

RFP 15-036 SUBMITTAL DOCUMENT

SUBMITTAL INSTRUCTIONS

Proposer must complete and submit all sections of this RFP Submittal Document as its Proposal. Please follow these instructions carefully.

Proposal

The Proposer's Proposal must include all completed sections of this Submittal Document as listed below:

1. Letter of Submittal
2. Proposer's Authorized Offer
3. Proposer Information
4. Minimum Qualifications
5. Subcontractor Information
6. Diverse Business Inclusion Plan
7. Non-Cost Proposal
8. Cost Proposal

- A. Complete Proposals** must be received electronically on or before **February 5, 2016; 2pm (PT)**. Proposer must complete and submit all sections of this Submittal Document as listed above, as its Proposal. Proposer may attach additional sheets as necessary.
- B. Delivery of Proposal:** The Proposal must be delivered as follows:
- 1) Attach the completed **Submittal Document** to a single email message and send it to contracts@hca.wa.gov.
 - 2) Clearly mark the subject line of the email: RFP- 15-036 Vendor Name (e.g. RFP- 15-036, ABC Company).
 - 3) The preferred software formats are Microsoft Word 2000 (or more recent version) and PDF. If this presents any problem or issue, contact the Procurement Coordinator immediately. To keep file sizes to a minimum, Proposers are cautioned not to use unnecessary graphics in their Proposals.
 - 4) It is preferred that electronic signatures appear on all documents requiring signature. However, an email date stamp will be accepted as signed by the legally authorized representative of the firm for the purpose of this Proposal only.
- C. Time of receipt** will be determined by the e-mail date and time **received** at the HCA's mail server in the contracts@hca.wa.gov inbox. The "receive date/time" posted by the HCA's email system will be used as the official time stamp. The HCA is not responsible for problems or delays with e-mail when the HCA's systems are operational. If a Proposal is late, it may be rejected.

Proposals should be submitted in the format described in this solicitation. All proposals and any accompanying documentation become the property of the HCA and will not be returned. Incomplete Proposals may be rejected. Proposals submitted by fax, will not be accepted and will be considered non-responsive.

LETTER OF SUBMITTAL

The Proposer's Letter of Submittal must be signed by the individual within the organization authorized to bind the Proposer to the offer. Along with introductory remarks, the Letter of Submittal is to include by attachment the following information about the Proposer and any proposed subcontractors:

- Name, address, principal place of business, DBA name (if any), telephone number, and fax number/e-mail address of legal entity or individual with whom contract would be written.
- Name, address, and telephone number of each principal officer (President, Vice President, Treasurer, Chairperson of the Board of Directors, etc.)
- Names, addresses, e-mail addresses and telephone numbers of the sole proprietors, partners, or principle officers as appropriate to the organization.
- A list identifying by name which individuals have the authority to sign contracts/amendments on behalf of the organization

PROPOSER’S AUTHORIZED OFFER
(PROPOSAL SIGNATURE PAGE)

Third Party Administrator of Bundled Payment Center of Excellence Program
RFP 15-036

Issued by the Washington State Health Care Authority

Certifications and Assurances

We make the following certifications and assurances as a required element of the Response, to which it is attached, affirming the truthfulness of the facts declared here and acknowledging that the continuing compliance with these statements and all requirements of the RFP are conditions precedent to the award or continuation of the resulting Contract.

1. The prices in this Response have been arrived at independently, without, for the purpose of restricting competition, any consultation, communication, or agreement with any other offeror or competitor relating to (i) those prices, (ii) the intention to submit an offer, or (iii) the methods or factors used to calculate the prices offered. The prices in this Response have not been and will not be knowingly disclosed by the offeror, directly or indirectly, to any other offeror or competitor before Contract award unless otherwise required by law. No attempt has been made or will be made by the offeror to induce any other potential Proposer to submit or not to submit an offer for the purpose of restricting competition. However, we may freely join with other persons or organizations for the purpose of presenting a single Proposal.
2. The attached Response is a firm offer for a period of 120 days following the Response Due Date specified in the RFP, and it may be accepted by the Washington State Health Care Authority (HCA) without further negotiation (except where obviously required by lack of certainty in key terms) at any time within the 120 day period. In the case of protest, our Response will remain valid for 180 days or until the protest and any related court action is resolved, whichever is later.
3. In preparing this Response, we have not been assisted by any current or former employee of the state of Washington whose duties relate (or did relate) to this solicitation, or prospective Contract, and who was assisting in other than his or her official, public capacity. Any exceptions to this assurance are to be described in full detail on a separate page and attached to the Proposer’s Response, along with a full description of any financial interest in the outcome of this Response that such a person or any member of that person’s immediate family may have.
4. We understand that the Washington State Health Care Authority (HCA) will not reimburse us for any costs incurred in the preparation of this Response. All Responses become the property of the HCA, and we claim no proprietary right to the ideas, writings, items or samples unless so stated in the Response. Submission of the attached Response constitutes an acceptance of the evaluation criteria and an agreement to abide by the procedures and all other administrative requirements described in the solicitation document.
5. We understand that any Contract awarded, as a result of this RFP will incorporate all the solicitation requirements. Submission of a Response and execution of this Certifications and Assurances document certify our willingness to comply with the Contract terms and conditions appearing in Appendix B, Solicitation Standards, [or substantially similar terms], if selected as a contractor. We also understand that our standard contract will not be considered as a replacement for the terms and conditions appearing in Appendix C of this solicitation.
6. We (circle one) **are** / **are not** submitting proposed Contract exceptions.

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7. The authorized signatory below acknowledges having read and understood the entire solicitation and agrees to comply with the terms and conditions of the solicitation in submitting and fulfilling the offer made in its Proposal.

8. By submitting this Proposal, Proposer hereby offers to furnish materials, supplies, services and/or equipment in compliance with all terms, conditions, and specifications contained in this solicitation.

The signatory below represents that he/she has the authority to bind the company named below to the Proposal submitted and any contract awarded as a result of this solicitation.

Proposer Signature

Company Name

Title

Date

PROPOSER INFORMATION

Proposer Profile:

Proposer must provide the following:

Firm Name _____

DBA Name _____

Street Address _____

City, State, Zip _____

Federal Tax ID Number _____

WA State UBI Number _____

WA Statewide Vendor Number _____

Website URL _____

Legal Status of Firm: Corporation Partnership Sole Proprietor Other: _____

Proposer Authorized Representative:

Proposer must designate an Authorized Representative who will be the principal point of contact for the HCA Contract Administrator for the duration of this RFP process. Proposer’s Authorized Representative will serve as the focal point for business matters and administrative activities.

Representative Name: _____

Street Address _____

City, State, Zip _____

Telephone: _____

Email: _____

Proposer Principal Officer(s):

Proposer is instructed to identify each principal officer of the company (i.e. President, Vice President, Treasurer, etc.) not already identified herein. Proposer may add rows as necessary to incorporate all necessary information.

Name: _____	Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

Proposer Certifications and Status:

Proposer must check the applicable boxes and provide Certification numbers as appropriate for each category below:

Washington State Certified Minority and/or Woman Owned Business

- Not Applicable
 - Minority Owned
 - Woman Owned
 - Minority and Woman Owned
- Washington State
OMWBE Certification #: _____

Washington State Certified Veteran Owned Business

- Not Applicable
 - Certified Veteran Owned Business
- Washington State DVA
Certification #: _____

Self-Certified Washington Small Business

- Not Applicable
- Micro Business
- Mini Business
- Small Business

Statement of Conflict of Interest:

Proposer must identify below any state employees or former state employees employed by the Proposer or on the Proposer’s governing board as of the date of the Proposal. Include their position and responsibilities within the Proposer’s organization. Proposer must also identify below if any owner, key officer, or key employee of Proposer is related by blood, marriage, or qualified domestic partner to a member of the Public Employees Benefits Board or an employee of HCA or has close personal relationship to the same. If Proposer is aware of any other real or potential conflict of interest, Proposer must state so below. If following a review of this information, HCA determines that a conflict of interest exists; the Proposer may be disqualified from further consideration for the award of a contract. *If not applicable, Proposer is instructed to enter “NA” in the box below.*

Statement of Prior Contract Termination:

Proposer must disclose below if the Proposer’s firm and/or any proposed subcontractors have had a contract terminated for either cause or convenience in the last five (5) years. If a contract was terminated for cause or convenience during this timeframe, submit full details of the termination including but not limited to, the reason for termination, the other party’s contact information (name, address, email address, and telephone number), and the Proposer’s position on the matter. The HCA will evaluate the information and may, at its sole discretion, reject the Response based on the risk to the Agency. *If not applicable, Proposer is instructed to enter “NA” in the box below.*

Statement of Financial Viability & Stability:

Proposer must disclose below any judgments, pending or expected litigation, or real or potential financial events that could affect the viability or stability of the Proposer’s firm. This information must be provided for each person or organization proposed as a contributor to the project. *If not applicable, Proposer is instructed to enter “NA” in the box below.*

Proprietary or Confidential Information:

Proposer must indicate below any pages and/or sections of its response that Proposer desires to claim as proprietary and exempt from disclosure under the provisions of Chapter 42.56 RCW. Indicate below the pages of Proposer’s response that have been marked “Confidential” and the particular exception from disclosure upon which the Proposer is making the claim. Please see Section 20 of the RFP Solicitation Standards document for more detail on Proprietary or Confidential Information as it relates to this solicitation. *If not applicable, Proposer is instructed to enter “NA” in the box below.*

MINIMUM QUALIFICATIONS

Please keep responses clear and concise while preparing your response for the Minimum Qualifications Submittal. Responses to each question should be two (2) pages or less.

Minimum Qualifications:

Please answer the questions listed below to verify that your firm meets the minimum qualifications specified in Section 1.5 of the RFP. Please attach additional pages as necessary.

1. **Business License.** Please confirm below that your organization is currently licensed to conduct business in the state of Washington. If your firm is not currently licensed, please provide a commitment that your firm will become licensed within thirty (30) calendar days of being selected as the Apparent Successful Proposer.
2. **Agreement.** Please confirm that your organization agrees to enter into a binding agreement with the HCA to offer services stated in RFP 15-036, Section 1.3 State of Work if Contract is awarded to your organization.
3. **Experience.** Please confirm below that your organization has experience as a TPA.
4. **Capacity.** Please confirm below your organization has the capability of making payments to contracted Center(s) of Excellence (COE) on behalf of HCA.
5. **Capacity.** Please confirm below that your organization is capable and has the capacity to create and maintain lists of facilities, surgeons, anesthesiologists, DME providers; and other professionals who are participants in the COE Program.
6. **Capacity.** Please confirm below that your organization is capable of maintaining the credentialing standards necessary for the contracted COE(s) participating in the COE Program.
7. **Resources.** Please confirm below that your organization has resources that can be assigned to work directly with the COE(s) in the implementation and operationalization of the COE Program.

SUBCONTRACTOR INFORMATION

Check the applicable box:

Yes No Your firm intends on utilizing subcontractors to fulfill the service requirements outlined in RFP K 15-036, Third Party Administrator of COE Program.

Contractor will be required to perform all work under this contract using his/her own employees carried on payroll or by using approved subcontractors. Where subcontractors are used in the performance of the contract, proposers will indicate as required with their response to seek approval. Contractor will be held responsible for all work performed or not performed by the subcontractor(s). Subcontractors will be required to bill through the Contractor.

If revisions are required in the subcontract assignment, new parties are to be proposed in advance of assignment, in writing to the HCA and the Contract Administrator.

All subcontractors are to submit a letter on company letterhead indicating the contract has been read, the standard terms and conditions reviewed and agreeing to all requirements presented. The subcontractors shall be required to meet all requirements established for Contractor staff.

If applicable, Proposer shall identify below all subcontractors who will perform services in fulfillment of contract requirements, including their name, the nature of services to be performed, address, telephone, facsimile, email, federal tax identification number (TIN), Washington State Uniform Business Identifier (UBI), and expected work to be performed of each subcontract:

Subcontractor 1

Name: _____
 Services: _____
 Address: _____
 Telephone: _____
 Email: _____
 Fed ID: _____
 UBI: _____
 OMWBE certified: Yes No
 DVA certified: Yes No
 WA Small Business: Yes No

Subcontractor 2

Name: _____
 Services: _____
 Address: _____
 Telephone: _____
 Email: _____
 Fed ID: _____
 UBI: _____
 OMWBE certified: Yes No
 DVA certified: Yes No
 WA Small Business: Yes No

Subcontractor 3

Name: _____
 Services: _____
 Address: _____
 Telephone: _____
 Email: _____
 Fed ID: _____
 UBI: _____
 OMWBE certified: Yes No
 DVA certified: Yes No
 WA Small Business: Yes No

Subcontractor 4

Name: _____
 Services: _____
 Address: _____
 Telephone: _____
 Email: _____
 Fed ID: _____
 UBI: _____
 OMWBE certified: Yes No
 DVA certified: Yes No
 WA Small Business: Yes No

Diverse Business Inclusion Plan

In accordance with legislative findings and policies set forth in RCW 39.19, the state of Washington encourages participation in all contracts by firms certified by the office of Minority and Women's Business Enterprises (OMWBE), set forth in RCW 43.60A.200 for firms certified by the Washington State Department of Veterans Affairs, and set forth in RCW 39.26.005 for firms that are Washington Small Businesses. Participation may be either on a direct basis or on a subcontractor basis. However, no preference on the basis of participation is included in the evaluation of Diverse Business Inclusion Plans submitted, and no minimum level of minority- and women-owned business enterprise (MWBE), Washington Small Business, or Washington State certified Veteran Business participation is required as a condition for receiving an award. Any affirmative action requirements set forth in any federal Governmental Rules included or referenced in the contract documents will apply.

Do you anticipate utilizing or is this firm a State Certified: [Check all that apply]

- Minority-Owned Business?
- Women-Owned Business?
- Minority and Women-Owned Business?
- Veteran- Owned Business?
- Small Business?

Do you anticipate utilizing or is this firm a Self-Identified: [Check all that apply]

- Minority-Owned Business?
- Women-Owned Business?
- Minority and Women-Owned Business?
- Veteran- Owned Business?
- Small Business?

If your firm is anticipating utilizing subcontractors, please list the percentage of subcontracted work to be completed by each group:

- Minority-Owned _____%
- Women-Owned _____%
- Veteran-Owned _____%
- Small Business _____%

Please provide contact information for the individual whom manages the firms Diversity Inclusion Plan.

Name: _____
Title: _____
Phone: _____
Email: _____

NON-COST PROPOSAL

In this section, you are expected to propose how and why you are the most qualified to perform these services. You will also propose your plans, approach and methodology as to how you intend to perform these services.

Please keep responses clear and concise. Your response to each question is limited to one (1) page.

Proposal Questions:

Please answer the questions listed below attaching additional pages as necessary: (180 overall max score)

A. TPA Experience and Expertise

1. Please list purchasers, employers and providers that your organization has worked with and how long your organization has worked with each. (10 points)
2. Please describe how your organization has been engaged directly with an employer or provider (facility or medical group) to administer a COE benefit for a bundled payment program for total knee and hip replacement. (10 points)
 - a. Did the bundled payment program include a warranty period? If so, please describe. (2 points)
 - b. Please describe the payment process (i.e. prospective or retrospective payment structure, etc.) (3 points)
 - c. Please describe if providers have been able to aggregate all claims from all providers participating in the program into a single claim file and invoice for payment. (4 points)
 - d. Please describe if there was a risk-sharing/gain-sharing arrangement, and the general structure of the arrangement. (1 point)
3. Please describe your organization's provider credentialing process. What credentialing standards does your organization use? How often are providers credentialed? (5 points)
4. Based on the information provided, why would your organization be a good fit for HCA for the services requested? (5 points)

B. Implementation and Operationalization

1. Please describe how your organization coordinates with providers to implement and operationalize a bundled payment program. (10 points)
2. Please describe your organization's process for provider referrals, including authorization and documentation. (10 points)
3. Please describe how your organization assists providers with reporting and invoicing for prospective bundled payments. (10 points)
4. Please describe the typical process your organization uses to assist members in using the bundled payment benefit. Please include a flow diagram and include the average length of time from initial patient referral to acceptance, and the average length of time from acceptance into the program to the date of the procedure. (15 points)

C. Member Support

1. Please describe how your organization works with an employer client regarding member communications about the bundled program and program benefits. (10 points)
2. Please describe the support your organization provides to members throughout the process for preadmission services and pre-and post-procedure programs. (20 points)
3. Please describe how your organization works with patients who may or may not qualify for the bundle, including communications, triage, etc. (10 points)
4. Please describe if (currently or prior to January 1, 2017) your organization can, or will be able to, make information regarding COE(s) available online, including provider names, cost of services, quality information, and benefit coverage. (20 points)
5. Please describe how your organization assists members who are required to travel for their surgery. (5 points)

D. Data and Reporting

1. Please describe if your organization is capable of generating the necessary reports for internal use and to share with providers, including case summaries, case completion rates, and warranty claims. A list of evaluation measures and provider performance measures are in Exhibit 1 of this Appendix A, Submittal Document. (20 points)
 - a. Please include a list of any other reports that your organization creates for clients. (5 points)
2. Please provide any recommendations of additional program or provider quality metrics other than those listed in Exhibit 1 that your organization may have, keeping in mind these are core metrics. (5 points)

COST PROPOSAL

The evaluation process is designed to award this procurement not necessarily to the Proposer of least cost, but rather to the Proposer whose Proposal provides the overall best value to the Health Care Authority. However, Proposers are encouraged to submit proposals which are consistent with State government efforts to conserve state and federal resources.

Instructions to Proposer: Proposer shall complete Table 1 below by entering their pricing information as specified in each table. Proposer has the option to complete Table 2 below for other cost considerations or explanation of costs in Table 1.

Expenses related to day-to-day performance under the contract, including but not limited to, travel, lodging, meals, materials, and incidentals will not be reimbursed to the Proposer. Proposer’s response to the Cost Proposal must include these costs.

DO NOT ADD ANY FURTHER SECTIONS TO THIS TABLE.

A Compensation table will be negotiated as part of the contract that will incorporate the prices listed here but breaking down the prices into deliverables with associated schedules.

Table 1: Deliverable Pricing (120 max points)

If on average there are six hundred (600) Total Joint Replacement (TJR) procedures and one-hundred and forty-four (144,000) eligible Members per year, please provide the annual fee for each service below.

Service	Total Fee
1. Member Care Concierge	\$____ total
2. Engagement Plan	\$____ total
3. Managing the COE(s)	\$____ total
4. Billing/Payment	\$____ total
5. Quality and Performance Reporting	\$____ total
TOTAL Annual Fee to HCA: For TPA Services as stated in Section 1.3, Statement of Work of this RFP <i>(Sum of Total Cost of Items 1-5 above)</i>	\$____ total

Table 2: Other Considerations (optional)

Proposer is instructed to provide other cost considerations or explanation of costs above for Year 1.

Other Cost Considerations or Explanation

EXHIBIT 1

Standards	Total Knees			Total Hips		
	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage
1. Standards for Appropriateness						
a. Number of TKR/THR patients receiving formal shared decision-making decision aids pre-operatively	Number of TKR patients receiving formal shared decision-making decision aids pre-operatively	Total number of TKR patients.		Number of THR patients receiving formal shared decision-making decision aids pre-operatively	Total number of THR patients.	
b. Number of TKR/THR patients with documented patient-reported measures of quality of life and musculoskeletal function prior to surgery (Knee Osteoarthritis Outcome Score (KOOS), Hip Osteoarthritis Outcome Score (HOOS), or PROMIS-10 Global Health tools may be used.	Number of TKR patients with documented patient-reported measures of quality of life and musculoskeletal function prior to surgery, Knee Osteoarthritis Outcome Score (KOOS), or PROMIS-10 Global Health tools may be used.	Total number of TKR patients.		Number of THR patients with documented patient-reported measures of quality of life and musculoskeletal function prior to surgery, Hip Osteoarthritis Outcome Score (HOOS), or PROMIS-10 Global Health tools may be used.	Total number of THR patients.	
c. Results of measures from 1b, specifically including responses Quality of Life (Q2 and Q4) and Pain (P1, and P4-5) scores for KOOS and HOOS and questions						

<p>regarding everyday physical activities (Question 7) and pain (Question 10) on the PROMIS-10 survey. Please list the average scores in the percent column.</p>						
<p>2. Standards for Evidence –Based Surgery</p>						
<p>a. Number of TKR/THR patients receiving measures to manage pain while speeding recovery in a multimodal format in the peri-operative period.</p>	<p>Number of TKR patients receiving measures to manage pain while speeding recovery in a multimodal format in the peri-operative period.</p>	<p>Total number of TKR patients.</p>		<p>Number of THR patients receiving measures to manage pain while speeding recovery in a multimodal format in the peri-operative period.</p>	<p>Total number of THR patients.</p>	
<p>b. Number of TKR/THR patients receiving measures to reduce risk of venous thromboembolism and pulmonary embolism in the peri-operative period.</p>	<p>Number of TKR patients receiving measures to reduce risk of venous thromboembolism and pulmonary embolism in the peri-operative period.</p>	<p>Total number of TKR patients.</p>		<p>Number of THR patients receiving measures to reduce risk of venous thromboembolism and pulmonary embolism in the peri-operative period.</p>	<p>Total number of THR patients.</p>	
<p>c. Number of TKR/THR patients receiving measures to reduce blood loss such as administration of tranexamic acid in the peri-operative period.</p>	<p>Number of TKR patients receiving measures to reduce blood loss such as administration of tranexamic acid in the peri-operative period.</p>	<p>Total number of TKR patients.</p>		<p>Number of THR patients receiving measures to reduce blood loss such as administration of tranexamic acid in the peri-operative period.</p>	<p>Total number of THR patients.</p>	

d.	Number of TKR/THR patients receiving measures to reduce infection such as administration of prophylactic antibiotics in the peri-operative period.	Number of TKR patients receiving measures to reduce infection such as administration of prophylactic antibiotics in the peri-operative period.	Total number of TKR patients.		Number of THR patients receiving measures to reduce infection such as administration of prophylactic antibiotics in the peri-operative period.	Total number of THR patients.	
e.	Number of TKR/THR patients receiving measures to maintain optimal blood sugar control in the peri-operative period.	Number of TKR patients receiving measures to maintain optimal blood sugar control in the peri-operative period.	Total number of TKR patients.		Number of THR patients receiving measures to maintain optimal blood sugar control in the peri-operative period.	Total number of THR patients.	
3. Standards for Ensuring Rapid Return to Function							
a.	Number of TKR/THR patients with documented physical therapy within 24 hours of surgery.	Number of TKR patients with documented physical therapy within 24 hours of surgery.	Total number of TKR patients.		Number of THR patients with documented physical therapy within 24 hours of surgery.	Total number of TKR patients.	
b.	Number of TKR/THR patients with documented patient-reported measures of quality of life and musculoskeletal function six months following surgery (same as used as in standard 1b).	Number of TKR patients with documented patient-reported measures of quality of life and musculoskeletal function six months following surgery (same as used as in standard 1b).	Total number of TKR patients.		Number of THR patients with documented patient-reported measures of quality of life and musculoskeletal function six months following surgery (same as used as in standard 1b).	Total number of THR patients.	
c.	Results of measures from 3b, specifically including						

responses to the questions identified in standard 1c (Quality of Life (Q2 and Q4) and Pain (P1, and P4-5) scores for KOOS and HOOS and questions regarding everyday physical activities (Question 7) and pain (Question 10) on the PROMIS-10 survey). Please list the average scores in the percent column.						
4. Standards for the Patient Care Experience						
a. Number of TKR/THR patients surveyed using HCAHPS.	Number of TKR patients surveyed using HCAHPS.	Total number of TKR patients.		Number of THR patients surveyed using HCAHPS.	Total number of THR patients.	
b. Results of measures from 4a, specifically responses to Q6 and Q22 if HCAHPS is used						
5. Standards for Patient Safety and Affordability						
a. Number of TKR/THR patients readmitted to the hospital within 30 days of discharge, all causes.	Number of TKR patients readmitted to the hospital within 30 days of discharge, all causes.	Total number of TKR patients.		Number of THR patients readmitted to the hospital within 30 days of discharge, all causes.	Total number of THR patients.	
b. Number of TKR/THR patients readmitted to the hospital within 30 days of discharge for any of the nine complications included under the terms of the warranty.	Number of TKR patients readmitted to the hospital within 30 days of discharge for any of the nine complications included under the terms of the warranty.	Total number of TKR patients.		Number of THR patients readmitted to the hospital within 30 days of discharge for any of the nine complications included under the terms of the warranty.	Total number of THR patients.	

