

**ATTACHMENT A**  
**RFI Dental Health Plan**  
**Response Form**

Thank you for taking the time to complete this Request for Interest (RFI) for the Medicaid Dental Managed Care Contract.

Dental Health Plan input, information, and feedback is critical to Department of Health Care Services, Contract Services Branch (DHCS/CSB) in the development of state contracts. Your participation in this RFI is important, as it will aid the DHCS/CSB in its effort to establish Medicaid contracts that meet the business needs of the State. Dental Health Plans **are required** to submit a response to this RFI in order to participate in the solicitation process.

**Completion Instructions:**

- Fill in the required fields with your information;
- Attach any additional documentation as applicable;
- For questions, please contact the Procurement Official listed in the RFI Medicaid Dental Managed Care Contract Notice.

**SECTION I – Dental Health Plan Information**

<b>Company Name:</b>	
<b>Mailing Address:</b>	
<b>City, State, Zip Code:</b>	
<b>Contact Name:</b>	
<b>Telephone Number:</b>	
<b>Email Address:</b>	

**SECTION II – Narrative Questions**

*Please provide responses to the following questions. Please limit responses to yes/no, where applicable. For each yes response, please provide detailed supporting documentation in one page or less; single spaced, 12 point Arial font, per question. All responses should be limited to your experience with respect to Medicaid dental services.*

**Medicaid Performance Measures**

1. In which state(s) do you currently have Medicaid dental plans?
2. Does your plan achieve 60% utilization of annual dental visits (ADV) for children and adults combined?
3. Does your plan achieve 11% utilization of sealants for children ages 6-9 and 19-14 combined?
4. Does your plan achieve 60% utilization of preventive services for children and adults combined?
5. Does your plan conduct targeted provider and member outreach as a strategy to increase utilization?
6. Does your plan provide member incentives as a strategy to increase utilization?
7. Does your plan provide provider incentives as a strategy to increase your provider network?

**Medicaid Access and Availability**

1. Does your plan conduct routine monitoring at set intervals to ensure members' access to a Primary Care Dentists (PCD) within the required time and distance standard (10 miles or 30 minutes)?
2. Does your plan ensure compliance with the required provider to member ratios (1 PCD to 2,000 members; 1 network dentist to 1,200 members)?
3. Does your plan conduct routine monitoring at set intervals to ensure members' timely access to appointments within the required standards for initial (4 weeks), routine (4 weeks), preventive (4 weeks), specialist (adults – 30 business days; children – 30 calendar days), urgent (72 hours), and emergency (24 hours) appointments?
4. Does your plan regularly track provider specialty referrals (even those which do not require prior authorization) to ensure its network of specialty providers is sufficient in numbers and types to meet the dental needs of its members? Does your plan enter into contracts with out-of-network providers as necessary?
5. Does your plan conduct routine validation checks at set intervals to ensure that its Provider Network Report only

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represents those contracted providers who render services at the locations specified?

6. Does your plan conduct routine monitoring at set intervals to ensure that front-desk staff at each provider office provide members with accurate information regarding all contracted providers practicing at the specified location?
7. Does your plan conduct routine monitoring at set intervals to ensure appropriate in-office and telephone wait times at each provider office?
8. Does your plan conduct routine monitoring at set intervals to ensure members' access to after-hour calls and emergency services at each provider office?
9. Does your plan conduct routine monitoring at set intervals to ensure each provider office has processes in place to consistently follow-up on no-show appointments?
10. Does your plan routinely coordinate and track members' requests for transportation services?
11. Does your plan offer non-emergency medical transportation as well as non-medical transportation?
12. Does your plan routinely conduct onsite visits of each provider office to assess compliance with required standards? (access and availability, dental record (chart), utilization review of encounter data, encounter data submittal and performance measures)
13. When instances of provider non-compliance are discovered, does your plan conduct necessary follow-up and re-measurement activities to confirm remediation of identified deficiencies?
14. Does your plan conduct routine monitoring at set intervals to ensure the provision of 24-hour interpreter services (e.g., telephone and in-office) at all key points of contact?
15. Does your plan have a language line that supports DHCS' identified 16 threshold languages: Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Punjabi, Russian, Spanish, Tagalog, Thai, and Vietnamese?
16. Does your plan make materials available in alternative formats?

**Medicaid Utilization Management**

1. Does your plan timely adjudicate all prior authorization requests received from providers within required standards (within 5 business days from receipt of information reasonably necessary to make a determination but no more than 14 calendar days from receipt of the request)?
2. Does your plan consistently request further information from providers in an attempt to obtain documentation to substantiate medical necessity prior to outright denying services in an effort to avoid further delaying care for members who must subsequently go through the appeal process?
3. Does your plan, aside from inter-rater reliability testing, conduct routine monitoring at set intervals to ensure consistent application of Medi-Cal criteria and guidelines when denying services?
4. Does your plan conduct routine monitoring at set intervals to ensure all denial notices clearly document the clinical reason for the denial and identify the criteria/guideline that has not been met?
5. Does your plan conduct routine monitoring at set intervals to ensure appropriate appeal rights are attached to member denial notices?
6. Does your plan continually monitor for over and under-utilization of services and conduct necessary root cause analysis and follow-up to address identified trends?
7. Does your plan have an established referral tracking system in place to track all specialist referrals (even those that do not require prior authorization) from referral to service completion?
8. Does your plan conduct routine monitoring at set intervals to ensure the provision of Early and Periodic Screening Diagnostic and Treatment (EPSDT) services for all children under the age of 21?
9. Does your plan maintain a robust system for the oversight of its delegates, including a documented process for the receipt and review of data reports and deliverables on no less than a monthly basis?

**Medicaid Grievance and Appeals**

1. Does your plan conduct routine monitoring at set intervals to ensure timely resolution of grievances within 30 calendar days, including full investigation and documented response from providers?
2. Does your plan conduct routine monitoring at set intervals to ensure grievances that cannot be fully resolved by the next business day or do not meet the definition of exempt grievances are not inadvertently classified as exempt and processed as such?
3. Does your plan have clinical staff who oversee the grievance and appeal system to ensure consistent identification of all quality of care grievances?
4. Does your plan analyze appeal decisions to confirm accuracy of the initial decision-making process?

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**Medicaid Administrative & Organizational Capacity**

1. Does your plan meet or exceed the minimum loss ratio of 85%?
2. Does your plan maintain effective systems of controls to ensure the integrity of encounter data submitted to the State?
3. Does your plan screen the provider network against all state and federal mandated databases to ensure program integrity?
4. Does your plan have a robust system for the screening, enrollment, and credentialing/re-credentialing of providers and does not contract with any network providers who have not been fully vetted through this process?
5. Does your plan utilize allied dental providers?
6. Does your plan have the infrastructure to offer case management?

**SECTION III – Feedback**

*Please provide additional comments below.*