Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM THREE
QUESTIONS and ANSWERS

Date: October 21, 2016

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5427 Z1
to be opened October 31, 2016 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
1.	Glossary of Terms	xiii	Appears to be a very broad definition of subcontractors, covering any entity that does any work related to the contract, example, a company that simply assembles creditialing information for DentaQuest to review to make creditialing decisions. Is that the intent?	A subcontractor is any organization or person who provides a function or service outside the scope of a provider agreement.
2.	Project Desctition and Scope of Work	Page 140 j-Subcontractors	There are several detailed requirements, such as page 140 tracking hours, in which we do not do for most of our subcontractorsIn the cases it does not apply, is it okay to put "not applicable" in these circumstances?	The intent is for the bidder to provide i -iv for any and all subcontractors. If "not applicable" is the appropriate response, provide as such.
3.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Will you be providing a narrative that identifies the specific data assumptions and methodologies behind the specific payment rates for each age band?	Please review the PowerPoint presented during the Pre-Proposal Conference for the specific assumptions within the rate development. MLTC will provide a data book when the rates are updated in the Spring of 2017. The PowerPoint can be found at the following website: http://das.nebraska.gov/materiel/purchasing/5427/5427.html. And the direct link to the PowerPoint is: http://das.nebraska.gov/materiel/purchasing/5427/Optumas%20Dental%20Rate%20Presentation.pptx
4.	Attachment 7	Attachment 7	What Fee Schedules were used during the experience period as well as any fee schedule changes during the experience period and expected during contract year?	The underlying reimbursement for the rate development is Medicaid FFS. The only fee schedule change was for the repricing of the UNMC provider services at the average of the top 5 Commercial Dental Providers in Nebraska.

5.	Attachment 7 and 14	Attachment 7 and 14	Will you be providing membership growth or decline as well as providing monthly membership in relation to FY 2014, FY 2015 and future expectations?	Due to the fluctuation in the monthly membership, the annual membership provided in Attachment 7 is a more accurate data point to use in your own calculation of risk as it relates to the capitation rates offered in the RFP. The projected membership has not been fully defined as it related to the upcoming biennium budget.
6.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Will you be providing the member access rates (Current) and Expected?	The access rate assumed within the rate development is consistent with the access rate that was present within FFS during the base data time period of FY14-FY15. The State's actuaries will not be providing any additional information surrounding expected access.
7.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	What assumptions were used for Trending?	Please see Slide 9 and 10 of the FY18 Rates PowerPoint that was presented during the Pre-Proposal Conference for the trend assumptions. The PowerPoint can be found at the following website: http://das.nebraska.gov/materiel/purchasing/5427/5427.html. And the direct link to the PowerPoint is: http://das.nebraska.gov/materiel/purchasing/5427/Optumas%20Dental%20Rate%20Presentation.pptx
8.	Attachment 7 and 14	Attachment 7 and 14	Will you be providing Claim Lag data for the FY 2014 and FY 2015?	Since the IBNR adjustment shown on Slide 7 of the Optumas Dental Rate Presentation (please find link in the response to Question 7) is "de minimis" no further information will be provided.
9.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Will you be providing the assumptions for Coordinated care savings or Managed care savings?	There are no assumptions for coordinated care savings or managed care savings. Those savings are dependent upon how the DBPM manages the program. The State

				does not anticipate savings, but requires the DBPM to manage a more efficient and sustainable program.
10.	Attachment 7	Attachment 7	Will you be providing DCode level experience/utilization?	Yes, please see Attachment 16.
11.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Will you be providing any program changes assumed in the rating?	All adjustments, including policy adjustments was shared during the Pre-proposal Conference (please find link in the response to Question 7).
12.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Confirmation that "Net Medical Rate" only includes claim cost.	Confirmed.
13.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Confirmation that "Loaded Rate" excludes ACA/HIPF Taxes.	Since the program is new during FY18, the ACA/HIPF tax does not apply during the first contract year.
14.		Page viii	**"Auto assignment"** states that an enrollee, who does not select a dental home within a predetermined length of time during enrollment activities is automatically assigned to a dental home." How does automatic assignment work?	The DBPM will develop an algorithm that MLTC must approve. The algorithm may account for previous member-provider relations, familial relations, provider location, etc.
15.			Can dentists through the DBM get assistance with reasonably priced language interpretation so they are in compliance with OCR 1557 Rule? Language line is approximately $4.95/minute. Can this be added to the contract?	This will not be required of the DBPM. The DBPM could propose this as a value-add service.
16.			What is the total cost of the contract? We couldn't find it listed. If you do the math, it appears to be in the range of $55 million. Why is not just stated?	The total cost of the contract is dependent on the final capitation rates and the membership mix for each month of the contract.
17.			Can you require that the dentist portal include the ability to access the amount of	The bidder should provide a response that meets the requirements of the RFP.

			the $1,000 cap that has been spent for an adult patient? Otherwise, the dentist has no way of knowing what was spent in another clinic and could go over the cap.	
18.		Page 38	"*Providers may not bill members any amount greater than would be owed if the DBPM provided the services directly (i.e., no balance billing by providers is permitted)*." With a $1,000 cap on adult benefit, how will non-covered services be handled? How will covered services once the member reaches the annual maximum be handled? Are these determinations being left to the DBPM?	The DBPM may provide value-added services above what Medicaid currently covers. There are no planned changes to the policy related to Non-covered services.
19.		Page 40	"*The Dental Director must be currently licensed as a Doctor of Dentistry ("dentist") with no restrictions or other licensure limitations*." – The Dental Director should be licensed in the state of Nebraska.	Please see Addendum Four, #3.
20.		Page 48	*Value added services: Minimizing the occurrences of missed appointments through member incentives, technology-based appointment reminders, member education, or other mechanisms identified by the DBPM*. Consider that case management services also be included specifically in this sentence.	Case management is not precluded as a proposed value-added service.
21.	**8(e)(ii)**	Page 8	discusses minimizing the occurrences of missed appointments through member incentives, technology-based appointment reminders, member education, or other mechanisms identified by the DBPM. Is there a mechanism that requires the DBM to track missed/late cancelled appointments to help the Provider?	No. MLTC identified that as a priority for potential value-added services, but the DBPM will have the discretion to decide which value-added services it would like to propose. Please see Section IV.E.8.d.

22.		Page 57	Notice to Members of Provider Termination mentions "When timely notice from the provider is received, the notice to the member must be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider." Timely notice is not defined. Include standard protocol that a dentist may to discontinue seeing a patient as long as patient is provided 30 days of emergency care while in transition of finding a new dental home.	Please see Addendum Four, #4.
23.			Can MLTC require the dentist portal to include what dental services the patient has received in the last 12 months to avoid duplicating services and billing? For example, dentist #1 could place a sealant, but in 6 months it falls off. Dentist #2, not knowing that the sealant was placed, billed, and lost, places another sealant and bills for it. Now dentist #2 is in violation of the rule that sealants can only be billed out every 2 years.	Please see response to Question 17.
24.		Page 64/65	*For the first year of the contract period, the DBPM must accept into its network any dental provider participating in the Medicaid program provided the dental provider is licensed and in enrolled with DHHS and accepts the terms and conditions of the contract offered to them by the DBPM. This provision also does not interfere with measures established by the DBPM to control costs and quality consistent with its responsibilities under this contract nor does it preclude the DBPM from using different reimbursement amounts for different*	The DBPM and provider will negotiate reimbursement through the contracting process but are required to reimburse no less than the published Medicaid fee-for-service rate in effect on July 1, 2016 for the first year of the contract.

			specialties or for different practitioners in the same specialty [42 CFR §438.12(b)(1)]. Note this opens the door to the DBPM negotiating rates with individual providers just like the commercial sector. Some dentists may experience lowering reimbursement rates especially after the first year. It sounds like the DBPM can pay a differentiated rates for dentists in network for good reason (under provider incentives). Good reason might be one dentist in the whole community/county being in network or a lack of specialists and one specialist is seeing a disproportionate amount of patients/members. Are we understanding this correctly?	
25.		Page 68	*Credentialing and Re-credentialing of Providers and Clinical Staff* – The contract does not appear to stipulate how quickly credentialing should be accomplished. This is a problem in some states that takes up to 6 months to credential a new provider and this becomes an issue. 30 days is preferred.	Please see Addendum Four, #8.
26.		Page 74	The DBPM must develop, establish, and maintain a provider advisory committee to create network development and management strategies and procedures. Include the requirement that the DBPM should share the *Reporting Dashboard* (page 125) with the advisory committee.	The Reporting Dashboard is an internal tool to ensure accountability. While MLTC or the DBPM may share the dashboard with external stakeholders, MLTC will not include that requirement in the RFP.
27.		Page 77	*QAPI Committee*: The RFP asks the DBPM to describe how they will get provider input into any QAPI plan. Include a representative from the NDA on the QAPI Committee.	Per Section IV.M.2.a.i-iii of the RFP establishes the minimum QAPI Committee membership. The bidder should provide a response that meets the requirements of the RFP.

28.		Page 82	*The DBPM must submit an electronic copy of the UM policies and procedures to MLTC for written approval within thirty (30) calendar days from the date of award, annually thereafter, and prior to any revisions*. The NDA requests that state to share this for input or request the state include a requirement in the contract that the DBPM needs to seek input on these from the NDA.	The bidder must meet all of the requirements of this RFP. The bidder should provide a response that meets the requirements of the RFP.
29.		Page 99	*For the first year of the contract, the DBPM rate of reimbursement must be no less than the published Medicaid fee-for-service rate in effect on July 1, 2016, unless MLTC has granted an exception for a provider-initiated alternative payment arrangement*." Can MLTC stipulate that the FFS fee schedule is the floor always rather than just the first year?	No, the DBPM and the providers should negotiate and contract alternative payment methods rather than only rely upon the fee schedule.
30.			Will the provider manual be available to dentists before they are asked to sign the provider contract?	MLTC will require the DBPM to submit for approval to MLTC its provider manual within thirty (30) days after contract award. Providers are free to contract with the DBPM before or after receiving the Provider Manual.

31.		Page 111	*MLTC reserves the right to review any claim paid by the DBPM or its designee. The DBPM has the right to collect or recoup any overpayments identified by the DBPM from providers of service in accordance with existing laws or regulations. However, if an overpayment is identified by the State or its designee one year or later from the date of payment, the DBPM will collect and remit the overpayment to MLTC. In the event the DBPM does not collect mispayments from the provider within 30 calendar days of notification of the overpayment, the DBPM must refund the overpayment to MLTC. Failure by the DBPM to collect an overpayment from a provider does not relieve the DBPM from remitting the identified overpayment to MLTC*." Nowhere in the contract does it say how far back the DBPM can go to claim overpayments. Neb.Rev.Stat. § 68-974 states that all recovery audit contractors retained by the department when conducting a recovery audit shall review claims within two years from the date of the payment. Does this two year lookback period apply to the DBPM? If not, include a two year lookback limitation.	The bidder must meet all of the requirements of this RFP. MLTC cannot limit the timeframe associated with any audit the Medicaid program is subject to.
32.			Would you mind clarifying Form A Bidder Contact Sheet? Do you have a specific order or location you would like this included in the response?	Bidders should complete Form A, Bidder Contact Sheet and include with their proposal response. The State does not have a specific order or

				location. The sections of the proposal response should be separated by an identified tab.
33.	Section IV.C.2	Page 35	Will a certificate of authority to conduct the business of accident and health insurance issued by the Nebraska Department of Insurance to a foreign (Texas) insurer satisfy the licensure requirements of this RFP?	No, the contractor will be required to obtain a certificate of authority from the State of Nebraska before go live.
34.	Section II.P	Page 6	According to the Nebraska Secretary of State's Office, and Chapter 21 Section 20,168 (4) The Requirements of the Business Corporation Act shall not be applicable to foreign or alien insurers, which are subject to the requirements of Chapter 44. Please confirm that a foreign insurer authorized to transact the business of accident and health insurance by the Nebraska Department of Insurance will not be required to submit a Secretary of State certification with their bid, pursuant to Section II.P of the RFP.	The State is looking into this and will provide a response at a later date.
35.	Section D Staffing Requirements 2.c	Page 38	Is the replacement of key staff approved by state prior to job offer? Is this also required for initial hires?	MLTC must approve initial and replacement hires of key staff prior to the key staff starting.
36.	Section D Staffing Requirements	Page 42	What will Dental QA and Government Quality be doing, separation of responsibilities?	MLTC requires the DBPM to employ a staff member dedicated to the daily business of quality management and improvement. MLTC's role in quality assurance is to review and audit the DBPM's quality measures and initiatives.

37.	Section E Core Medicaid Dental Benefits	Page 45	How often are the state benefit grid (from website) updated with CDT codes?	The program reviews the yearly release of any new code updates from the ADA around November or December for the following year. MLTC implements or makes needed additions or revisions to the codes and fee schedule for a January 1 release. MLTC also reviews and adds or revises the fee schedule during our fiscal year with a release date of each July 1.
38.	Section E Core Medicaid Dental Benefits	Page 45	Will we have access to the incumbent's current clinical guidelines?	This is a new program and there is no incumbent. Nebraska Medicaid's clinical guidelines can be found in the Medicaid & Long-Term Care Rules and Regulations.
39	Section H Grievance and Appeals	Page 59	Is there a time period when a member cannot file a grievance, i.e. 180 days after date of service or occurrence?	The DBPM must establish their grievance system that meets all relevant Federal and State regulatory requirements.
40.	Section H Grievance and Appeals 4.d.ii	Page 61	Requirement of only 1 level of appeal-does it then required to go to a Fair Hearing?	Per 42 CFR 438.402, the DBPM may have only one level of appeal for enrollees.
41.	Section H Grievance and Appeals 7.a	Page 63	Are all Fair Hearings telephonic? Are there any requirements to present in person?	Fair hearings are held in the DHHS Hearing Office in the State Office Building in Lincoln. The parties are permitted to appear in person or by telephone.
42.	Section H Grievance and Appeals 7.a	Page 65	Will we be provided the number of grievances, appeals, Fair Hearings historically?	The Fair Hearing Office opens appeals as directed by the Divisions. They opened 2 Medical Assistance Dental appeals in 2016 and 10 in 2015. In addition, they opened 99 Recovery Audit Contractor appeals in 2015, all of which appear to

				involve dental providers. It is estimated that a number of appeals opened as Medical Assistance Payment appeals involved dental providers, but they do not track those appeals by provider type.
43.	Section I Provider Network Requirements	Page 64	Will the State consider Letters of Intent or Letters of Agreements as acceptable for the necessary network coverage requirements?	Letters of Intent and Letters of Agreement are not required as part of the proposal. MLTC will determine network adequacy by the provider enrollment file, as well as data and analysis attesting to the sufficiency of the DBPM's network.
44.	Section I Provider Network Requirements 1.f	Page 65	Can the Plan terminate providers "without cause"	No, except when the provider does not act on re-validation. In this case, the plan may terminate.
45.	Section I Provider Network Requirements 1.h.v	Page 65	Is the methodology of the access surveys determined by the dental plan?	Yes, but the DBPM must submit the survey for MLTC's approval.
46.	Section I Provider Network Requirements 5.c	Page 66	We do not currently contract and list prosthodontists, will this be required for NB?	No. Contracts are not required but the services must be available.

47.	Section I Provider Network Requirements 5.e	Page 67	Is the dental plan able to interpret this requirement, and have a mechanism to require some requirements for specialty referrals, or are all specialty referrals to be "self-directed"?	The DBPM will submit their proposed process for MLTC approval during contract finalization.
48.	Section V Proposal Instructions A	Page 138	Where would the State prefer the Scope of Work response to be included within the Technical Proposal?	The State does not have a specific order. The sections of the proposal response should be separated by an identified tab.
49.	Attachment 4 Dental Access Standards		Will the State be providing a census?	Yes, please see Attachment 17. This is a census based on CFS service areas, which can be found here: http://dhhs.ne.gov/children_family_services/Documents/SvcAreaMap-NEW.pdf
50.	Attachment 14 - COA-level Rate Development	Page 3	There is an UNMC % adjustment applied to the base data. Can you please provide additional detail on what this adjustment accounts for and how it was calculated?	The State provided their actuary with the UNMC provider IDs. The State's actuary used that information to identify the UNMC claims inherent in the FFS data, and repriced the claims to an enhanced fee schedule provided by the State. This enhanced fee schedule reflects the average reimbursement of the top 5 Commercial Dental Providers in Nebraska.
51.	Attachment 1		Are there any limitations on the levels of Incentive Bonuses or Activities that improve health care quality that can be included as Net Qualified Medical Expense?	The definition for activities that improve quality is consistent with the Medicaid Managed Care Final Rule released by CMS. As such, there is no predefined maximum associated with these types of services.

52.	Attachment 1		Please define what is considered to be "related-party medical margin"	Related-party medical margin is any margin built into sub-capitation arrangements between a parent and subsidiary company, to the extent they exist.
53.	Attachment 1		Is the 2% Hold Back included in the calculation of "revenue earned" described in Section 3 of the MLR Calculation description? If so, is an adjustment allowed in the event a porion of the holdback is not ultimately "earned" by the DBPM?	The MLR calculation will include the portion of the hold back that is ultimately earned by the DBPM.
54.	Attachment 7		Please describe what, if any, adjustments have been made to the base experience data presented in the data book. Were any claims excluded and, if yes, why? Was there any repricing of historical claims to reflect payment at 100% of the dental fee schedule?	No dental claims were excluded. All claims are reimbursed at a 100% dental fee schedule so claims were not repriced.
55.	Attachment 7		Can the state provide the mapping used to align dental service codes with the CoS descriptions contained in the data book?	Please see Attachment 18.
56.	Attachment 7		Please describe the methodology used to categorize members in specific age cells. Is cell determined based on age at a point in time or does a member change cells within a SFY on their birthdate?	The rating cohorts are based on the member's age at the time the claim was incurred within the rate development. Operationally, a member's age cohort will be determined on a monthly basis when capitation payments are made.
57.	Attachment 7		Does the state anticipate any significant shifts in the projected population distribution relative to what was seen in the base experience period(s)? If yes, please describe.	MLTC does not anticipate shifts in the population distribution relative to the base data.

58.	Attachment 7		Please confirm that the Units column reflects the sum of actual service units submitted for each claims and does not represent visits or encounters.	Confirmed.
59.	Attachment 8		Please confirm that there are no planned adjustments to the capitation rates shown in this exhibit. It is assumed rates will be paid as shown with no adjustments for risk, region, gender differences in a particular DCO's membership distribution.	The rates will be updated in the Spring of 2017 to incorporate more recent base data and any new policy changes that may be in effect during the FY18 contract period.
60.	Attachment 13		Please provide a file containing projected membership by each county within the state	Due to counties having populations small enough to potentially identify individuals enrolled in Medicaid, MLTC cannot provide that information. However, please see the response to Question 49.
61.	Attachment 14		Please provided further detail around the UNMC Repricing factors applied in the rate development. What is the purpose of this adjustment? How were the SFY14 and SFY15 Adjustments estimated?	Please see response to Question 50. There was no estimated adjustments because MLTC had actual data.
62.	Attachment 14		What is the rationale for the 50/50 blending of SFY14 and 15 claims experience? I would expect greater weight would be assigned to the more recent data.	During the rate development process the FY14 data is trended forward one year to FY15 in order to place both years of data on the same basis prior to blending. There were no significant reasons that led MLTC to believe the FY15 base data more accurately represents the expected experience for the FY18 contract period, thus an equal blend of FY14 and FY15 was used when developing the final rates.

63.	Attachment 14		Please describe the process for determining the 2.0% Utilization Trend assumed in the rate development. Any detailed analysis supporting this estimate would be appreciated.	MLTC reviewed historical FFS data to help inform the aggregate PMPM trend across all services. This aggregate PMPM trend was uniformly distributed between the utilization and unit cost components of the trend assumption. These trend assumptions will be refined at the more detailed category of service level when the FY18 rates are updated in the Spring of 2017.
64.	Attachment 14		Please describe the process for determining the Unit Cost Trend assumed in the rate development. Are there any known changes to the state fee schedule included in this estimate? Any detailed analysis supporting this estimate would be appreciated.	See the response to Question 63.
65.	Attachment 14		Please confirm that the rate development assumes the annual trends shown in this exhibit will be compounded annually across a 36 month period. Additionally, please confirm that the annualized trends are EXACTLY as they appear in the exhibit (i.e. rounded to the nearest tenth of a percent) and that the 36 month compounding is NOT rounded in the calculation.	Confirmed. The FY14 base data was trended for 12 months in order to place both years of data on the same basis prior to blending. The two years were then blended together and trended from the midpoint of the FY15 time period (12/30/2014) to the midpoint of the FY18 time period (12/30/2017). The trends shown during the Pre-proposal Conference are the exact trends used in the rate development. However, please note that trends are applied at the COA and COS level of detail. As such, the trends shown on the “COA Rate Development” exhibit will be the effective COA trends across all services.

66.	RFP Document P.2.k	97	Can the state provide the certification document referenced in P.2.k on page 97? The rate development has been provided in Attachment 14 but the accompanying narrative would be helpful in better understanding the specific components of the development.	MLTC will provide a databook when the rates are updated in the Spring of 2017.
67.	RFP Document P.7.	101	Please provide further detail around the supplemental payments DBPM's are required to "pass through" to UNMC providers. Is it the intention of this program to be revenue neutral to the DBPM or does over/under utlization risk exist? Additionally, what is meant by the statement "these payments are calculated into the captiation rate on a quarterly basis"? This would imply the capitation rates shown in Attachment 8 will be modified multiple times per year???	The UNMC supplemental payment is a per member per month amount that is calculated based on utilization of service provided by the UNMC providers. The intention is to be revenue neutral. The UNMC supplemental payment is calculated quarterly and does not impact capitation rates.
68.	RFP Document R.12.a	112	Has the states actuary assumed a certain level of expected Third Party Liability payments in their rate development and, if so, what is the projected amount? This question is meant to include COB dollars as well.	The dollars underlying the rate development are the Medicaid paid amounts inherent in the FFS data. As such, MLTC is assuming that the TPL recovered in the contract period will resemble the level of TPL inherent in the base data.
69.	Section IV.C.3 Accreditation	35	Section IV.C.3, page 35, requires that the DBPM obtain Health Plan Accreditation through NCQA. Per our understanding of NCQA accreditation requirements, the DBPM would not qualify to apply for Health Plan Accreditation through NCQA. The DBPM could apply for NCQA Certification for the functions of Utilization Management	MLTC will accept URAC for accreditation.

			and/or Credentialing. Additionally URAC offers a comprehensive Dental Benefit Plan Accreditation. Can the State please clarify the requirement around NCQA? Is the requirement meant to reference NCQA Certification in Utilization Management and/or Credentialing? Additionally, would the State consider URAC accreditation in lieu of NCQA certification as the URAC accreditation is more comprehensive than NCQA certification.	
70.	IV.G Member Services and Education	51	Describe proposed member education content and materials and "attach examples" used with Medicaid or CHIP populations in other states. Describe innovative methods the DBPM has used for member education. Describe how the DBPM will provide equitable member education throughout the State. "Provide examples" and descriptions of how member education will be used to improve service coordination including: - The use of technological tools, including social media and mobile technology. - Partnership with community-based organizations for education and outreach. **Please confirm requested examples are not included in the page limit.**	MLTC confirms that requested examples are not included in the page limit.
71.	RFP Dental Management Document	4	Would the state please confirm that all attachments can be placed behind a tab for attachments behind the technical narrative?	This formatting is acceptable to the State.

72.	RFP Dental Management Document	4	Will the State please confirm that Calibri 11pt. Font with 1 inch margins on all sides is acceptable for all required responses?	This formatting is acceptable to the State.
73.	RFP Dental Management Document	4	Please confirm that a 10pt. font is acceptable for all tables and figures.	This formatting is acceptable to the State.
74.	Attachment 11 - Proposal Statements and IV.L Care Coordination Question 40	9	"Describe how the DBPM will assist members to identify and gain access to community resources that provide services the Medicaid program does not cover." Is the State solely referring to the identification and access to dental resources the Medicaid program does not cover?	MLTC requires the DBPM to direct members to community resources that broadly help improve health outcomes.
75.	SPB RFP Revised: 01/29/2016 page 41	41	Can the State please clarify that question #1. should be "dental health services" and not "physical and behavioral health services"? Tribal Network Liaison* The Tribal Network Liaison is responsible for: 1. Planning and working with Provider Services staff to expand and enhance physical and behavioral health services for American Indian members. 2. Serving as the single point of contact with tribal entities and all DBPM staff on American Indian issues and concerns. 3. Advocating for American Indian members with case management and member services staff.	Please see Addendum Four, #9.
76.	R. Claims Management, 6. Paid Claims Sampling, a.	107	Does the State require the provision of EOBs for all Medicaid recipients?	MLTC does not require this but the DBPM must have a method to verify services.

77.	R. Claims Management, 6. Paid Claims Sampling, c.	107	Regarding the language,"The service verification surveys may be conducted at any point after a claim has been paid, but no more than 45 calendar days after the date of payment. This sampling may be performed by mail, telephonically, or in person (e.g., during case management on-site visits)." Please provide additional detail regarding expectations for conducting service verification surveys, i.e., what should these surveys contain? and is the expectation that this process is conducted as part of credentialing and/or UM?	The DBPM will submit for MLTC's approval their proposed surveys. While this process may be used for credentialing or utilization management, the primary purpose is to ensure the DBPM and MLTC comply with Federal law regarding claims payment, processing, and verification that beneficiaries received billed for services. The bidder should provide a response that meets the requirements of the RFP.
78.	R. Claims Management, 6. Paid Claims Sampling, c.	107	Regarding the language, " Concurrent review will be allowed when tied back to a successfully adjudicated claim." Is the State's expecation that the plan conducts concurrent reviews for dental services?	Yes.
79.	Attachment 11	p.2, Q18	Question 18 requests "an overview of the proposed member website, including how it will satisfy requirements in this RFP." The Scope does not mention a member website; will the state please provide additional detail regarding the requirements for a "member website" and "member portal."	Please see Addendum Four.
80.	Attachment 11	p.2, Q17	Question 17 requests written material and references the "appropriate reading level" for all member materials. Please provide the appropriate grade reading level for the state of Nebraska.	The DBPM must write all member materials in a style and reading level that will accommodate the reading skill of the members. In general, the writing should be at no higher than a 6.9 grade level, as determined by the Flesch–Kincaid Readability Test.

81.	Attachment 12	p.1	Will the state provide additional detail regarding requirements for the draft copy of a Member Handbook? Section IV.G; is the Member Handbook also called Member Orientation as referenced in IV.G.4.a?	Yes. Please see Addendum Four, #5.
82.	Covered Benefits	43	Is transportation the responsibility of the member's health plan?	No
83.	Covered Benefits	43	Is the facility component of an emergency room visit the the responsibility of the member's health plan?	Yes, the DBPM will not be responsible for outpatient or inpatient hospital claims.
84.	Covered Benefits	43	Is the facility component of dental services performed in a hospital setting (in patient or outpatient) the responsibility of the member's health plan?	Yes, please see the response to Question 83.
85.	Provider Network Requirements	64	Can the state provide a file of their existing provider network, including name, address and phone numbers?	Please see Attachment 19. The spreadsheet provides the following: Provider Number, Business Name, Title Code, Provider Type Code, Practice Type Code, Address, City, Pay to Name, Pay to Name Address, Pay to Name City. MLTC looked at paid dental claims on MLTC's claims history database, and found there were two Provider Types who bill on dental claims: • Dentists (DDS) – Provider Type 40 • Tribal 638 Clinic – Provider Type 26 MLTC also found two different provider types usually listed as the rendering provider: • Dentists (DDS) – Provider Type 40 • Licensed Dental Hygienist – Provider

				Type 42 Furthermore, there were a small number of claims where the rendering provider was a personal care aid (Provide Type 33) or MD (Provider Type 01) or DO (Provider Type 02). MLTC did not consider them for this listing. The attached spreadsheet lists all active providers with a Provider Type of 40, 42, or 26 There can be multiple entries for the same provider/person if: • The provider has multiple Medicaid Provider IDs (normally to bill with multiple locations) • The provider has multiple NPIs attached to a single Medicaid Provider ID • The provider has multiple Taxonomy codes attached to a single Medicaid Provider ID
86.	III.F.3 "Insurance Coverage Amounts Required"	10	The RFP contains a requirement for Abuse & Molestation Insurance as part of the Commercial General Liability Insurance the bidder is to maintain. Would the State of Nebraska waive this requirement?	Provide all exceptions to Section III. Terms and Conditions under "NOTES/COMMENTS" in the applicable table.
87.	III.F.3 "Insurance Coverage Amounts Required"	10	The RFP contains a limit of $7,000,000 for Commercial Crime Coverage. Would the State of Nebraska accept $2,000,000?	See the response to Question 86.

88.	III.F.3 "Insurance Coverage Amounts Required"	10	The RFP contains a limit of $15,000,000 for Cyber Liability Coverage. Would the State of Nebraska accept $10,000,000?	See the response to Question 86.
89.	III.F.4 "Evidence of Coverage"	11	Several of the coverage limits contained in III.F.3 would require an adjustment to the bidder's current insurance limits which would come at a cost to the bidder. The RFP states in III.F.4: "The Contractor should furnish the State, <u>with their proposal response</u>, a certificate of insurance coverage complying with the above requirements …." Is this a mandatory requirement? May the bidder provide a certificate of insurance coverage evidencing required coverage after the intent to award decision?	The Certificate of Insurance is not a mandatory requirement of the RFP. Bidders may provide a Certificate of Insurance in their proposal response. The awarded bidder must provide a certificate of insurance coverage after the intent to award.
90.	IV.I.1 "Provider Network Requirements"	64 (78)	Is Bidder expected to build a network of Providers on a contracted Provider Agreement or Letter of Intent basis before we submit our bid? Or will we show in the RFP how we will build the Medicaid network if awarded?	No. MLTC requires the DBPM to provide a description of how the bidder will build their Medicaid network if awarded.
91.	Attachment 8 – Dental Rates	Attachment 8	Is the Total Loaded Rate ($19.94) the full-risk price for all 5-years until December 31, 2022? Or is it only for Fiscal-Year 2018?	These rates are only applicable for the SFY18 contract period.

<table>
<tr><td></td><td></td><td></td><td>
<table>
<tr><th colspan="5">FY2018 Rate Summary</th></tr>
<tr><th>Age Band</th><th>FY15 MMs</th><th>Net Medical Rate</th><th>NML</th><th>Loaded Rate</th></tr>
<tr><td>0-1</td><td>295,534</td><td>$ 1.63</td><td>9.0%</td><td>$ 1.80</td></tr>
<tr><td>2-5</td><td>467,090</td><td>$ 16.71</td><td>9.0%</td><td>$ 18.36</td></tr>
<tr><td>6-18</td><td>1,191,822</td><td>$ 25.61</td><td>9.0%</td><td>$ 28.13</td></tr>
<tr><td>19-24</td><td>123,094</td><td>$ 13.20</td><td>9.0%</td><td>$ 14.51</td></tr>
<tr><td>25-54</td><td>494,494</td><td>$ 16.75</td><td>9.0%</td><td>$ 18.40</td></tr>
<tr><td>55-64</td><td>123,876</td><td>$ 15.45</td><td>9.0%</td><td>$ 16.97</td></tr>
<tr><td>65+</td><td>218,284</td><td>$ 10.40</td><td>9.0%</td><td>$ 11.43</td></tr>
<tr><td>Total</td><td>2,914,194</td><td>$ 18.15</td><td>9.0%</td><td>$ 19.94</td></tr>
</table>
</td><td></td></tr>
<tr><td>92.</td><td>IV.4.2 “Key Staff Positions”</td><td>39-40 (53-54)</td><td>May we contact the current Nebraska Dental Director, Dr. Charles Craft?</td><td>No, that would be a violation of the RFP; Section II. D. Communication with State Staff and Evaluators.</td></tr>
<tr><td>93.</td><td>IV.4.2 “Key Staff Positions”</td><td>39-40 (53-54)</td><td>Is Bidder expected to hire a Dental Director <u>before</u> the RFP is awarded? Or can we identify a candidate, and upon award of the contract, hire that person before go-live?</td><td>MLTC does not expect the DBPM to hire a Dental Director before MLTC awards the contract. Please see Section IV.D.2 of the RFP to find MLTC’s requirements regarding the hiring key staff.</td></tr>
<tr><td>94.</td><td>IV.4.2 “Key Staff Positions”</td><td>39-40 (53-54)</td><td>What specifically is/was Dr. Craft’s job description?

Do his responsibilities require him to be present in the office M-F, 9a-5p?</td><td>Dr. Craft is employed by the DHHS, Division of Public Health. He is not a member of MLTC’s staff.

MLTC does not have that information.</td></tr>
<tr><td>95.</td><td>II.P “Secretary of State/ Tax Commissioner”</td><td>6 (20)</td><td>Bidder is registered with the Secretary of State. We cannot find anything about registering with the Tax Commissioner.

What are the requirements here?</td><td>The Secretary of State and the Tax Commissioner do not have separate requirements.</td></tr>
</table>

96.	Att. 11 #58 Section IV.O	13, of Attachment 11	Question 58 refers to RFP Section IV.O, however the body of the question "Describe the DBPM's method and process for capturing TPL and payment information from its claims system. Explain how the DBPM will use this information". Seems to be referring to Section IV.R of the main document. Can you confirm?	Yes, MLTC confirms. Please see Addendum Four, #14.
97.	Att. 15	BAA	Does the Business Associate Agreement which is contained in Attachment 15 need to be signed by the offerer and included in the proposal or whether the State and the successful bidder sign the BAA during the contract finalization period.	The State will require the awarded contractor to sign a Business Associate Agreement (BAA). The bidder is not required to submit the signed BAA as part of the proposal response.
98.	Att. 11 "Proposal Statements and Questions" #3	Att. 11, p.1	Question No. 3 states: "Describe the approach the DBPM will take to ensure compliance with all relevant provisions of Part 438 of Chapter 42 of the CFR, Title 471, 477, and 482 NAC." There is no page limit to the bidder's response. There are several hundred pages of regulations contained within the above cited sections. Bidder respectfully requests that the State explain if bidders are to address in general terms their compliance "approach" and how, in general, they will ensure compliance with Part 438 of Chapter 42 of the CFR, Title 471, 477, and 482 NAC or whether the State requests a detailed explanation of how the bidder will "ensure compliance with all relevant provisions" of these sections.	Bidders should describe their general approach to compliance regarding the cited regulations; however, the State did not put a limitation on the depth of detail the bidder may provide. The bidder should provide a response that meets the requirements of the RFP.

99.	I. Scope of the Request for Proposal, A. Schedule of Events	Page 1	a. Will any extensions be considered or granted to the bid deadline of October 25, 2016? b. Will any alternative effective dates (other than July 1, 2017) be considered? c. What activities will be completed in the contract finalization period? i. What process will be used for this activity?	a. See Addendum Two – Revised Schedule of Events. b. The State anticipates to go-live with this program on July 1st. c. The contract finalization period is the time allowed to negotiate terms and conditions, process a compliant Certificate of Insurance, Performance Bond, and Certificate of Good Standing. . i. this process will be facilitated by the State Purchasing Bureau.
100.	II Procurement Procedures, B. General Information.	Page 2	a. Will any other forms of contract be considered besides a fixed price contract?	No.
101.	II Procurement Procedures, C. Customer Service.	Page 2	a. With respect to development of enhancements, please define what the State envisions as the needed enhancements? i. How will success be defined? ii. How will success be measured? b. What are the customer service industry's best practices and processes? i. How are these determined? ii. What measurable criteria is the State considering?	Section II, C. Customer Service on page 2 refers to Customer as the State of Nebraska. This requirement is an overarching requirement of the Contractor in relation to the State.
102.	III. Terms and Conditions.	Page 7	a. Does the following sentence mean that if the Bidder requires a contract deviation that the bidder will not be considered? *"The State of Nebraska will not*	The State will not substitute the contractor's contract for the State's contract. The State will negotiate terms, but not to the point that our contract does not exist.

			consider proposals that…or terms for those of the State of Nebraska's." b. It appears that the Terms and Conditions section indicates the Bidder must accept the Terms and Conditions as written with no modifications. The State may then consider additional elements from the Bidder but only if the Bidder agrees to the Terms and Conditions as stated first. Is this a correct interpretation?	a. "The State of Nebraska will not consider proposals that **propose the substitution of the bidder's contract, agreements, or terms** for those of the State of Nebraska's." The State will not replace its terms and conditions for the bidder's contract, agreements or terms. b. "Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, and (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable." The bidder may either "Accept", "Reject" or "Reject & Provide Alternative within RFP Response". The State will negotiate Terms and Conditions with the awarded bidder during the contract finalization period.

103.	III. Terms and Conditions. A. General.	Page 7	a.	Please define and/or direct us to the rules of contract interpretation as established in the State of Nebraska?	Case law statutes
104.	F. Insurance Requirements.	Page 9	a.	What is the State turnaround time for approval?	Once a compliant Certificate of Insurance is received by the awarded bidder; the approval will be determined in a couple of business days.
105.	L. State of Nebraska Personnel Recruitment Prohibition.	Page 13	a.	Are there any circumstances under which this prohibition could be altered? For example, the expertise of State employees currently engaged in delivering the Medicaid Dental services could be of value to the plan members and in the best interests of the members to continue to engage rather than lose due to the transition.	See the response to Question 86.
106.	Z. Early Termination.	Page 17	a.	Is the correct interpretation that the Contractor may not terminate the plan before 12/31/22? For any reason?	See the response to Question 86.
107.	8. Merger, Reorganization , and Change of Ownership	Page 36	a.	Does this requirement apply to just the Contractor, or does it also apply to any Subcontractors?	This requirement only applies to the Contractor, although MLTC expects the Contractor to notify MLTC of any material change that would affect members or providers.
108.	2. Key Staff positions	Page 39	a. b.	Does the State have existing job descriptions for each position? Will the State furnish those descriptions to the Bidders?	MLTC only provides the minimum duties and requires that hired staff are qualified. MLTC requires the DBPM to produce the job descriptions.

109.	E1a. General Provisions	Page 43	a. What are considered the prevailing dental community standards? i. How are these determined? ii. What measurable criteria is the State considering?	Prevailing dental community standards are determined by Medicaid's Rules and Regulations and the measurable criteria MLTC is considering can be found in Attachment 6 of the RFP.
110.	F. Fee-For-Service (FFS). 1. DBPM FFS Claim Services.	Page 48	i. Is this an additional service the Contractor is to provide without regard to incremental additional costs to the Contractor? ii. Is there any amount included in the administration fee for the Contractor's general or other administrative expenses? iii. Is there any amount included in the administration fee for Contractor profit margin?	MLTC will not make any additional considerations regarding the additional service of paying fee-for-service claims. Section IV.F.1 DBPM FFS Claim Services of the RFP prescribes payment.
111.	I. Provider Network Requirements.	Page 64	a. Will the state provide a list of all providers (including TIN, location, claim volume, etc.) currently contracted with the State for this Medicaid Dental program. i. If so, when will this list be provided? b. Are there any exception or non-standard payments, or fee schedules, to providers for access or other reasons? i. If so, how are these amounts determined? ii. If so, under what circumstances are these exceptions allowed? iii. If so, how do these amounts	a. Please see Question 85. b. There are only two exceptions to the fee schedule. The UNMC supplemental payment, which calculated in accordance with the following link: http://dhhs.ne.gov/medicaid/Documents/4.19bitem10.pdf The other exception is the encounter rate paid to IHS facilities as determined by Medicare.

			differ from the standard fee schedule set by the MLTC?	
112.	I. Provider Network Requirements. 4. Geographic Standards.	Page 64	a. Will the State make any allowances in the Geographic Standards for current gaps between the existing State provider network and the Geographic Standards? b. How does the State envision the Contractor resolving gaps between access and Geographic Standards when no provider exists in an area that meets the Geographic Standards? c. What is the timeframe in which a Contractor must meet the Geographic Standards when a new member residence is identified that is not within the Geographic Standards?	a. MLTC will not make any allowances for network adequacy gaps. b. MLTC requires the DBPM to develop a provider network availability plan to identify such gaps and describe the remedial action(s) that the DBPM will take to address those gaps. c. MLTC requires the DBPM to have an adequate network, as stated in the RFP, at the contractor start date.
113.	I. Provider Network Requirements. 10. Provider Enrollment in Medicaid.	Page 68	a. Does this requirement only apply to the provider network the Contractor develops for this Medicaid Dental program? b. When a Contractor maintains multiple commercial provider networks, does this requirement mean the Contractor must require providers in those commercial networks to become providers to NE Medicaid Dental?	a. Yes, this requirement only applies to providers who wish to provide Nebraska Medicaid dental benefits. b. No provider is required to become a Nebraska Medicaid provider. However, the DBPM must contract with all providers the DBPM intends to reimburse for providing Medicaid dental services.

114.	P. DBPM Reimbursement.	Page 96	a. If there are any exception or non-standard payments, or fee schedules to providers for access or other reasons, are these amounts included in the determination of the capitation rate? b. Is the intent for the Contractor to agree to any method of determination and/or any assumptions used in the determination of the capitation rate? c. How often during the life of the contract will capitation rates be updated? Annually? Semi-Annually? i. On what date? ii. How far in advance of their effective date/application? d. If the method and/or assumptions for determining the capitation rate changes from time to time, does the Contractor have the ability to approve of these changes? Or is this element "take it or leave it"? e. If the fee schedule for providers is changed by the State (for any reason), will the capitation rate be changed prior to the implementation of the fee schedule changes? f. Have the implications of the requirements of the RFP been factored into the determination of the future capitation rates? i. In other words, if the RFP includes changes, enhancements,	a. There were no adjustments related to reimbursement other than the UNMC adjustment described in the response to Question 50. b. The Contractor should evaluate the proposed capitation rate and the associated actuarial assumptions and determine if the proposed rates are feasible for the Contractor's business model. c. Capitation rates will be updated on an annual basis and will be submitted to CMS no later than April 1st of the preceding contract period (i.e. the SFY19 rates will be submitted to CMS by April 1st, 2018). d. MLTC will provide substantiation and documentation of all aspects of the rate development methodology, however, the State will look to CMS/OACT for approval. The Contractor should evaluate the proposed capitation rate and the associated actuarial assumptions and determine if the proposed rates are feasible for the Contractor's business model. e. Significant changes in fee schedules will prompt a review of existing rates. To the extent that the impact is greater than +/- 1.5%, MLTC will update the rates prior to implementation. f. MLTC has developed the rates consistent with State policy. As such,

			improvements, system changes and other requirements that increase utilization and/or cost compared to current practices and outcomes, have these components been factored into the determination of the future capitation rate? ii. Will such prospective implications be included in the determination? Or will the capitation rate always be "after the fact"? g. Is there any allowance for the Contractor's costs of initial implementation included in the capitation rate? h. Is there any allowance for the Contractor's costs of on-going changes, enhancements, system changes, future implementations, etc. included in the capitation rate?	utilization is assumed to only increase by the secular utilization trend. To the extent MLTC knows ahead of time of the rate implications, MLTC does include them. g. The capitation rates do not include any additional funds for implementation costs. h. MLTC intends to use the DBPM's encounter data for prospective contract periods. As such, any enhancements or system changes that are reflected in the encounter data will be considered in future rate development cycles.
115.	U. Contract Monitoring.	Page 126	a. Is there a maximum limit to the amount of monetary actions, damages, sanctions, penalties, etc. that may be applied under the Contract for any one item? b. Is there an aggregate annual maximum on the amount of monetary actions, damages, sanctions, penalties, etc. that may be applied under the Contract? i. If so, is it limited to the 2%	a. No. b. No. i. No, the 1.5% (please see Addendum Four) holdback constitutes the maximum amount available to the DBPM to earn via the quality performance program. ii. There is no maximum to liquated damages, sanctions, penalties, etc.

			holdback? ii. If not limited to the 2% holdback, what is the maximum? iii. If no maximum, please confirm that the correct interpretation is that there is no limit to the amount of these items that may be levied on the Contractor.	iii. That is the correct interpretation.
116.			I wanted to email you and ask about the NCQA Certification that is required in the dental RFP. Dental plans aren't eligible for HPA through NCQA and wanted to point that out. We have noticed this is a requirement in the RFP? I am not sure if this was just carried over by mistake from the Heritage plan requirements with the health plans?	See response to Question 69.
117	Quality Performance Program Measures – CY1	Attachment 9	Does the performance guarantee **Average Speed to Answer:** Calls to Member/Provider lines must be answered on average within 30 seconds imply the call center will answer 100% of the calls within 30 seconds? Can this be negotiated to fall in-line with standards of 80% of calls answered in 30 seconds?	MLTC does not expect the DBPM call center to answer 100% of the calls within 30 seconds. MLTC does require the average time for the call center to answer a call to be within 30 seconds. MLTC predicates this metric on average call wait-times and it is not negotiable.
118	Section III, OO – Proprietary Information	23	We would like clarification on how the State wishes for Proprietary Information to be marked on Original Proposal? Would it be acceptable to redact the proprietary information on the original RFP,	Yes, it would be acceptable for the bidder to redact the proprietary information on the original RFP and provide a document with the applicable information. Package proprietary information according to

			then, on a separate document named PROPRIETARY, include the information redacted from the original RFP, along with the page number and paragraph where the information would be included?	Section III. OO Proprietary.
119	Section IV, F, -Fee-For-Service (FFS) Dental Claims Management and Processing	48	How many FFS members will there be under the FFS arrangement? How will the State identify FFS members?	Remaining fee-for-service members are yet to be determined. MLTC will identify the FFS members by their eligibility category.
120.	Section IV.F FFS-Claims Management and Processing	Attachment 11, page 16	Please elaborate on what is meant by claim brokering. What is the state looking for specifically with Question 76 and 77? Is the state referring to claim negotiating and financial settlement with providers?	See Section IV.F.1: The State is currently in the process of replacing its aged Medicaid Management Information System (MMIS). As part of this transition, the State is moving toward a model of contracting with risk-bearing entities for the provision of services for nearly all Medicaid members and services. As this transition continues, the State will be responsible for processing fewer FFS claims for fewer members. Rather than procure a standalone claims processing system for these remaining needs, the State intends to enter into a services agreement with the DBPM for the management and processing of remaining FFS dental claims. In addition to the DBPM responsibilities outlined in this RFP, MLTC will pay the DBPM an administrative

				processing fee for each unique adjudicated FFS claim or adjustment on a monthly basis. MLTC will provide the per unique claim initial rate. Payment for FFS dental claims management services will be paid separately from managed care capitation payments.
121.	Terms and Conditions, F 4 Evidence of Coverage		Under the Terms and Conditions, F 4 Evidence of Coverage, it asks we provide a certificate of insurance, but not sure if we are to fax it or include in our response or both. If we do need to fax the form, can you confirm we need fax by the opening date of 10/25? **F. 4. EVIDENCE OF COVERAGE** The Contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer at 402-471-2089 (fax) Administrative Services State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508 These certificates or the cover sheet must reference the RFP number, and the certificates must include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and	See the response to Question 89. The Certificate of Insurance does not need to be faxed before the opening date.

			types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto. Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder must be submitted immediately to ensure no break in coverage.	
122.	III.FF "Performance Bond"	19-20	The RFP states: "The Contractor will be required to supply a bond executed by a corporation authorized to contract surety in the State of Nebraska, payable to the State of Nebraska, ***which shall be valid for the life of the contract*** to include any renewal and/or extension periods." The contract term is 5 years and there are two potential 1 year extensions after the initial term for a potential 7 year contract. Bidder is unable to obtain a 5 to 7 year bond term but is able to obtain the bond for the first year which will be extended via a continuation certificate/annual bond form every year thereafter, including extensions. Can the State of the Nebraska please advise if it will accept a one year, continuous renewal bond?	Yes, the State of Nebraska will accept a one year, continuous renewable bond.

123.			I refer to RFP 5427 Z1 (Medicaid Dental Benefit Program). The RFP provides for page limitations for responses. As a courtesy to the reader, our format includes a copy of the question before each of our responses. While some questions may be one or two sentences long, other questions are more extensive in length. We would like to confirm that a recitation of the question would not contribute towards our page limitations.	The recitation of the question will not contribute towards the page limitations.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.