**ADDENDUM NO. 1**

**September 7, 2023**

**REQUEST FOR PROPOSAL (RFP) NUMBER H23-0057**

**TITLE: DENTAL AND VISION BENEFIT MANAGEMENT SERVICES**

1. **General**
   This addendum revises RFP documents. This addendum is issued to respondents of record prior to execution of contract and forms a part of contract documents and modifies previously issued documents. Insofar as previously issued contract documents are inconsistent with modifications indicated by this addendum, modifications indicated by this addendum shall govern. Where any part of the contract documents is modified by this addendum, all unaltered provisions shall remain in effect.

2. **Addendum Acknowledgement Form**
   Acknowledge receipt of this addendum in the space provided on the Addendum Acknowledgement Form. Proposers must include the signed form with their response. Failure to do so will subject Proposers to disqualification.

3. **Changes and Clarifications**
   A. **Proposal Due Date** has been **changed** September 15, 2023, **to October 13, 2023, by 2:00 P.M. CT**.

   B. Responses to questions receive before August 15, 2023

4. **Attachments**
   A. None

**Responses to Vendor Questions**

| | Question | Response |
|---|---|---|
| 1 | "4.4.3.3 Describe how the Proposer's utilization review/peer review policies and procedures that meet the requirements in Appendix E. Also 4.4.10.3. Please provide Appendix E. It was not included in the RFP. " | See Appendix E of this Addendum 1, below. |
| 2 | "4.4.6.1 Describe how the Proposer's QAP meets the requirements in Appendix F. Provide two specific examples of quality improvement activities performed in the last three (3) years. Provide outcomes data, if available, to illustrate the effectiveness of improvement activities Also 4.4.13.1. Please provide Appendix F. It was not included in the RFP. " | See Appendix F of this Addendum 1, below. |
| 3 | "4.4.10.5.4 Polycarbonate eyeglass lenses for adults, age 21 and over (see Appendix O-2a in the Policy Manual for specific information).<br><br>Please provide Appendix O-2a. It was not included in the RFP. " | Appendix O-2a will not be provided. However please see below:<br>Polycarbonate eyeglass lenses:<br>- All children through age 20, no prior authorization required<br>- Adult age 21 and over, with prior approval and a prescription of + 2.50 |
| 4 | We noticed a few references to Medicare Health Plan, do you have any Medicare members currently, or is there the possibility that you plan to expand into the MA-PD line of business by the end of the contract term for your vendor? If yes, would we need to build a Medicare network for the start of this contract term, or would you give us ample notice in the future, if we are lucky enough to be selected by Cook County Health? | We do not have any Medicare members currently. If we expand into the MA-PD line of business, we will give ample notice |
| 5 | 4.4.16.4 Include appeals and grievances timeliness performance metrics for the past 24 months by quarter.<br>The CCH Standards are not included in the table presented. Please provide the CCH Standards for the appeal and grievance timeliness performance metrics. Thank you." | At least 95% of standard appeals will be processed within 15 business days of appeal receipt. Turnaround time includes appeal receipt, decision, effectuation of appeal decision (if applicable), and Enrollee and/or Provider notification.<br><br>At least 95% of expedited appeals will be processed within 24 hours of receipt of all required information for the appeal. Turnaround time includes appeal receipt, decision, effectuation of appeal decision (if applicable), and Enrollee and/or Provider notification.<br><br>Member grievances must be investigated as expeditiously as the member's health requires, but no later than 20 calendar days after receipt.<br><br>Provider grievances must be investigated and responded to within 20 calendar days. |

| | Question | Response |
|---|---|---|
| 6 | "5.6 Cost Proposal: Proposers must submit pricing RFP in a separate sealed envelope clearly marked with the RFP number and the label "Pricing RFP." Proposers are required to submit one (1) paper copy (original) and one (1) electronic copy emailed to the email addresses specified on the cover page). Please verify the due date of the separate paper copy. Does it need to be received at the same time as the electronic submittal or can it be overnighted for next day delivery? Also, please provide the physical address to submit the paper copy as it is not included on the cover page of the RFP. Thank you." | An electronic copy is required for the response to this RFP. Your Proposal must be emailed to purchasing@cookcountyhhs.org. The email must clearly indicate the RFP Number and Title.<br><br>Proposers are required to submit one (1) electronic copy of their Proposal response.<br>• Each submission must have one (1) complete electronic response package (including attachments in excel, word, or pdf format). The Technical Response must be a single electronic file (do not submit a file per RFP section).<br>• One (1) Cost Proposal must be submitted separate from the rest of the response<br>• One (1) EDS copy must be submitted separate from the rest of the response.<br>• Material should be organized following the order of the Required RFP Content Section separated by labeled tabs.<br>• CCH reserves the right to waive minor variances |
| 7 | There was not a procurement timeline included in the RFP. Please provide a timeline including evaluation dates, possible presentation dates, award notification dates, and the anticipated start date of the contract and preferred go-live date of the system. | Please review the following:<br><br>Tentative Presentation dates: End of October, beginning of November (TBD)<br><br>Award Notification: Tentative December/ January 2024<br><br>Anticipated Go-Live: Q3/Q4 2024 |
| 8 | Section 5.6: Cost Proposal. Can CCH please provide clarity to the collection's aspect of this section and how it applies to dental and vision service administration fees? | Sections A and B are no longer applicable to this RFP; however, proposers should submit pricing on a PMPM basis and state all assumptions clearly. |
| 9 | Will CCH provide any dental and vision historical membership and claims information? Will CCH provide a count of child and adult members? | See Appendix G of this Addendum 1 for 2022 Vision and Dental Claims<br><br>As of 8/24/2023, count of child members 20 years and younger is 211,041.<br><br>As of 8/24/2023, count of adult members 21 and older is 245,577 |
| 10 | Section 4.3; page 7 - Bidders are required to state how we can/cannot meet each of the requirements. Should bidders place explanations within each cell immediately following Y, N or NA? | You do not have to put your explanation in the same cell as the Y, N, or NA distinction, however it has to be very clear what requirement your explanation is in relation to, by at minimum placing the requirement number immediately preceding the explanation (ex 4.5.2.3 – explanation). |

| | Question | Response |
|---|---|---|
| 11 | "Section 4.4.2.5; page 12 - 4.4.2.5 the Proposer's contracted dental network must include providers within all dental specialties and sub-specialties, must include all of Cook CCH's safety-net providers delivering dental care. Can the CCH outline all desired dental specialties, sub-specialties, and safety-net providers? | Dental specialties in our network:<br>Advanced Practice Dental Therapist<br>Dental Public Health<br>Dentist<br>Dentist Anesthesiologist<br>Endodontics<br>Family Medicine - Family Medicine<br>General Practice<br>Oral & Maxillofacial Surgery<br>Oral and Maxillofacial Pathology<br>Oral and Maxillofacial Surgery<br>Orthodontics and Dentofacial Orthopedics<br>Pediatric Dentistry<br>Pediatrics - Pediatrics<br>Periodontics<br>Prosthodontics<br>Single Specialty - Single Specialty<br>Student in an Organized Health Care Education/Training Program - Student in an Organized Health Care Education/Training Program |
| 12 | "In Sections 5.0 and 8.7; pages 34 and 43 - In 5.0: Required Proposal Content it states that, "CCH is supplying a base of information to ensure uniformity of responses. It must be noted, however, that the guidelines should not be considered so rigid as to stifle the creativity of any Proposer responding. However, in Section 8.7: Alteration/Modification of Original Documents it states that the proposer, "The proposer certifies that no alterations or modifications have been made to the original content of this Bid/RFP or other procurement documents (either text or graphics and whether transmitted electronically or hard copy in preparing this RFP)." Can the CCH confirm that the bidder may respond in our own template and formatting if no other changes to numbering, content, or stated requirements are made? " | Confirming that the bidder may respond in your own template and formatting if no other changes to number, content or stated requirements are made, and make it very clear what requirement your explanation is in relation to, by at minimum placing the requirement number immediately preceding the explanation (ex 4.5.2.3 – explanation). |
| 13 | Section 5.4; page 35 - Re: Cook CCH Assumed Business Name Certificate> Where can a bidder obtain this certificate? Is this on file with CCH? | The Cook County Clerk's office registers business names known as "assumed names" (or DBA) for new businesses in accordance with Illinois law.<br><br>https://www.cookcountyclerkil.gov |

| | Question | Response |
|---|---|---|
| 14 | Sections 5.16 and 8.3; pages 38 and 42 - In 5.16: Cost proposal – the bidder is instructed to submit the cost proposal as one (1) paper copy and one (1) electronic copy. Section 8.3: Number of Copies instructs bidders to submit the response as one (1) electronic copy. Can the CCH clarify if it wants ONLY the cost section submitted electronically and also as a hard copy? Or shall it be submitted as one (1) electronic copy just like the rest of the bid? Should our Cost proposal be submitted in a separate email from the rest of our bid or just in a separate zip file with the rest of our bid? | See response to Question 6. |
| 15 | Sections 8.3, 8.5, and 5.12; pages 42 and referenced on page 39 - 8.3: Number of copies – the bidder is instructed to submit one (1) electronic copy of its bid; however, in 8.5 it's indicated that Attachment C – Economic and Disclosures Statement should be submitted in the same email, which in section 5.12 it states that it must be submitted with the pricing proposal in a separate envelope. Can the CCH clarify where to submit Attachment C? | See response to Question 6. |
| 16 | Sections 8.13, page 42 - In 8.3: Number of Copies it states that the technical response must be a single electronic file. Does the CCH want Attachment D: CCH Security Questionnaire to be converted to a PDF so it may be included in that section, or should it stay as an Excel file as an attachment? E | The security questionnaire may be submitted as an Excel file attachment. |

**APPENDIX E**

## Utilization Review and Peer Review

1. Utilization Review and Peer Review Committees. Proposer, on behalf of CCH, shall provide CountyCare with utilization review and peer review committee(s) whose purpose will be to review data gathered and the appropriateness and quality of care. The committee(s) shall review and make recommendations for changes when problem areas are identified and report suspected FWA to CCH or its designee. The committees shall keep minutes of all meetings, the results of each review and any appropriate action taken and those records shall be available to CCH within ten (10) Business Days after CCH's request. At a minimum, these programs must meet all applicable federal and State requirements for utilization review. Proposer and CCH may further define these programs.

2. Utilization Review Plan. Proposer, on behalf of CCH, shall implement a Utilization Review Plan, approved CountyCare's Chief Medical Officer or their designee, including dental and vision peer review as required. Proposer shall provide CCH with documentation of its utilization review process. The process shall include:

a. Written Program Description. Proposer, on behalf of CCH, shall have a written Utilization Management Program description which includes, at a minimum, procedures to evaluate medical necessity criteria used and the process used to review and approve the provision of medical services.

b. Scope. The program shall have mechanisms to detect under-utilization as well as over-utilization.

c. Preauthorization and Concurrent Review Requirements. Proposer shall:

i. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;

ii. Utilize practice guidelines that have been adopted, pursuant to **Attachment F, Quality Assurance Plan**.

iii. Ensure that review decisions are supervised by qualified medical or dental professionals and any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested must be made by a qualified professional who has appropriate clinical expertise in treating the Enrollee's condition or disease;

iv. Endeavor to obtain all necessary information, including pertinent clinical information, and consultation with the treating Provider, as appropriate;

v. Ensure that the reasons for decisions shall be clearly documented and available to the Enrollee and the requesting Provider, provided, however, that any decision
to deny a service request or to authorize a service in an amount, duration or scope that is less than requested shall be furnished in writing to the Enrollee;

vi. Ensure that there shall be written well-publicized and readily available Appeal mechanisms for both Network Providers and Enrollees;

vii. Ensure that decisions and appeals shall be made in a timely manner as required by the circumstances and shall be made in accordance with the timeframes specified in this RFP for standard and expedited authorizations;

viii. Ensure that there shall be mechanisms to evaluate the effects of the program using data on Enrollee satisfaction, Network Provider satisfaction or other appropriate measures; and

ix. Ensure that if it delegates responsibility for utilization management to a Subcontractor, that there are mechanisms to ensure that these standards are met by the Subcontractor.

4. UR Regular Review. Contractor shall review the utilization review procedures, at regular intervals, but no less frequently than annually, for the purpose of amending same, as necessary in order to improve said procedures. All amendments must receive Prior Approval. Proposer further agrees to supply CCH and its designee with the utilization information and data, and reports prescribed in its approved utilization review system or the status of such system.

5. Utilization Management program evaluation (UMPE): Proposer will send annually a UMPE to assure high-quality care and services for our enrollees by aggressively seeking opportunities to improve the performance of the care delivery system. This report is a summary of year's activities to monitor and improve both the care status and experience of our members. It highlights our successes, examines lessons learned, and outlines next step.

6. Peer Review Program. Proposer, on behalf of CCH, shall establish and maintain a peer review program, subject to Prior Approval, to review the quality of dental and vision care being offered by CountyCare. This program shall provide, at a minimum, the following:

a. A peer review committee comprised of relevant Providers, formed to organize and proceed with the required reviews for dental and vision Network Providers:

i. A regular schedule for review;

ii. A system to evaluate the process and methods by which care is given; and

iii. A medical record review process.

b. Proposer, on behalf of CCH, shall maintain records of the actions taken by the peer review committee with respect to Providers and those records shall be available to CCH Corporate Compliance or its designee upon request.

c. A system of internal review, including dental services, medical evaluation studies, peer review, a system for evaluating processes and outcomes of care, health education, systems for correcting deficiencies, and utilization review.

d. At least two (2) medical evaluation studies must be completed annually that analyze pressing problems identified by Proposer, the results of such studies, and appropriate action taken. One of the studies may address an administrative problem noted by Proposer and one may address a clinical problem or diagnostic category. One brief follow-up study shall take place for each medical evaluation study in order to assess the actual effect of any action taken. CountyCare's medical evaluation studies' topic and design must receive Prior Approval.

7. Peer Review Regular Review. Proposer shall review the peer review procedures, at regular intervals, but no less frequently than annually, for the purpose of amending same in order to improve said procedures. All amendments must be approved by CCH. Proposer shall supply CCH, or its designee with the information and reports related to its peer review program upon request.

8. Peer Review Request. CCH may request that peer review be initiated on specific Network Providers or any of their Subcontractors providing Covered Services at any time and may conduct its own peer reviews at its discretion.

**APPENDIX F**

# Quality Assurance Plan

Proposer shall establish procedures approved by the Director of Population Health & Performance Improvement of CountyCare such that CCH shall be able to demonstrate it meets the requirements of the County MCCN Contract and applicable Governing Law related to Quality Assurance Plans ("QAP") and Quality Assurance Program. Proposer shall require its Network Provider Networks and Network Providers to cooperate with Proposer's and CCH's QAP with respect to the following and provide any information required by CCH or its designee in order to administer the QAP.

Proposer shall, and shall assist CCH with the following:

1. QAP. Proposer shall have a QAP that:

   a. Comprehensively addresses both quality of clinical care and non-clinical aspects of service, such as and including, availability, accessibility, coordination and continuity of care.

   b. incorporates widely accepted practice guidelines that meet nationally recognized standards and are distributed to Network Providers, as appropriate, and to Enrollees and Potential Enrollees upon request, and that at a minimum:

      (i) Are based on valid and reliable clinical evidence;

      (ii)Consider the needs of Enrollees;

      (iii)Satisfy community standards;

      (iv)Are adopted in consultation with Network Providers; and

      (v)Are reviewed and updated periodically as appropriate.

   c. Includes fraud control provisions including, but not limited to, a designated special investigations unit (SIU) to oversee Fraud, Waste and Abuse investigations;

   d. Uses systematic data collection of performance and Enrollee results to evaluate the provision of dental and vision services, provides interpretation of this data to its Network Providers and institutes needed changes;

   e. Includes written procedures for taking appropriate remedial action and developing corrective action and quality improvement whenever, as determined under the Quality Assurance Program, inappropriate or substandard services have been furnished or Covered Services that should have been furnished have not been provided;

   f. Monitors the dental and vision services CountyCare provides, including assessing the appropriateness and quality of care;

   g. Stresses health outcomes and monitors Enrollee risks status and improvement in health outcomes related to dental or vision services;

   h. Provides review by Physicians and other qualified dentists or optometrists of the process followed in the provision of dental and vision services;

   i. Establishes and monitors access standards;

   j. Describes its health education procedures and materials for Enrollees; processes for training, monitoring, and holding providers accountable for dental and vision education; and oversight of Provider requirements to provide dental and vision education topics and outreach documents using evidence based guidelines and best practice strategies;

k. Describes its processes for addressing Abuse and Neglect and unusual incidents in the community setting; and

l. Provides for systematic activities to monitor and evaluate the dental services.

m. Outlines its process for developing, implementing, and evaluating plans necessary to support children transitioning into adulthood to ensure continuity of dental or vision services.

n. Support review of the entire range of care provided, by assuring that all demographic groups, care settings, and types of services are included in the scope of the review.

o. Describes key staff, leadership and committee structure needed to provide oversight of the QAP and its deliverables.

p. Implements a Cultural Competence plan ensuring that all dental and vision services are provided in a culturally competent manner, aligning with NCQA Standards for Culturally Linguistically Appropriate Services in Health Care (CLAS Standards).

2. Use of Quality Indicators. Quality indicators are measurable performance variables relating to a specified area, which are reviewed over a period of time to monitor the process of outcomes of care delivered in that service area:

a. Proposer, on behalf of CCH, shall identify and use quality and performance indicators that are objective, measurable, and based on current knowledge and clinical experience.

b. Proposer, on behalf of CCH, shall document that its methods and frequency of data collected with respect to quality indicators are appropriate and sufficient to detect the need for a program change.

c. For any priority areas specified by CCH, Proposer, on behalf of CCH, shall monitor and evaluate quality of care through studies which address, but are not limited to, the quality indicators also specified by HFS.

3. Monitoring. Appropriate Persons shall monitor and evaluate the quality of dental and vision services through review of individual cases where there are questions about the services, and through studies analyzing patterns of utilization. Dental and vision service areas requiring improvement shall be identified and documented, and a corrective action plan shall be developed and monitored.

4. Conduct Performance Improvement Projects (PIPs)/Quality Improvement Projects (QIPs). PIPs/QIPs (as described in 42 C.F.R. 438.240 (1) (d)), shall be designed to achieve, through ongoing measurements and intervention, significant improvement of the quality of services rendered, sustained over time, and resulting in a favorable effect on health outcome and Enrollee satisfaction. Performance measurements and interventions shall be submitted to CCH annually as part of the QA/UR/PR Annual Report to be submitted to HFS and at other times throughout the year upon request by HFS. If CCH, or its designee, implements a PIP/QIP that spans more than one (1) year, Proposer shall report annually the status of such project and the results thus far.

5. Implementation of Remedial or Corrective Actions. The QAP shall include written procedures for taking appropriate remedial action, which shall be taken by Proposer with respect to its administrative services and the services of its Network Providers and their Subcontractors, if applicable, whenever, as determined under the QAP, inappropriate or substandard services are furnished. Quality Assurance actions that result in remedial or corrective actions shall be forwarded by Proposer to CCH or its designee, as directed by CCH, on a timely basis. Written remedial or corrective action procedures shall include:

a. specification of the types of problems requiring remedial or corrective action;

b. specification of the person(s) or entity responsible for making the final determinations regarding quality problems;

c. specific actions to be taken;

d. a provision for feedback to appropriate Network Providers and any staff;

e. the schedule and accountability for implementing corrective actions;

f. the approach to modifying the corrective action if improvements do not occur; and

g. procedures for notifying a Network Provider that such Provider is no longer eligible to provide services to Enrollees.

6. Assessment of Effectiveness of Corrective Actions. CCH or its designee, shall monitor and evaluate corrective actions taken to confirm that appropriate changes have been made. CCH or its designee, shall follow-up on identified issues to confirm that actions for improvement have been effective and provide documentation of the same.

7. Provider Qualifications. The QAP shall contain provisions to ensure that Network Providers are qualified to perform their services as set forth herein.

8. QA Findings. The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QA activity, shall be documented and reported to appropriate individuals within the organization and through the established QA channels. Proposer, on behalf of CCH, shall document coordination of QA activities and other management activities.

a. QA information shall be used in re-contracting and annual performance evaluations of Network Providers.

b. QA activities shall be coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of Enrollee complaints and grievances.

C. In the aggregate, without reference to Network Provider or Enrollee identifying information, all Quality Assurance findings, conclusions, recommendations, actions taken, results or other documentation relative to QA shall be reported to CCH or its designee on a quarterly basis, or as requested otherwise requested by CCH~~S~~ or HFS.

9. Cooperation. Proposer shall, at the direction of CCH or its designee, cooperate with the external, independent quality review process conducted by the EQRO. Proposer shall address the findings of the external review through its Quality Assurance Program by developing and implementing performance improvement goals, objectives and activities, which shall be documented in the next quarterly report submitted by Proposer following the EQRO's findings.

10. Proposer shall perform and report Healthcare and Quality of Life Performance Measures identified in Table 1 in this Attachment using HEDIS and HEDIS-like Quality Measure Specifications methodology, as provided by HFS or CCH.

11. Quality Management Coordinator. Proposer's designated Quality Management Coordinator and Proposer's dental and vision directors shall have substantial involvement in QA activities and shall be responsible for the required reports.

a. Adequate Resources. The QAP shall have sufficient material resources, and staff with the necessary education, experience, or training, to effectively carry out its specified activities.

b. Provider Participation in the QAP

i. Network Providers shall be kept informed about the written QAP.

ii. Proposer shall include in Network Provider Contracts a requirement securing cooperation of Network Providers and their Subcontractors with the QAP.

iii. Contracts shall specify that Network Providers will allow, and shall require their Subcontractors to allow, access to the medical records of its Enrollees to Proposer.

12. Delegation. Proposer shall remain accountable for all QAP functions, even if certain functions are delegated to other entities. If Proposer delegates any QA activities to Subcontractors:

a. There shall be a written description of the following: the delegated activities; the Subcontractor's accountability for these activities; and the frequency of reporting to Proposer.

b. Proposer shall have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

c. Proposer shall be held accountable for Subcontractor's performance and must assure that all activities conform to this attachment's requirements.

d. There shall be evidence of continuous and ongoing evaluation and oversight of delegated activities, including approval of quality improvement plans and regular specified reports, as well as a formal review of such activities. Oversight of delegated activities must include no less than an annual audit, analyses of required reports and Encounter Data, a review of Enrollee complaints, grievances, Provider complaints and appeals, and quality of care concerns raised through Encounter Data, monitoring activities, or other venues. Outcomes of the annual audit shall be submitted to HFS as part of the QA/UR/PR Annual Report.

e. If Proposer or Subcontractor identifies areas requiring improvement, Proposer and Subcontractor, as appropriate, shall take corrective action and implement a quality improvement initiative. If one or more deficiencies are identified, the Subcontractor must develop and implement a corrective action plan, with protections put in place by Proposer to prevent such deficiencies from reoccurring. Evidence of ongoing monitoring of the delegated activities sufficient to assure corrective action shall be provided to HFS through quarterly or annual reporting.

Standards. All services provided by or arranged to be provided by Proposer shall be in accordance with prevailing professional community standards. All clinical practice guidelines shall be based on established evidence-based best practice standards of care, promulgated by leading academic and national clinical organizations, and shall be adopted by the Quality Oversight Committee with sources referenced and guidelines documented in the QAP. The QAP shall be updated no less than annually and when new significant findings or major advancements in evidence-based best practices and standards of care are established. Proposer, on behalf of CCH, shall provide ongoing education to Network Providers Medicaid and Medicare Advantage Dental and Optical Services RFP on required clinical guideline application and provide ongoing monitoring to assure that its Network Providers are utilizing them.

**APPENDIX G 2022 Vision and Dental Claims**

| Vision | Contact Lenses | Exams | Frames | Lenses | Medical | Other | Grand Total |
|---|---|---|---|---|---|---|---|
| Jan-22 | $14,978.87 | $170,059.70 | $63,748.00 | $43,160.00 | $9,200.00 | $155,424.18 | $456,570.75 |
| Feb-22 | $13,474.96 | $194,812.75 | $72,103.00 | $49,451.00 | $10,894.00 | $174,978.77 | $515,714.48 |
| Mar-22 | $17,883.97 | $287,008.75 | $96,969.20 | $57,524.36 | $15,142.00 | $242,045.89 | $716,574.17 |
| Apr-22 | $16,014.89 | $215,830.55 | $77,717.60 | $55,254.38 | $11,184.00 | $184,751.63 | $560,753.05 |
| May-22 | $13,396.98 | $233,044.15 | $76,399.80 | $50,453.10 | $9,619.38 | $196,378.24 | $579,291.65 |
| Jun-22 | $15,514.95 | $263,706.80 | $71,611.00 | $54,746.00 | $12,822.00 | $212,861.58 | $631,262.33 |
| Jul-22 | $13,510.97 | $192,167.15 | Chart Area | $41,761.50 | $8,967.00 | $148,509.43 | $481,408.05 |
| Aug-22 | $16,188.96 | $299,011.60 | $114,556.18 | $70,810.50 | $11,895.02 | $261,950.29 | $774,412.55 |
| Sep-22 | $14,616.01 | $191,679.45 | $75,024.00 | $45,445.00 | $10,993.00 | $165,140.57 | $502,898.03 |
| Oct-22 | $14,125.99 | $200,271.50 | $82,103.41 | $52,185.00 | $10,350.09 | $172,565.66 | $531,601.65 |
| Nov-22 | $17,095.15 | $279,348.45 | $93,760.00 | $56,871.00 | $10,832.91 | $222,844.15 | $680,751.66 |
| Dec-22 | $11,368.98 | $146,502.70 | $64,396.00 | $41,697.00 | $8,514.00 | $131,172.94 | $403,651.62 |
| **Grand Total** | **$178,170.68** | **$2,673,443.55** | **$964,880.19** | **$619,358.84** | **$130,413.40** | **$2,268,623.33** | **$6,834,889.99** |

| Dental | Diagnostic | Periodontics | Preventive | Adjunctive General | Prosthodontics | Restorative | Oral and Maxillofacial | Orthodontics | Endodontics | Prosthodontics (Fixed) | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Jan-22 | $839,159.20 | $160,978.79 | $896,516.87 | $137,469.99 | $56,558.79 | $742,666.41 | $376,367.48 | $197,769.15 | $99,324.06 | $0.00 | $3,506,810.74 |
| Feb-22 | $959,007.41 | $186,469.03 | $1,129,976.17 | $127,017.85 | $49,696.00 | $682,397.63 | $308,819.35 | $228,686.95 | $70,616.01 | $0.00 | $3,742,686.40 |
| Mar-22 | $1,285,223.13 | $286,960.56 | $1,679,126.66 | $118,522.67 | $63,457.88 | $738,360.64 | $320,683.17 | $293,979.40 | $56,617.80 | $498.70 | $4,843,430.61 |
| Apr-22 | $1,074,575.97 | $277,145.71 | $1,319,862.40 | $92,563.85 | $71,682.19 | $636,632.80 | $269,147.16 | $226,870.20 | $52,338.83 | $0.00 | $4,020,819.11 |
| May-22 | $971,773.01 | $223,738.57 | $1,206,406.23 | $92,436.73 | $58,421.12 | $537,246.50 | $215,665.16 | $233,734.20 | $35,998.83 | $0.00 | $3,575,420.35 |
| Jun-22 | $1,098,042.62 | $286,964.63 | $1,307,137.95 | $92,626.71 | $96,117.15 | $698,376.54 | $271,013.20 | $282,475.90 | $50,075.47 | $0.00 | $4,182,830.17 |
| Jul-22 | $1,091,615.60 | $198,201.32 | $1,028,928.87 | $100,740.96 | $46,328.04 | $599,002.18 | $215,116.84 | $184,941.00 | $47,217.62 | $0.00 | $3,512,092.43 |
| Aug-22 | $1,426,642.63 | $231,577.27 | $1,474,510.50 | $130,593.58 | $71,365.19 | $756,864.18 | $302,847.52 | $275,710.90 | $47,014.40 | $0.00 | $4,717,126.17 |
| Sep-22 | $965,158.45 | $205,268.47 | $983,956.54 | $98,418.72 | $54,594.62 | $572,523.44 | $238,691.57 | $215,384.95 | $38,137.40 | $0.00 | $3,372,134.16 |
| Oct-22 | $1,052,531.12 | $242,179.73 | $1,095,610.68 | $128,894.23 | $52,499.28 | $630,354.05 | $239,049.69 | $240,670.70 | $44,027.33 | $32.90 | $3,725,849.71 |
| Nov-22 | $1,141,790.35 | $279,545.14 | $1,328,248.16 | $121,887.84 | $70,256.26 | $776,093.90 | $266,905.59 | $279,508.90 | $58,683.24 | $0.00 | $4,322,919.38 |
| Dec-22 | $823,686.45 | $206,596.12 | $919,930.89 | $96,176.21 | $55,341.16 | $517,595.51 | $188,289.01 | $202,041.60 | $34,809.49 | $677.50 | $3,045,143.94 |
| **Grand Total** | **$12,729,205.94** | **$2,785,625.34** | **$14,370,211.92** | **$1,337,349.34** | **$746,317.68** | **$7,888,113.78** | **$3,212,595.74** | **$2,861,773.85** | **$634,860.48** | **$1,209.10** | **$46,567,263.17** |

**ADDENDUM ACKNOWLEDGEMENT FORM**

As required by the RFP, Proposers must submit this acknowledgement form with their response. One acknowledgement form per response, listing all addenda, is appropriate.

**Addendum No.: _____**

**Addendum No.: _____**

**Addendum No.: _____**

**Addendum No.: _____**

**Addendum No.: _____**

**Addendum No.: _____**

**Company Name:** _____

**Representative's Name:** _____

**Signature:** _____

**Date:** _____

END OF ADDENDUM