals, SRC# 8, Provider Network Development, Evaluation Criteria 6. The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.

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216	DentaQuest	A-4-a	N/A	7	12	Reimbursement to providers for teledentistry services has just recently become available, and guidelines established for the State of FL by the telemedicine work group over the past couple weeks. As such, should examples be utilized from other states for evaluation criteria 3(b); and if not, how can this be applicable to respondents at this point in time within the state of Florida?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
217	DentaQuest	A-4-a	C. Recipient Experience	14	24	SRC #14 asks respondent to ensure access to "mobile dental services." SRC #27 asks respondent to demonstrate experience with "mobile dental units" (per F.S. 409.906). Florida Statutes at 409.906 at (1)(c) and (6) regulate Medicaid reimbursement of services provided in a "mobile dental unit." However, the statute or any Florida rules do not define "mobile dental unit." Since respondents must ensure access to mobile dental services and demonstrate experience with mobile dental units, our question is what does the state consider "mobile dental services" and "mobile dental units"? Is portable dental equipment considered a "mobile dental service" under the ITN and is portable dental equipment considered a "mobile dental unit" under the state and rules of Florida?	The requirements of s. 409.906, F.S. apply to this ITN. The respondent should utilize the form of response it determines best meets the requirements of the ITN.
218	DentaQuest	A-4-a	F. Oversight And Accountability	37	57	The language in the contract indicates the PDHP shall show or get "full health plan accreditation" and lists NCQA as one body that provides such accreditation. Since NCQA does not provide "full health plan accreditation" to dental plans, but does provide "certification" in certain area such as credentialing. Does this "certification," which is the highest level a dental plan can attain through NCQA, suffice as "accreditation" as used in the SRC and in the contract? In other words what does the Agency consider NCQA "certification" when NCQA does not provide full accreditation of dental plans?	See Addendum No. 3.
219	DentaQuest	A-4-a	B. Agency Goals	11	20	Would one example of a failure to meet a contractually required standard for ADV and one example of a failure to meet a contractually required standard for Preventive Dental Services be considered responsive to this SRC? If not, how many examples would the Agency like to see for this SRC in order to be responsive?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
220	DentaQuest	A-4-a	A. Respondent Background/Experience	1	3	Is the Agency expecting the respondents to list terminated contracts since 2012, or should this information only be included in SRC 3?	Terminated contracts should be listed in both SRC# 1 and SRC# 3.

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221	DentaQuest	A-4-a-3	F. Oversight And Accountability	36	N/A	The instructions of A-4-a-3 state that each respondent shall complete the scoring template by submitting the total number of agreements/contracts with Prepaid Dental Providers. Does "total number of agreements/ contracts" actually mean total number of unique providers? A contract may cover 20+ providers in some cases. In reviewing the Scope of Service, it appears ratios will be based on unique provider count.	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
222	DentaQuest	A-4-a-3	F. Oversight And Accountability	36	N/A	We are unable to type anything in the "count" box for "sedation total count" for any of the region tabs in Exhibit A-4-a-3. Can the Agency provide an updated version of this Excel document with those cells unlocked so we can enter in our data?	See Addendum No. 3.
223	DentaQuest	A-4-a	B. Agency Goals	7	12	Regarding evaluation criteria 3(a) - The requirement asks the respondent to indicate how many providers within its network are authorized to provide telemedicine service. It is our understanding that in Florida, all providers are technically "authorized" to provide telemedicine services. Is that accurate? If not, please define the criteria that would authorize a dental provider to provide services through telemedicine.	Refer to Attachment B - Scope of Service-Core Provisions, Section VI. Coverage and Authorization of Services, Sub-Section E. Coverage Provisions, Item 4. Telemedicine Coverage Provisions, Sub-Item 1. The respondent should utilize the form of response it determines best meets the requirements of the ITN.
224	DentaQuest	A-4-a-1	A. Respondent Background/Experience	2	5	The following seven operational functions are identified: 1) claims processing; 2) enrollee/member services; 3) provider relations; 4) utilization and prior authorization; 5) case management; 6) quality functions; and 7) finance and administration. Will bidders receive 5 or 4 points for performing all 7 functions in Florida, or if there are more than seven operational functions that will be scored, what are those additional operational functions? As written, the scoring for Item #2 does not align with the number of functions listed (7). Will a bidder performing all 7 functions in Florida would get 4 or 5 points?	See Addendum No. 3.
225	DentaQuest	A-4-a-1	A. Respondent Background/Experience	2	5	In scoring Item #1, will the state consider partial credit for a corporate headquarters in FL for bidders that are a subsidiary of or joint venture with another entity located out of state (even if the parent organization's corporate headquarters is located out of state)?	See Addendum No. 3.
226	DentaQuest	A-4-a-1	B. Agency Goals	9	15	Bidders must provide a detailed description of notable points in the system of care coordination, including a "Health Risk Assessment". Can the state please confirm the "Health Risk Assessment" is a combination of the defined terms "Health Assessment" and "Risk Assessment", and can be considered a tool that supports the "oral assessment" referred to on p. 58 of Attachment B?	See Addendum No. 3.

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227	DentaQuest	A-4-a-1	E. Delivery System Coordination	27	42	In subsection a. of SRC #27, about Dental and Medical Health Coordination, should there be a comma between "dental home" and "medical providers", so that the question reads as follows: "A description of the process designed to facilitate coordination of services between the dental home, medical providers, the SMMC plan, and community partners."?	See Addendum No. 3.
228	DentaQuest	A-4-a-1	F. Oversight And Accountability	31	48	Subsection e. of SRC #31 requests "documentation of the most recent three (3) years of encounter data submission compliance ratings, corrective actions… for Florida Medicaid." Also, bidders will be evaluated on the "adequacy of the respondent's encounter data submission historical compliance ratings." Because dental has been carved into the medical plan contracts since 2015, we do not believe we have any "compliance ratings" directly from the Agency in the last three years. Is there is other information or data bidders must submit about their historical encounter data performance, or should bidders generally answer the SRC in the manner it believes best responds to the requirements of the ITN?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
229	DentaQuest	A-4-a-1	F. Oversight And Accountability	34	52	Evaluation Criteria #4 in SRC #34 refers to the "extent to which the respondent uses innovative technology for the purposes of verifying home-based visits and services." Is this criteria referring to home- and community-based services, which pre-paid dental plans do not provide? If it is, will the Agency consider deleting this evaluation criteria as not applicable to pre-paid dental plans?	See Addendum No. 3.
230	Scion Dental		B. Agency Goals	5	9	Can the State provide data or metrics on potentially preventable emergency room department visits for the target population, for the purpose of answering this SRC?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
231	Scion Dental		C. Recipient Experience	16	26	What is the State's definition of performance indicator?	The plain meaning of performance indicator should be used in preparing a response.
232	Scion Dental		F. Oversight And Accountability	30	46	Are the mentioned "change control IT processes" in reference to the Software Development Lifecycle (such as enhancements or bug fixes)?	Yes.
233	Scion Dental		F. Oversight And Accountability	36	55	Are letters of agreement or letters of intent acceptable in lieu of an actual provider agreements for purposes of the RFP?	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.