

**State of Indiana, Dental Benefits Management RFI-12-87
Questions and Answers**

Question No.	Question	Response
1	Is the fiscal agent, Hewlett Packard (HP), currently paying providers 100% of the current Medicaid allowable fee schedule?	Please see the dental section of Chapter 8 of the IHCP Provider Manual located at indianamedicaid.com.
2	<p>In the absence of utilization/encounter information by county or provider, what organization does the provider contracting, and who owns the Provider Agreements? Is it:</p> <p>a. The Indiana Family and Social Services Administration (FSSA)</p> <p>b. Indiana Office of Medicaid Policy and Planning (OMPP)</p> <p>c. Indiana Health Coverage Programs (IHCP)</p>	The OMPP is one of five divisions within the FSSA. The OMPP administers the IHCP. See Chapter 4 of the IHCP Provider Manual located at indianamedicaid.com regarding provider agreements.
3	Do any of the three organizations listed above and/or the fiscal agent, Hewlett Packard, reimburse for services utilizing fee schedules that are above and beyond the normal contracted fee schedule? If yes, please provide details.	The State reimburses dental services based on a fee-for-service with a set maximum rate. The State does not reimburse "above and beyond" the established rate. The IHCP pays a percentage of the maximum allowed amount or the billed amount, whichever is less.
4	Will the Dental Benefits Management (DBM) absorb the Provider Agreements that are currently in place or will the DBM be able to re-contract the network on DBM or State of Indiana's paper?	The State has not yet determined whether it will implement a DBM program. Respondents may suggest an approach for the State's consideration.
5	Is there an allowable fee schedule that is the "minimum" or floor? Meaning, if a Provider/Dentist agrees to re-contract, can some of these Provider Agreements be paid at a slightly lower rate than 100% of the Medicaid allowable fee schedule (assuming this is the contracted norm)?	Utilize established IHCP fee schedules. The OMPP requires rates that would support a network of providers without creating access of care issues for members due to insufficient reimbursement.
6	How many contracted providers are currently in the program?	<p>As of February 21, 2012 the total number of enrolled dental providers is 2,195, which breaks down into the following unduplicated classifications:</p> <ul style="list-style-type: none"> · 106 Dual Providers (a sole proprietor and a member of a group) · 1,075 Rendering-only Providers (cannot bill claims but can render services) · 666 Billing Providers (can bill claims and render services) · 348 Dental Groups (can bill claims and employ dual or rendering-only providers) <p>These counts are at the Medicaid provider number level (not NPI) and do not represent the number of service locations that exists. The geographic location for these providers is not limited to in-State.</p>
7	Is a list of the current contracted providers by county available? If yes, can a copy of the list be forwarded?	A list of providers is not relevant to the requested response to this RFI.

8	In order to provide the Indiana Office of Medicaid Policy and Planning (OMPP) an accurate estimate of cost savings from an Administrative Services Only (ASO) contract or a capitated/risk-based (full-risk) contract, [vendor] respectfully requests encounter/utilization data on any provider/dentist claim paid during CY (calendar year) 2009 and 2010, and/or the encounter data supporting Milliman's financial analysis and conclusions.	OMPP expects that vendors experienced in this area should be capable of providing a reasonable savings estimate based on the information available. Detailed data may be provided if and when OMPP decides to conduct a procurement for these services.
9	On page 4 of the RFI, it states: All narrative responses must be provided to the State in Microsoft Word format. Narrative responses shall be limited to ten (10) single-spaced pages written with a font size no smaller than 10 pt. Can the State please clarify if the ten page requirement is per section (Background and Experience and Capabilities) or per bullet point within the section, or total response?	The ten (10) page limit refers to the total response for Background and Experience and Capabilities.
10	Does the state intend to consider using more than one DBM services for the state's Medicaid and CHIP populations?	The State has not yet determined whether it will implement a DBM program.
11	What licensing requirements does the state have for a DBM to provide services to the state's Medicaid and CHIP populations?	Licensing requirements will be addressed if and when OMPP decides to conduct a procurement for these services.
12	What access requirements does the state have for a DBM to provide services to the state's Medicaid and CHIP populations? Do these requirements vary by region or area of the state?	Access requirements will be addressed if and when OMPP decides to conduct a procurement for these services.
13	What effective date is the state considering for the implementation of DBM services to the state's Medicaid and CHIP populations?	Implementation timing will be addressed if and when OMPP decides to conduct a procurement for these services.
14	In Attachment A, what is the difference between pages 7 and 8? It appears both are summaries of experience for CHIP but have significantly different membership numbers.	The second of the two pages (the one with the smaller enrollment) is CHIP II, or SCHIP. The first is CHIP I or MCHIP.
15	It is noted that there was a \$600 cap on most dental services for adults 21+ during 2009 and 2010. Does the State intend on implementing that cap (or other cost control measures) in the future? Does the data contained in Attachment A reflect the experience with the cap or has the data been adjusted by Milliman?	OMPP is interested in exploring cost control opportunities consistent with federal and state law which are available through a dental benefits management program. FSSA previously implemented a \$1000.00 cap pursuant to Rule 405 IAC 5-14-1(b). The cap took effect on January 1, 2011. A lawsuit was filed against FSSA. The complaint alleged the cap violated federal Medicaid law. FSSA contested the allegations. On November 4, 2011, the Court issued a Preliminary Injunction Order enjoining FSSA from enforcing the cap. Thus, currently, FSSA has no cap in effect. The data contained in Attachment A reflects the experience with the \$600 cap. It has not been adjusted by Milliman.
16	Can the State provide a listing of covered services (and frequencies) by code for each population?	Please refer 405 IAC 5-14, Chapter 8 of the IHCP Provider Manual and the Indiana Medicaid Fee Schedule for covered services.
17	Are there any Utilization Management restrictions for DBM's to consider?	Please refer to 405 IAC 5-14 and Chapter 8 of the IHCP Provider Manual for specific criteria pertaining to prior authorization and utilization.
18	Is the transmittal letter considered part of the ten page response document?	No, the transmittal letter is not considered part of the ten page response.
19	Are there any administrative services that the State would like to retain?	Respondents should describe their suggested approach.
20	May we utilize our proprietary fee schedules or are we required to use Medicaid fee schedules?	Please see question five (5).

21	Please provide a Medicaid census by county or zip code and by segment (age).	Detailed data may be provided if and when OMPP decides to conduct a procurement for these services.
22	Please provide a complete listing of covered services by code, in addition to any applicable exclusions and limitations.	Please refer to 405 IAC 5-14, Chapter 8 of the IHCP Provider Manual and the Indiana Medicaid Fee Schedule for covered services.
23	What date was the cap eliminated? Additionally, how is the cap reflected in the provided data?	<p>FSSA implemented a \$1000.00 cap pursuant to Rule 405 IAC 5-14-1(b). The cap took effect on January 1, 2011. A lawsuit was filed against FSSA. The complaint alleged the cap violated federal Medicaid law. FSSA contested the allegations. On November 4, 2011, the Court issued a Preliminary Injunction Order enjoining FSSA from enforcing the cap. FSSA has appealed the Preliminary Injunction Order. The cap is not being enforced at this time pursuant to the Preliminary Injunction Order.</p> <p>FSSA is interested in exploring utilization and cost control opportunities consistent with federal and state law. Whether or not FSSA will consider using a cap as a utilization and cost control measure is dependent upon the results of the litigation challenging the cap.</p> <p>The referenced cap was in effect for the entire period for which the previous data was provided. There are currently no caps in place. See also http://member.indianamedicaid.com/resource-center/news/dental-cap.aspx.</p>
24	Please provide a complete description of the predetermination process, in addition to any expeditious dental coverage review decision requirements.	Please see www.indianamedicaid.com .
25	Please define what constitutes a partially eligible member.	This is a partial dual eligible member. These individuals do not receive dental benefits.
26	Please detail any and all eligibility requirements.	Please see www.indianamedicaid.com
27	Please provide a detailed code-level breakdown for all utilization included in the attachments.	Detailed data may be provided if and when OMPP decides to conduct a procurement for these services.
28	Is there any annual cap currently in place?	No.