# Dental Submittal Form Packet

# DENTAL SUBMITTAL FORM 1 – Offeror Information and Certifications

**PROJECT INFORMATION**

RFP NUMBER: ____________________
PROJECT NAME: ____________________________________________________________

**OFFEROR INFORMATION**

Company Name: ____________________________________________________
Address: ____________________________________________________
Tax ID: ____________________________________________________
Alaska Business License #: ____________________________________________________

**CONTACT INFORMATION**

Provide contact information for the individual that can be contacted for clarification regarding this proposal:

Name ____________________________________________________________
Title ____________________________________________________________
Address ____________________________________________________________
Email ____________________________________________________________
Telephone ____________________________________________________________

**CRITICAL TEAM MEMBERS**

Provide the names of all critical team members that will be assigned to this contract. Note: These individuals cannot be removed or replaced from this project, or their positions, unless approved in writing the project director or contracting officer.

Name of Account Manager ________________________________________________
Name of Implementation Manager ________________________________________________
Name of Clinical Reviewer ________________________________________________
Name of Network Manager ________________________________________________
Name of Member Services Manager ________________________________________________

**ADDENDA ACKNOWLEDGEMENT**

The offeror acknowledges receipt of the following addenda and has incorporated the requirements of such addenda into their proposal. Failure to identify and sign for all addendum may subject the offeror to disqualification. The offeror must list all addenda's (by number), then initial and date to confirm that you have received and incorporated them into your proposal. *The offeror may add more rows as necessary.*

| Number | Initials & Date |
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| | |

| Number | Initials & Date |
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| | |

| Number | Initials & Date |
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| | |

**CERTIFICATIONS**

| | Criteria | Response* |
|---|---|---|
| 1 | The Offeror is presently engaged in the business of providing the services and work required in this RFP. | □ Yes □ No |
| 2 | The Offeror confirms that it has the financial strength to perform and maintain the services required under this RFP. | □ Yes □ No |
| 3 | The Offeror accepts the terms and conditions set out in the RFP (including the Standard Agreement Form – Appendix A) and agrees not to restrict the rights of the State. | □ Yes □ No |
| 4 | The Offeror confirms that they can obtain and maintain all necessary insurance as required on this project. | □ Yes □ No |
| 5 | The Offeror certifies that all services provided under this contract by the contractor and all subcontractors shall be performed in the United States. | □ Yes □ No |
| 6 | The Offeror is not established and headquartered or incorporated and headquartered, in a country recognized as Tier 3 in the most recent United States Department of State's Trafficking in Persons Report. | □ Yes □ No |
| 7 | Offeror complies with the American with Disabilities Act of 1990 and the regulations issued thereunder by the federal government. | □ Yes □ No |
| 8 | The Offeror certifies that programs, services, and activities provided to the general public under the resulting contract are in conformance with the Americans with Disabilities Act of 1990. | □ Yes □ No |
| 9 | Offeror complies with the Equal Employment Opportunity Act and the regulations issued thereunder by the federal government. | □ Yes □ No |
| 10 | Offeror complies with the applicable portion of the Federal Civil Rights Act of 1964. | □ Yes □ No |
| 11 | The Offeror can provide (if requested) financial records for the organization for the past three years. | □ Yes □ No |
| 12 | The Offeror has not had any contracts terminated by the State of Alaska (within the past five years). | □ Yes □ No |
| 13 | The Offeror certifies that it is not currently debarred, suspended, proposed for debarment, or declared ineligible for award by any public or federal entity. | □ Yes □ No |
| 14 | The Offeror certifies that they do not have any governmental or regulatory action against their organization that might have a bearing on their ability to provide services to the State. | □ Yes □ No |
| 15 | The Offeror certifies, within the last five years, they have not been convicted or had judgment rendered against them for: fraud, embezzlement, theft, forgery, bribery, falsification or destruction of records, false statements, or tax evasion. | □ Yes □ No |
| 16 | The Offeror does not have any judgments, claims, arbitrations or suits pending/outstanding in which an adverse outcome would be material to the company. | □ Yes □ No |
| 17 | The Offeror is not (now or in the past) been involved in bankruptcy or reorganized proceeding. | □ Yes □ No |
| 18 | Offeror certifies they comply with the laws of the State of Alaska. | □ Yes □ No |

** Failure to answer or answering "No" may be grounds for disqualification. Please complete the grid below with additional information on any subject where the Offeror responded "No" to a question above*

**"No" Answers Clarification (add rows as necessary)**

| No. | Clarification |
|---|---|
| | |
| | |
| | |
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| | |

**CONFLICT OF INTEREST STATEMENT**

Indicate below whether or not the firm or any individuals that will work on the contract has a possible conflict of interest (e.g., currently employed by the State of Alaska or formerly employed by the State of Alaska within the past two years) and, if so, the nature of that conflict. The Commissioner of the Department of Administration reserves the right to consider a proposal non-responsive and reject it or cancel the award if any interest disclosed from any source could either give the appearance of a conflict or cause speculation as to the objectivity services to be provided by the offeror. The Commissioner's determination regarding any questions of conflict of interest shall be final

| Does the Offeror, or any individuals that will work on this contract, have a possible conflict of interest? | ☐ Yes ☐ No |
|---|---|

** Failure to answer may be grounds for disqualification.*

If "Yes", please provide additional information regarding the nature of that conflict:

| |
|---|
| |

**ALASKA PREFERENCES**

Identify if your firm qualifies for any Alaska Preferences:

| | |
|---|---|
| **Alaska Bidder Preference:** Do you believe that your firm qualifies for the Alaska Bidder Preference? Note: If you answer 'yes', please complete the additional information requested below. | ☐ Yes ☐ No |
| **Alaska Veteran Preference:** Do you believe that your firm qualifies for the Alaska Veteran Preference? Note: If you answer 'yes', please complete the additional information requested below. | ☐ Yes ☐ No |
| Please list any additional Alaska Preferences below that you believe your firm qualifies for. | |
| **1.** **2.** **3.** **4.** **5.** **6.** | |

**ALASKA BIDDER PREFERENCE**

To qualify for and claim the Alaska Bidder Preference, you must answer YES to all questions below. If the procuring agency is unable to verify a response, the preference may not be applied. Knowingly or intentionally making false or misleading statements on this form, whether it succeeds in deceiving or misleading, constitutes misrepresentation per *AS 36.30.687* and may result in criminal penalties.

If you answered 'yes' to the Alaska Bidder Preference, complete the following information:

| | | |
|---|---|---|
| 1 | Does your business hold a current Alaska business license per *AS 36.30.990(2)(A)*<br>• If YES, enter your current Alaska business license number | ☐ Yes ☐ No |
| 2 | Is your business submitting a bid or proposal under the name appearing on the Alaska business license noted in Question 1 per *AS 36.30.990(2)(B)*? | ☐ Yes ☐ No |
| 3 | Has your firm maintained a place of business within the state staffed by the bidder or offeror, or an employee of the bidder or offeror, for a period of six months immediately preceding the date of the proposal per *AS 36.30.990(2)(C)*?<br>• If YES, please complete 3A and 3B | ☐ Yes ☐ No |
| 3A | **Place of Business**<br>Street Address:<br>City:<br>ZIP:<br>"**Place of business**" is defined as a location at which normal business activities are conducted, services are rendered, or goods are made, stored, or processed; a post office box, mail drop, telephone, or answering service does not, by itself, constitute a place of business per *2 AAC 12.990(b)(3)*.<br>• Do you certify that the Place of Business described in Question 3A meets this definition? | ☐ Yes ☐ No |
| 3B | The bidder or offeror, or at least one employee of the bidder or offeror, must be a resident of the state under *AS 16.05.415(a)* per *2 AAC 12.990(b)(7)*.<br>• Do you certify that the bidder or offeror OR at least one employee of the bidder or offeror is physically present in the state with the | ☐ Yes ☐ No |

| | | |
|---|---|---|
| | intent to remain in Alaska indefinitely and to make a home in the state per AS 16.05.415(a)(1)?<br>• Do you certify that that the resident(s) used to meet this requirement has maintained their domicile in Alaska for the 12 consecutive months immediately preceding the deadline set for receipt of bids or proposals per AS 16.05.415(a)(2)? | ☐ Yes ☐ No |
| | • Do you certify that the resident(s) used to meet this requirement is claiming residency ONLY in the State of Alaska per AS 16.05.415(a)(3)? | ☐ Yes ☐ No |
| | • Do you certify that the resident(s) used to meet this requirement is NOT obtaining benefits under a claim of residency in another state, territory, or country per AS 16.05.415(a)(4)? | ☐ Yes ☐ No |
| 4 | Per AS 36.30.990(2)(D), is your business (**CHOOSE ONE**):<br>• Incorporated or qualified to do business under the laws of the state? | ☐ Yes ☐ No |
| | ○ If YES, enter your current Alaska corporate entity number: | |
| | • A sole proprietorship AND the proprietor is a resident of the state? | ☐ Yes ☐ No |
| | • A limited liability company organized under AS 10.50 AND all members are residents of the state? | ☐ Yes ☐ No |
| | • A partnership under former AS 32.05, AS 32.06, or AS 32.11 AND all partners are residents of the state? | ☐ Yes ☐ No |

**ALASKA VETERAN PREFERENCE**

If you answered 'yes' to the Alaska Veteran Preference, complete the following information:

| | |
|---|---|
| Does your firm hold a current Alaska business license prior to the deadline for receipt of proposals? | ☐ Yes ☐ No |
| Does your firm qualify under AS 36.30.990(2) as an Alaska bidder? | ☐ Yes ☐ No |
| Is your firm a sole proprietorship owned by an Alaska veteran? | ☐ Yes ☐ No |
| Is your firm a partnership under AS 32.06 or AS 32.11 if a majority of the partners are Alaska veterans? | ☐ Yes ☐ No |
| Is your firm a limited liability company organized under AS 10.50 if a majority of the members are Alaska veterans? | ☐ Yes ☐ No |
| Is your firm a corporation that is wholly owned by individuals, and a majority of the individuals are Alaska veterans? | ☐ Yes ☐ No |

**SIGNATURE**

By signature below, I certify under penalty of law that I am an authorized representative of Click or tap here to enter text. and all information on this form is true and correct to the best of my knowledge.

Printed Name ____________________

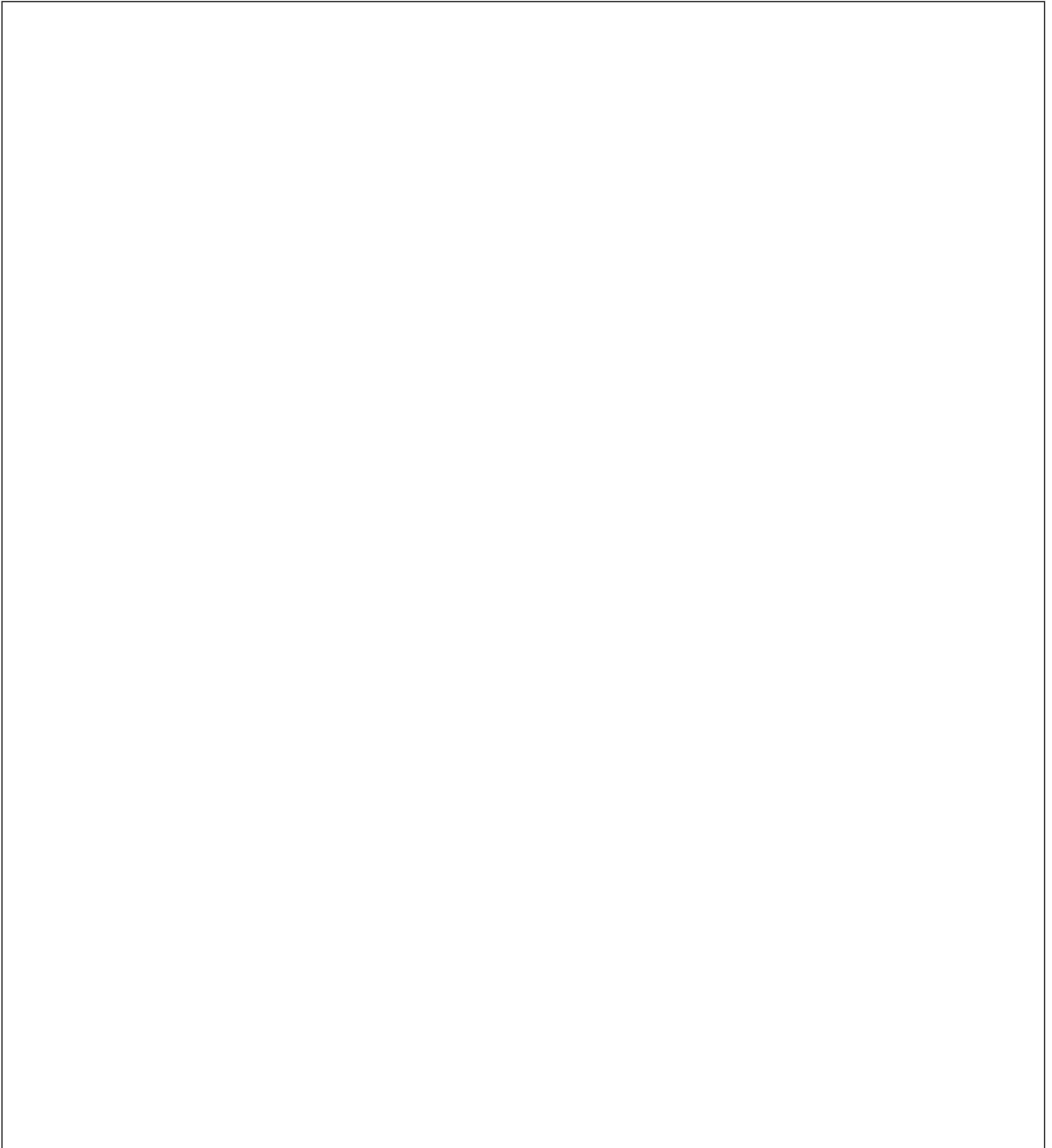
Title ____________________

Date ____________________

Signature ____________________

# DENTAL SUBMITTAL FORM 2 – Service Approach

SPECIAL REQUIREMENTS: This Submittal Form must not contain any names that can be used to identify who the proposer is, must not identify the proposers cost/fee, and must not exceed five pages (reference RFP section 4.02 and 4.04).



# DENTAL SUBMITTAL FORM 3 – Risk Assessment Plan

## PART 1 – Assessment of Controllable Risks

SPECIAL REQUIREMENTS: This Submittal Form must not contain any names that can be used to identify who the proposer is, must not identify the proposers cost/fee, and must not exceed two pages (reference RFP section 4.02 and 4.05).

**Risk 1:** ______________________________

**Description:** ______________________________

**Strategy:** ______________________________

**Risk 2:** ______________________________

**Description:** ______________________________

**Strategy:** ______________________________

**Risk 3:** ______________________________

**Description:** ______________________________

**Strategy:** ______________________________

**Risk 4:** ______________________________

**Description:** ______________________________

**Strategy:** ______________________________

**Risk 5:** ______________________________

**Description:** ______________________________

**Strategy:** ______________________________

# DENTAL SUBMITTAL FORM 3 – Risk Assessment Plan

## PART 2 – Assessment of Non-Controllable Risks

SPECIAL REQUIREMENTS: This Submittal Form must not contain any names that can be used to identify who the proposer is, must not identify the proposers cost/fee, and must not exceed two pages (reference RFP section 4.02 and section 4.05).

**Risk 1:** ______________________________

**Description:** ______________________________

**Strategy:** ______________________________

**Risk 2:** ______________________________

**Description:** ______________________________

**Strategy:** ______________________________

**Risk 3:** ______________________________

**Description:** ______________________________

**Strategy:** ______________________________

**Risk 4:** ______________________________

**Description:** ______________________________

**Strategy:** ______________________________

**Risk 5:** ______________________________

**Description:** ______________________________

**Strategy:** ______________________________

# DENTAL SUBMITTAL FORM 4 – Value Opportunity Assessment

SPECIAL REQUIREMENTS: This Submittal Form must not contain any names that can be used to identify who the proposer is, must not identify the proposers cost/fee, and must not exceed two pages (reference RFP section 4.02 and section 4.06).

**Idea 1:** ______________________________

**Description:** ______________________________

**Idea 2:** ______________________________

**Description:** ______________________________

**Idea 3:** ______________________________

**Description:** ______________________________

**Idea 4:** ______________________________

**Description:** ______________________________

**Idea 5:** ______________________________

**Description:** ______________________________

# DENTAL SUBMITTAL FORM 5 – Performance Qualifications

The State of Alaska (Division of Retirement and Benefits) is analyzing performance information on Dental TPA/Networks and their critical personnel. The firm/individual listed below has identified you as a client. The State of Alaska greatly appreciates your time in completing this survey (reference RFP sections 4.02 and 4.07).

**PART A – VENDOR NAME**

Name of the Dental TPA Firm: ______________________________

Name of the Account Manager: ______________________________

**PART B – PROJECT BACKGROUND**

Client Name: ______________________________

Business Type: ______________________________

Location (City/State): ______________________________

Start Date of Service: ______________ Number of Employee Participants: ______________

End Date of Service: ______________ Number of Retiree Participants: ______________

Average Number of Claims Processed Per Month: ______________

**PART C – REFERENCE EVALUATION**

Please rate your overall level of satisfaction on a scale of 1 to 10 (with 10 representing that you were very satisfied and 1 representing that you were very unsatisfied).

| CRITERIA | UNIT | RATING |
|---|---|---|
| Ability to manage costs | (1-10) | |
| Ability to manage schedule | (1-10) | |
| Ability to meet quality expectations | (1-10) | |
| Overall customer satisfaction | (1-10) | |

Please provide any additional information regarding the vendor and/or the project (consider any significant accomplishments, anything you would do differently, challenges and risks, etc.).

| Printed Name of Evaluator | Title | Phone Number | Email | Signature |
|---|---|---|---|---|
| Printed Name of Alternate Contact | Title | Phone Number | Email | Signature |

Thank you for your time and effort in assisting us in this important endeavor.

**Please return the completed survey to:** ***<< The Vendor should enter a valid fax or email here >>***

# DENTAL SUBMITTAL FORM 6 – Mandatory Requirements

**Section 1 – Bid Qualifications**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm you are not a broker or submitting a third-party proposal. | ☐ Yes ☐ No |
| 2. | Confirm your firm has: | |
| | • Provided dental services that include claims administration and network management for at least one group of 20,000 or more eligible retirees for at least five years. | ☐ Yes ☐ No |
| | • Have provided dental services that include claims administration and network management for a government employer or public retirement plan for at least three years. | ☐ Yes ☐ No |
| | • Have five years of experience processing at least 5,000 claims per month. | ☐ Yes ☐ No |
| | • Have at least two million covered lives across your dental book of business. | ☐ Yes ☐ No |
| | • Have Alaska clients in your book of business totaling a minimum of 5,000 lives. | ☐ Yes ☐ No |
| 3. | Confirm that unless otherwise explained in this RFP, you agree that you will disclose all subcontractor arrangements, and any additional fees associated with the subcontractor arrangements, that involve the services provided to the State of Alaska. | ☐ Yes ☐ No |
| 4. | Confirm that you will provide no less than 30-day notice to the State of Alaska for any changes involving the sale, merger, data breaches, layoffs, participating provider facility terminations, consolidation or outsourcing of services to foreign workers that will impact the State of Alaska. | ☐ Yes ☐ No |
| 5. | Confirm you agree your contract will include an indemnification/hold harmless clause to protect the State from negligence of your employees. | ☐ Yes ☐ No |
| 6. | Confirm that all member claim records are the sole property of the State of Alaska. Sharing of the State of Alaska's data to outside entities must be disclosed and approved in writing in advance by the State of Alaska. All claims data obtained during the contract period and for up to seven years after the contract termination, is the property of the State of Alaska and must be available upon request. | ☐ Yes ☐ No |
| 7. | Confirm you acknowledge you are compliant with all state and federal applicable regulations and are not currently restricted or prohibited from conducting business in all states where the State's participants reside or access care. | ☐ Yes ☐ No |
| 8. | Confirm you will not assign or transfer the rights or obligations of the contract or any portion thereof, without the prior written approval of the State of Alaska. | ☐ Yes ☐ No |
| 9. | Confirm you agree the initial contract has a length of five (5) years beginning January 1, 2020 with up to five (5) years additional renewal options based on mutually agreed upon fees and terms. | ☐ Yes ☐ No |
| 10. | Confirm you agree that bid proposal and terms are guaranteed for the duration of the procurement process. | ☐ Yes ☐ No |

**Section 2 – Legal Responsibilities**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm you acknowledge that you are compliant with the Electronic Data Interchange ("EDI"), Privacy and Security Rules of the Health Insurance Portability and Accountability Act ("HIPAA"), and will execute the appropriate Business Associate Addendum ("BAA") as provided by the State. | ☐ Yes ☐ No |
| 2. | Confirm you agree that in the event of a dispute between the parties, about the payment or entitlement to receive payment, or any administrative fees hereunder, contractor and the State shall endeavor to meet and negotiate a reasonable outcome of said dispute. In no event shall the offeror undertake unilateral offset against any monies due and owed the State. | ☐ Yes ☐ No |

| No | CRITERIA | RESPONSE |
|---|---|---|
| 3. | Confirm you are in compliance with and will administer the proposed benefit plan(s) in accordance with all applicable legal requirements: including HIPAA, COBRA, DOL, ERISA, and state and local mandates. | □ Yes □ No |
| 4. | Confirm that you meet all applicable HIPAA, EDI, privacy, security, and HITECH requirements and agree to hold the State of Alaska harmless for breaches that are the result of your or any subcontractor(s) actions. Further, you agree to: perform all of the duties associated with breach notification, assume financial responsibility for the breach notice, notify plan participants if there is a breach, and pay for 24 months of identity theft repair and credit monitoring services for impacted plan participants. | □ Yes □ No |

**Section 3 - Termination Requirements**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm you agree, in the event of contract termination, that you will cooperate with the State of Alaska, or their representative, in the prompt, accurate, and orderly transfer of the State of Alaska's plan experience. Claims and utilization information will be transferred to the State or its designated succeeding health plan/carrier within 30 days of the termination, at **no added fee**. | □ Yes □ No |
| 2. | Confirm you agree the State of Alaska may terminate the contract at any time after the first complete plan year without cause, by giving 90 days' written notice. The State can terminate with cause with 30 days' notice unless proper remedy is provided by the vendor. The vendor may only terminate for cause with proper legal minimum notice requirements. | □ Yes □ No |

**Section 4 – Match Current Plan**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm you can, at a minimum, duplicate and administer the plan features and coverage of the State's current plan design(s) for each benefit plan, outlined in section 2.07 of the RFP, and will not require the State to alter any of the plan benefits in order to accommodate your claims administration system. | □ Yes □ No |

**Section 5 – Member and Account Services**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm you agree to provide designated/dedicated account resources including, but not limited to, an implementation manager, strategic account executive, and account manager. | □ Yes □ No |
| 2. | Confirm you will maintain at least seven years of the State of Alaska's claims data (all fields indicated on the billing) and eligibility information at all times. | □ Yes □ No |
| 3. | Confirm you will not automatically enroll the State in any programs that involve any type of communications with members without express written consent from the State. | □ Yes □ No |
| 4. | Confirm the State will have a dedicated toll-free phone line(s) to answer member and provider inquiries. | □ Yes □ No |
| 5. | Confirm that at a minimum your customer service representatives be available Monday – Friday 8:00AM – 6:00PM Alaska time zone. | □ Yes □ No |
| 6. | Confirm you agree that you will use call centers located within the United States (no outsourcing to non-U.S. based locations). | □ Yes □ No |
| 7. | Confirm you agree to document 100% of the State's member service calls through call recordings/notes and acknowledge that the State reserves the right to access all recordings/notes at any time. In addition, you agree the State will have access to recordings within two business days of request and that transcripts will be provided as soon as administratively possible. | □ Yes □ No |

| No | CRITERIA | RESPONSE |
|---|---|---|
| 8. | Confirm you agree to ad-hoc calls with the State to review member service issues and to allow the State to review member service quality issues to the resolution endpoint. In addition, the you agree to, at a minimum, semi-annual in-person meetings with the account team to review overall performance and trends. | □ Yes □ No |
| 9. | Confirm you agree to a minimum of one annual meeting with its call center executives to discuss services regarding enrollment and member issues. | □ Yes □ No |
| 10. | Confirm you can accept eligibility files in electronic 834 format. | □ Yes □ No |

**Section 6 – Claim Processing**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1 | Confirm you have the capability to accept electronic claims directly from providers and claim clearinghouses. | □ Yes □ No |
| 2 | Confirm you agree to make your prevailing charge data and calculations available to the State upon request. | □ Yes □ No |

**Section 7 – Network**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm you have a dental network. | □ Yes □ No |

**Section 8 – Audit Rights**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm you agree that once each year, or more frequently as reasonably determined by the State, or within two (2) years following termination of this Agreement, the State's third party auditor(s) ("auditor"), as reasonably approved by vendor (which approval shall not be unreasonably withheld), may inspect and verify claim data, eligibility, billing records, pricing discounts and terms, claims adjudication systems, dental benefits, subcontracted administrative services directly related to the State's member utilization and services, performance guarantees, and operational processes relating to the services provided to the State pursuant to this agreement to ensure vendor's compliance with the terms and conditions of this agreement, as the State deems appropriate. | □ Yes □ No |

**Section 9 – Appeals**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm you will follow the State's current appeals process for claim review and/or billing appropriateness for the plan. | □ Yes □ No |
| 2. | Confirm you agree to defend claims litigation based on decisions to deny coverage for clinical reasons, and that you will provide evidence-based guidelines for the denial of claims. | □ Yes □ No |
| 3. | Confirm that you will administer the claims appeals process as outlined in the Summary of Benefits and Coverage (SBC). | □ Yes □ No |
| 4. | Confirm you will be able to provide copies of all claim and appeal documents to the State for appeals that reach the State's level or any other appeals as requested by the State. | □ Yes □ No |
| 5. | Confirm you will coordinate external review requests with External Review Organizations (EROs). | □ Yes □ No |

**Section 10 - Banking**

| No. | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm that you will set up the State's account structure based upon their requirements. | □ Yes □ No |

| No. | CRITERIA | RESPONSE |
| --- | --- | --- |
| 2. | Confirm you will request an electronic transfer of funds from the State at regular intervals on a “checks cleared” basis and that the request will be by active employee and retiree dental claims. | □ Yes □ No |

**Section 11– Offeror’s Financial Terms Submitted with Pricing**

| No. | CRITERIA | RESPONSE |
| --- | --- | --- |
| 1. | Confirm that your Administrative Services Organization (ASO) rate includes the full list of core services required. | □ Yes □ No |
| 2. | Confirm that all rates provided for the services requested during the initial five-year contract, will not be re-evaluated due to variations in enrollment below 25% of the enrollment identified in this RFP. | □ Yes □ No |
| 3. | Confirm that pricing includes your broadest network offering. | □ Yes □ No |

# DENTAL SUBMITTAL FORM 7 – Contractual Requirements

The following are contractual expectations. The offeror must confirm that they can, or cannot, meet each requirement. A “no” response does not mean automatic rejection, but for each “no” response provide clarification (up to 250 word maximum) in the “Response Clarification and Explanation” section at the end of this document. The State reserves the right to seek additional clarification and negotiate terms regarding any offeror response.

**Section 1 – Match Current Plan**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm that your system allows the flexibility to move services from one class (e.g. preventive) to another (e.g. restorative). | ☐ Yes ☐ No |
| 2. | Confirm you are able to administer prevailing charge rate logic for out-of-network claims. | ☐ Yes ☐ No |

**Section 2 – Miscellaneous Services**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm you agree to allow for other Alaska public entities to participate in the State’s contract terms (subject to mutually agreed upon requirements) with the chosen offeror. | ☐ Yes ☐ No |

**Section 3 – Implementation**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm you agree to start the process of implementation upon award date of services/coverages and provide a detailed project management outline with milestones and roles/responsibilities. | ☐ Yes ☐ No |
| 2. | Do you agree to provide a one-time implementation credit to the State of $100,000 to cover expenses related general implementation? Implementation credit can be used for services associated with ensuring proper implementation of the program including (but not limited to) pre-implementation audit, general implementation assistance, communications, etc. | ☐ Yes ☐ No |
| 3. | Confirm the implementation process is performed by your firm (as opposed to a subcontractor). | ☐ Yes ☐ No |
| 4. | Confirm the implementation team is exclusively assigned to the State of Alaska until fully operational. | ☐ Yes ☐ No |
| 5. | Confirm you will generate and mail ID cards at least one month prior to the effective date. | ☐ Yes ☐ No |
| 6. | Confirm you provide welcome kits as part of the implementation process. | ☐ Yes ☐ No |

**Section 4 – Member Services**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm you can provide walk-in customer service to members and providers in the following locations: | |
| | Anchorage | ☐ Yes ☐ No |
| | Juneau | ☐ Yes ☐ No |
| | Other | ☐ Yes ☐ No |
| 2. | Will the locations above include both customer service and claims processing? | ☐ Yes ☐ No |
| 3. | Confirm you use a dedicated on-line call tracking and documentation system for customer service. | ☐ Yes ☐ No |
| 4. | Confirm there is a voice mail system for callers to leave messages after normal business hours. | ☐ Yes ☐ No |
| 5. | Indicate whether the following web tools are available for plan participants: | |
| | Check claim status | ☐ Yes ☐ No |

| No | CRITERIA | RESPONSE |
|---|---|---|
| | Print a temporary ID card<br>Request a new ID card<br>Claims Forms (Electronic)<br>Find a network dentist by specialty<br>Provider quality and/or outcomes<br>Provider reviews from other members<br>Get plan design information<br>Get estimated cost for a procedure/service<br>Review financial information (deductible/out-of-pocket)<br>Annual benefit summary by participant and/or family<br>View and print EOB history<br>Contact customer service (online chat or web email) | □ Yes □ No<br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No |
| 6. | Confirm you agree to allow the State to review, edit, or customize any communication from the contractor to its membership, including the AlaskaCare logo as the prominent feature. | □ Yes □ No |
| 7. | Confirm you have a mobile app for participants to use. | □ Yes □ No |
| 8. | Confirm you will provide a demo login and password so that the State can review your website. | □ Yes □ No |

**Section 5 – Account Services**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm you have a secure web-based eligibility system the State's staff may use to upload eligibility. | □ Yes □ No |
| 2. | Confirm your system supports online real time eligibility inquiries by the State. | □ Yes □ No |
| 3. | Confirm your system supports coordination with a third-party carrier providing direct bill services. | □ Yes □ No |

**Section 6 – Claim Processing**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm you will prepare, print and furnish to the State, at no cost, a Dental Expense Administration Manual. | □ Yes □ No |
| 2. | Confirm your claims system automatically matches claims with predetermination requests. | □ Yes □ No |
| 3. | Confirm your claims system coordinates benefits with medical coverage for services like dental implants. | □ Yes □ No |
| 4. | Are your negotiated provider reimbursements:<br>• The lower of a discount amount<br>• A prevailing charge rate | <br>□ Yes □ No<br>□ Yes □ No |
| 5. | Do you update your prevailing charge profiles:<br>• Once per year<br>• Twice per year<br>• Other | <br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No |
| 6. | Confirm you have the flexibility to change the percentile used to determine the prevailing charge rate for out-of-network claims. | □ Yes □ No |
| 7. | What source do you use in determining the prevailing charge rate for out-of-network claims:<br>• FAIR Health<br>• National Dental Advisory Service (NDAS)<br>• Book of Business<br>• Other | <br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No |

| No | CRITERIA | RESPONSE |
|---|---|---|
| 8. | Does your prevailing charge methodology differ based on geographic location? | ☐ Yes ☐ No |
| 9. | Do Alaska prevailing charge profiles reflect the differences between rural and urban areas of the State? | ☐ Yes ☐ No |

**Section 7 – Explanation of Benefits (EOB)**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Does your EOB show:<br>• The negotiated charge<br>• The actual charge<br>• Both | <br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No |
| 2. | Confirm your EOB includes the reason for denial or reduction of any line item charge. | ☐ Yes ☐ No |
| 3. | Confirm you have the capability to customize EOB messages. | ☐ Yes ☐ No |
| 4. | Confirm you have the capability to customize financial and service limit information that appears on your EOBs. | ☐ Yes ☐ No |
| 5. | Confirm monetary adjustments (whether they are provider write-off or member responsibility) are displayed on your EOBs. | ☐ Yes ☐ No |
| 6. | Are any accumulator fields (such as YTD individual or family deductible maximum or YTD maximums) displayed on your EOB? | ☐ Yes ☐ No |

**Section 8 – Eligibility and Account Structure**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm your system supports online real time eligibility inquiries by the State. | ☐ Yes ☐ No |
| 2. | Confirm you are able to administer, at a minimum, 120-day retroactive enrollment adjustments. | ☐ Yes ☐ No |

**Section 9 – Network**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | With respect to your network in Alaska, do you:<br>• Wholly own<br>• Partially own<br>• Lease | <br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No |
| 2. | Confirm that in-network providers are not allowed to balance bill. | ☐ Yes ☐ No |
| 3. | Confirm you will modify your network as requested by the State to address access issues and service provider areas where access is insufficient. | ☐ Yes ☐ No |
| 4. | Would you be willing to put fees at risk in these locations if you are not successful? | ☐ Yes ☐ No |
| 7. | Confirm you have the ability to add a custom network of providers initiated by the State that are <u>not</u> part of your current network. | ☐ Yes ☐ No |

**Section 10 - Audit Rights**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm you agree to grant the right of the State or its representative(s) to audit claims at any time, during and up to, two years following termination of the business relationship with prior written notification. The State will have access to 100% of all valid claim records to complete the audit at no cost. You agree to provide all necessary claims details, data definitions, and reasonable support to complete an independent claim audit for each completed year under | ☐ Yes ☐ No |

| No | CRITERIA | RESPONSE |
|---|---|---|
| | the contract in effect. The State will not be held responsible for time or miscellaneous costs incurred by the bidder in association with an audit including, but not limited to, the costs associated with providing audit reports, systems access, or onsite space. | |
| 2. | Confirm you agree audits will be based on either a 100% review of claims, or a statistically representative sample thereof, or a combination of methodologies as agreed to by the State and the vendor. Auditor's preliminary findings will be shared with the vendor. Any findings from a statistically representative sample of claims will be extrapolated to the total claims population for purposes of measuring overall financial dollar and incidence processing achievements; vendor will produce financial impact reports for confirmed systemic errors. In the instance where auditor has reviewed 100% of claims and identified suspect claims, the vendor may elect to review a mutually-agreed upon representative sample of the suspect claims. | □ Yes □ No |
| 3. | Confirm you agree the audit may include an onsite review of the sample claims by the auditor at the vendor's office. The auditor will provide the vendor with the sample claims thirty (30) calendar days in advance of the onsite review. The onsite review will last up to five (5) business days. | □ Yes □ No |
| 4. | Confirm you agree the scope of audits may include up to three (3) benefit plan years as determined by the State. | □ Yes □ No |
| 5. | Confirm you agree any and all costs and expenses of each party associated with the State's audit shall be borne by the party incurring the cost. The parties agree that the scope of audits by the State or auditor will not be duplicative of the SSAE-18 audit, but may include inspection and/or verification of certain information provided in the SSAE-18 audits to the extent necessary to give a more thorough understanding of, and support for, such information. Audit materials or documentation provided by vendor will be confined to client-specific information. | □ Yes □ No |
| 6. | If the audit discovers any validated overpayment of fees or claim payments by vendor or other errors that result in economic losses to the client for failure to meet all vendor guarantees or performance standards, confirm you agree vendor shall pay the amount owed to the client following completion of the audit, within 30 days of written confirmation from the State as to the agreed upon settlement terms and amounts. | □ Yes □ No |

**Section 11 – Claim Appeals**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Does your EOB include:<br>• Specific instructions on exactly how to appeal?<br>• Specific information on the timeframes for appealing?<br>• Ability for the State to customize language on the EOB? | <br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No |
| 2. | In the event of a denial, confirm your organization informs members of appeal rights and the appeal process. | □ Yes □ No |
| 3. | What guidelines, processes, or procedures do you use in determining whether services are "necessary" or "appropriate":<br>• Internal<br>• American Dental Association<br>• Attending Dentist<br>• Medicare or HHS<br>• State Dental Assoc. or Org<br>• Other | <br><br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No |

| No | CRITERIA | RESPONSE |
|---|---|---|
| 4. | Confirm you agree that the State reserves the right to review, edit, or customize appeal templates from the vendor to State's membership to ensure compliance with state law and due process requirements. | □ Yes □ No |
| 5. | Confirm you use a licensed dentist and/or outside dental review panel to review disputed claims for dental necessity and billing appropriateness. | □ Yes □ No |
| 6. | Confirm that the State has access to a licensed dentist as questions arise on appeal decisions. | □ Yes □ No |
| 7. | Confirm you will support the State in defending claims litigation based on decisions to deny coverage. | □ Yes □ No |
| 8. | Confirm you agree to allow the State the right to review, edit, or customize appeal templates from the contractor to State's membership to ensure compliance with state law and due process requirements. | □ Yes □ No |
| 9. | Confirm you have a designated or dedicated appeals staff. | □ Yes □ No |
| 10. | Confirm you agree to provide the State with a single point of contact for appeals related inquiries. | □ Yes □ No |

**Section 12 - Financial**

| No. | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Will the State have the ability to retrieve online banking, accounting and financial reports? | □ Yes □ No |
| 2. | Will you provide a temporary login/password for the State to evaluate the online financial tools available by your organization? | □ Yes □ No |
| 3. | Will you support an All Payer Claims Database (APCD) claims data layout for details provided? | □ Yes □ No |

**Section 13 – Banking**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm you will establish a separate bank account on the State's behalf. | □ Yes □ No |
| 2. | Confirm you will process claims and issue checks from the bank account you established on the State's behalf. | □ Yes □ No |
| 3. | Confirm you will provide the State with a monthly report reconciling the account balance, claims drafts and electronic transfers. | □ Yes □ No |
| 4. | Do you require that self-funded plans use a specific bank for funding claims? | □ Yes □ No |
| 5. | Do you require an imprest amount? | □ Yes □ No |
| 6. | Is the frequency of ACH transfers for claim funding:<br>Daily<br>5 days<br>Monthly<br>Other | <br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No<br>□ Yes □ No |

**Section 14 – Offeror's Financial Terms Submitted with Pricing**

| No | CRITERIA | RESPONSE |
|---|---|---|
| 1. | Confirm you agree renewal notification (starting with year six) will be at least 180 days in advance of the effective date and will include justification for any increase requested. | □ Yes □ No |

**Response Clarification and Explanation (add rows as necessary)**

| Section | No. | Clarification |
|---|---|---|
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# DENTAL SUBMITTAL FORM 8 – GeoAccess Analysis Active Employees

**State of Alaska**

**GeoAccess Instructions:** (GeoAccess analysis based on member zip codes in census file)

All reports are to be run using the census file provided. Results for this form should be run by active employees only. Do not exclude any zip codes or subscribers.

Use the following access criteria:

| Provider Type | Urban/Suburban | Rural |
|---|---|---|
| General and Family Dentist | 2 providers within 10 miles | 2 providers within 20 miles |
| Pediatric Dentist | 2 providers within 10 miles | 2 providers within 20 miles |
| Specialist (non-Ortho) | 2 providers within 15 miles | 2 providers within 30 miles |
| Orthodontists | 1 provider within 10 miles | 1 provider within 20 miles |

Provide your GeoAccess analysis in your proposal showing the number of subscribers that are with and without desired access. GeoAccess analysis should include a list of locations (by city, county, zip code) and **number of subscribers not meeting the access criteria** along with the number of miles to the nearest in-network provider. In addition, please complete the GeoAccess summary table below for key locations and provide as an excel attachment to your response:

**Census Data: Active Employees Only**

| Major/Town/City Zip Code | Provider Type | Total Members | Number of Members with Access | Number of Members without Access | Zip Code Urban/Suburban or Rural? |
|---|---|---|---|---|---|
| | General Dentist | | | | |
| | Pediatric Dentist | | | | |
| | Specialist (non-Ortho) | | | | |
| | Orthodontists | | | | |

# DENTAL SUBMITTAL FORM 8 – GeoAccess Analysis Retirees

**State of Alaska**

**GeoAccess Instructions:** (GeoAccess analysis based on member zip codes in census file)

All reports are to be run using the census file provided. Results for this form should be run by retirees only.
Do not exclude any zip codes or subscribers.

Use the following access criteria:

| Provider Type | Urban/Suburban | Rural |
|---|---|---|
| General and Family Dentist | 2 providers within 10 miles | 2 providers within 20 miles |
| Pediatric Dentist | 2 providers within 10 miles | 2 providers within 20 miles |
| Specialist (non-Ortho) | 2 providers within 15 miles | 2 providers within 30 miles |
| Orthodontists | 1 provider within 10 miles | 1 provider within 20 miles |

Provide your GeoAccess analysis in your proposal showing the number of subscribers that are with and without desired access. GeoAccess analysis should include a list of locations (by city, county, zip code) and **number of subscribers not meeting the access criteria** along with the number of miles to the nearest in-network provider. In addition, please complete the GeoAccess summary table below for key locations and provide as an excel attachment to your response:

**Census Data: Retirees Only**

| Major/Town/City Zip Code | Provider Type | Total Members | Number of Members with Access | Number of Members without Access | Zip Code Urban/Suburban or Rural? |
|---|---|---|---|---|---|
| | General Dentist | | | | |
| | Pediatric Dentist | | | | |
| | Specialist (non-Ortho) | | | | |
| | Orthodontists | | | | |

# DENTAL SUBMITTAL FORM 9 – Network Disruption Analysis

**Network Disruption Instructions:**

A claim repricing file is included as an Excel attachment that includes a field for indicating if the provider/facility is currently in your proposed network. Offerors are to include a completed claims file in the same format with the submission of their response. Additionally, offerors are to complete the network disruption tables below. All responses will be verified by Segal through review of the submitted claims file. Segal reserves the right to seek clarification on the submitted pricing through the state Procurement Officer. If there is any ambiguity between an offeror's response and the information provided in the claims repricing file, the claims repricing file will serve as the source of information for evaluation purposes.

**Active Employees**

| Baseline Data | Alaska | | | | | All Other States | Total |
|---|---|---|---|---|---|---|---|
| | 995 | 996 | 997 | 998 | 999 | | |
| # of Records Used[1] | | | | | | | |
| # of Providers[2] | | | | | | | |
| Billed Charges $$ | | | | | | | |

| Bidder Results[3] | Alaska | | | | | All Other States | Total |
|---|---|---|---|---|---|---|---|
| | 995 | 996 | 997 | 998 | 999 | | |
| # of Providers[2] | | | | | | | |
| % Match to Baseline | | | | | | | |
| Billed Charges $$ | | | | | | | |
| % Match to Baseline | | | | | | | |

**Retirees**

| Baseline Data | Alaska | | | | | All Other States | Total |
|---|---|---|---|---|---|---|---|
| | 995 | 996 | 997 | 998 | 999 | | |
| # of Records Used[1] | | | | | | | |
| # of Providers[2] | | | | | | | |
| Billed Charges $$ | | | | | | | |

| Bidder Results[3] | Alaska | | | | | All Other States | Total |
|---|---|---|---|---|---|---|---|
| | 995 | 996 | 997 | 998 | 999 | | |
| # of Providers[2] | | | | | | | |
| % Match to Baseline | | | | | | | |
| Billed Charges $$ | | | | | | | |
| % Match to Baseline | | | | | | | |

[1] # of Records Used - is the count of Excel rows utilized in your analysis.

[2] # of Providers - the provider counts should be based on unique tax IDs.

[3] Bidder results should reflect the counts or dollars where a record is associated with an in-network provider in your network.

# DENTAL SUBMITTAL FORM 10 – Subcontractors

Please complete the below form if using subcontractors. During the Clarification Period (RFP Section 5.11), the State will require a signed written statement from each subcontractor that clearly verifies the subcontractor is committed to performing the services required by the contract. Prior to contract award, the State will also require evidence that each subcontractor possesses a valid Alaska business license. If no subcontractors will be used for a listed service or any other service, please type N/A in the appropriate cells.

| | **Subcontractor Name** | **Address** | **% of Work Performing** |
|---|---|---|---|
| Claims Processing System | | | |
| Network Administration | | | |
| Network Credentialing | | | |
| Clinical review of appeals | | | |
| Call Center | | | |
| Data Reporting | | | |
| Other Services (list these services) | | | |
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# DENTAL SUBMITTAL FORM 12 – Administrative Performance Guarantees

Please complete the following table:

| Performance Guarantees | Measurement Frequency | Dollars at Risk (% or $) |
|---|---|---|
| 1. Vendor attendance at requested meetings:<br>• Attendance by vendor representatives when requested at meetings scheduled by the State during the contract period and implementation phase. | Quarterly | |
| 2. Vendor call (or e-mail) return timeliness:<br>• The State or designated consultant's calls (or e-mail) to vendor are returned within 24 business hours. | Quarterly | |
| 3. Processing weekly eligibility updates:<br>• All updates to eligibility or enrollment records will be made within 2 business days after the information is received by the vendor. | Monthly | |
| 4. Telephone call availability or answering speed:<br>• 90% of all calls are answered within 30 seconds. Telephone service is available between 8:00 AM (Alaska) and 6:00 PM (Alaska time) on business days. | Monthly | |
| 5. Customer satisfaction:<br>• Starting in the second year 90% customer satisfaction as determined by State annual survey (if conducted). Absent a State survey, determined by post-call vendor survey. | Monthly | |
| 6. Telephone call on-hold (in queue) time:<br>• An average of less than 2 minutes on hold before a human being answers. | Monthly | |
| 7. Telephone abandonment rate:<br>• An abandonment rate of less than 2.5% is maintained during standard business hours. | Monthly | |
| 8. Claims financial accuracy:<br>• 99% of claims dollars submitted for payment will be accurately processed and paid. Vendor must reimburse the State for all overpayments that are not recovered within 60 days after the overpayment is discovered. The State will assign its right to the vendor to collect any such overpayments. | Quarterly | |
| 9. Turnaround time on claim payment:<br>• 95% of all claims received will be completely processed (paid, denied, or pended for additional information) within 14 calendar days after they are received. 100% of claims will be processed within 30 days of receipt. | Quarterly | |
| 10. Claims processing accuracy:<br>• 95% of all claims will be coded with no errors. | Annually | |

| Performance Guarantees | Measurement Frequency | Dollars at Risk (% or $) |
|---|---|---|
| 11. Appeal reviews:<br>• State to review TPA appeal files forwarded to Division in response to a level 3 filing. Will review to ensure they meet minimum Alaska due process requirements. Findings to be reviewed with TPA. Penalty if less than 95% meet standard. | Annually | |
| 12. Implementation:<br>• Successful implementation is defined by key milestones. Include measurable milestones in your proposal. | Annually | |
| 13. Implementation customer satisfaction:<br>• Based on customer satisfaction survey, achieve all satisfaction of 80% or greater by the end of the second quarter. | Annually | |
| | | % of Admin Exp. |
| **Total Dollars at Risk** | | Total $ |