Exhibit E: Evaluation Questions

Terminology

"S" means "Scored." The question is scored as described in RFP Section 4, Evaluation of the RFP.

1. PROJECT APPROACH AND METHODOLOGY (SCORED)

1.1. PROJECT APPROACH (SCORED) [Max 13 points] (Page Limit: 5)

Include an overview of the Bidder's proposed approach and methodology for the project, both for implementation activities and for the day-to-day administration of the program. This section should convey Bidder's understanding of the Managed Care Dental Program, as described in sections 1.2, Background and 1.3, Objectives and Scope of Work of this RFP, as well as Attachment 1, Sample PAHP Apple Health Dental Services Contract.

2. PROJECT SCHEDULE (SCORED) [Max 40 points] (Page Limit: 3)

Include a project implementation schedule indicating when the project requirements, including building network capacity and tasks, will be completed. The project schedule must ensure that any deliverables requested by HCA are met. The Bidder must identify its capacity and flexibility to implement this program under the terms of the Contract with any other on-going contractual commitments. Provide a timeframe detailing services and the named staff dedicated by Bidder, including position, to ramp up and implement the Managed Care Dental Program for the following segments: first year; by month; by quarter; bi-annual; and annual basis.

3. RISKS (SCORED) [Max 25 points] (Page Limit: 2)

Bidder must identify potential risks considered significant to the success of the project. Include how the Bidder proposes to effectively monitor, manage, and mitigate these risks, including informing the HCA Contract Manager about risks, potential risks, and the plan to manage and mitigate those risks, ongoing during project implementation. Also to include communication with HCA Contract Manager about the success of those mitigation strategies. Include descriptions of how Bidder limits exposure and associated processes to minimize downtime and financial risk to Bidder, Bidder's clients, and the State of Washington when dealing with a data breach or IT system outage.

4. MANAGEMENT (SCORED)

4.1. Project Team Structure / Internal Controls (SCORED) [Max 25 points] (Page Limit: 3)

Provide a description of the proposed project team structure including the use of any subcontractors, and internal controls to be implemented during the course of the project. Provide an organizational chart of Bidder's organization indicating lines of authority for personnel involved in performance of this potential contract and relationships of this staff to other programs or

functions of the organization. Include where personnel, any subcontractors, and offices for all assigned staff are located.

If there will be staff changes between implementation phase and day-to-day administration, please include proposed project team(s) and related charts for both. These chart(s) must also show lines of authority to the next senior level of management. Include who within the organization will have prime responsibility and final authority for the work.

4.2. Staff Qualifications / Experience (SCORED) [Max 25 points] (Page Limit: 4)

Identify staff, including subcontractors, who will be assigned to the potential contract, for both the implementation phase and day-to-day administration (if there will be a difference), indicating the responsibilities and qualifications of such personnel, and include the amount of time each will be assigned to the project. Provide resumes for the named staff and subcontractors, which include information on the individuals' particular skills related to this project, education, experience, significant accomplishments, and any other pertinent information. The Bidder must commit the staff identified in its Proposal will actually perform the assigned work. Any staff substitution must have the prior written approval of HCA.

5. WORK PLAN (SCORED) [Max 512 points]

5.1. WORK PLAN (SCORED)

Develop a work plan that includes all project requirements and the proposed tasks, services, activities, etc., necessary to develop and implement the Managed Care Dental Program defined in this RFP and the attached Sample PAHP Apple Health Dental Services Contract, Attachment 1. This section of the Proposal must contain sufficient detail to convey to members of the HCA evaluation team that Bidder has the knowledge of the subjects and skills necessary to successfully implement and manage the Managed Care Dental Program. Include any involvement required of HCA staff to ensure program success.

Include in the Work Plan a description of the Bidder's current systems to meet the requirements of the following sections, or how Bidder will implement these systems by January 1, 2019, and how they comply or will comply with the Sample PAHP Apple Health Dental Services Contract and applicable laws, rules, and regulatory requirements:

5.2. Dental Benefit Plan. (Page Limit: 20)

5.2.1. [S, Max 16 points] Based on the minimum Benefit Package described in Attachment 2, of this RFP describe Bidder's approach to implementing this package.

5.2.1.1. What changes would Bidder propose to our minimum benefit package to offer an enhanced set of covered services?

5.2.1.2. Will the Bidder provide services in addition to those described in Attachment 2, Benefit Package? If so, what services?

5.2.2. [S, Max 8 points] ABCD Program:

5.2.2.1. How will Bidder collaborate with WDSF/Arcora to provide the ABCD Program? Include how Bidder will track and ensure compliance with the training and certification requirements of the ABCD Program.

5.2.2.2. How will Bidder ensure ABCD-certified providers remain in the Managed Care Dental Program?

Please only respond to question 5.2.3 if Bidder's Proposal includes a regional area that contains one or more of the three pilot counties (Cowlitz, Spokane, and Thurston) for the Oral Health Connections Pilot Project, described in Attachment 8. If Bidder's Proposal does not include a regional area that contains any of these three counties, please note this question as "N/A."

5.2.3. [S, Max 8 points] Oral Health Connections Pilot Project:

5.2.3.1. How will Bidder collaborate with WDSF/Arcora to ensure the success of the Oral Health Connections Pilot Project? Include how Bidder will track and ensure compliance with the training and certification requirements of the Oral Health Connections Pilot Project.

5.2.3.2. How will Bidder conduct outreach and engagement that ensures provider participation in the program and ensure adequate access to meet demand and accomplish project goals?

5.2.3.3. How will Bidder ensure the bi-directional relationship between medical and dental providers?

5.2.3.4. How will Bidder ensure providers are retained in the Managed Care Dental Program?

5.3. Third Party Liability (Page Limit: 4)

5.3.1. [S, Max 4 points] How does Bidder coordinate benefits with third-party insurers and manage Third Party Liability in provider billing? Please describe the process, including how Bidder identifies other coverage, verifies and maintains coverage, coordinates with third party insurers' prior authorization processes, and tracks/reports cost avoidance and recoveries.

5.3.1.1. Describe the Bidder's plan to update procedures and systems for coordination of benefits with other insurers to ensure state and federal programs, including the Indian Health Service, are the payer of last resort. Include: (1) details related to identification of other dental coverage, system

edits, and reports; (2) experience with post payment recoveries for third-party liability; and (3) how bidder will address third-party liability in specifically for managed care dental services.

5.3.2. [S, Max 4 points] Explain how, once notified of a good cause exemption, as defined below, Bidder would identify this within Bidder's systems and what mechanisms will be put in place to ensure cost avoidance and recovery functions are not communicated or pursued.

"Good cause" exemption means pursuit of third-party coverage would violate an Enrollee's right to confidentiality because the third-party:

1) Routinely sends verification of services to the third-party subscriber and that subscriber is someone other than the Enrollee;

2) Requires the Enrollee to use a primary care provider who is likely to report the Enrollee's request for family planning services to the subscriber;

3) The Enrollee has a reasonable belief that cooperating with the contractor in identifying TPL coverage would result in serious physical or emotional harm to the Enrollee, a child in their care, a child related to them, or;

4) The Enrollee is incapacitated without the ability to cooperate with the contractor.

5.4. Grievances and Appeals (Page Limit: 7)

5.4.1. [S, Max 8 points] Grievances. Describe Bidder's Grievances processes. Address processes for Client and provider Grievances, if they are different. Description should cover the process from initiation through resolution, include the levels of review, and how Grievances are incorporated into the overall quality management program.

5.4.1.1. Describe how most commonly occurring Grievances are identified and what specific actions are taken to address them.

5.4.2. [S, Max 8 points] Appeals. Describe Bidder's Appeals processes. Address the processes for Client and provider appeals, if they are different. Process description should cover: how appeals are received; how decisions are made; completion timelines; notification(s) to enrollees; continuation of services; and appeals.

5.4.2.1. Describe Bidder's process for the tracking, trending, and reporting of Appeals to monitor plan design and performance, and how Appeals are incorporated into the overall quality management program.

5.4.2.2. Describe Bidder's Prior Authorization Appeals processes, for when authorizations are denied, and the timeframes for handling requests with expedited timelines.

5.4.2.3. Describe Bidder's program department responsible for processing appeals, and its location (local or national). If appeals will not be handled locally, describe how processes will be coordinated to ensure compliance with HCA requirements, as outlined in the attached Sample PAHP Apple Health Dental Services Contract, Attachment 1.

5.4.3. [S, Max 6 points] Describe how Grievance and Appeal information is used. Explain how such data informs the Bidder's processes, such as staff training, Utilization Management decision making, and Enrollee experience. Provide two examples. Describe how data is used to improve performance of network-provider feedback and training.

5.4.4. [S, Max 6 points] Describe Bidder's methods of communicating Enrollee rights and responsibilities information to Enrollees and providers.

5.4.5. [S, Max 8 points] Describe the roles, responsibilities, titles, credentials (including types of licenses and certifications held by clinicians), and processes associate with medical necessity appeals.

5.5. Claims Adjudication and Payment (Page Limit: 10)

5.5.1. [S, Max 8 points] Describe Bidder's claims review and payment system, including the following information:

5.5.1.1. Are claims processed through a clearing-house, third-party administrator, subcontractor, or directly by Bidder? Describe that process fully including timeliness expectations.

5.5.1.2. How are claims processed? Include if they can be processed electronically, through a HIPAA-compliant system.

5.5.1.3. How does Bidder's system use a rules engine or other validation methodology to apply edits while processing claims? Is the claims adjudication process automated?

5.5.1.4. How does Bidder's system process retroactive claims adjustments?

5.5.1.5. How does Bidder's system interface Prior Authorization determinations with processing claims?

5.5.1.6. Describe how encounters are stored, validated, and audited prior to being submitted to HCA; describe how the encounter data will be submitted to HCA, including those reimbursed under a sub-capitation agreement.

5.5.2. [S, Max 16 points] How flexible is Bidder's claims processing system, and how quickly can changes be made?

5.5.2.1. Describe how Bidder's system would support correct claims payment applying rate differentials, benefit differentials, or service differentials which can be associated with a variety of factors (e.g. diagnosis, procedure code, population).

5.5.2.2. Describe how Bidder's system uses specific coding, including taxonomy, to isolate services identified in the Dental Benefits Package, Attachment 2.

5.5.3. [S, Max 6 points] Describe how Bidder will ensure claim data requirements include ICD-10 diagnosis code(s) and CDT code(s) representing level of risk (e.g. D0601, D0602, and D0603) for clients.

5.6. Quality Improvement and Oversight (Page Limit: 6)

5.6.1. [S, Max 8 points] Describe Bidder's quality assurance program and plan for ongoing quality improvement, including process flow and how the results are utilized. Include its policies and procedures, governance, scope, measurable goals and objectives, staffing structure, and staff responsibilities.

5.6.1.1. Describe Bidder's quality management efforts related to non-clinical administrative services, such as claims administration, provider contracting/credentialing, provider education, coordination of benefits, and customer service. What are the key performance indicators for those non-clinical administrative services? Describe how any suppliers or Subcontractors are involved in the quality management program for non-clinical services.

5.6.1.2. Describe the Bidder's quality management efforts related to Clinical Management Services, such as Utilization Management, Care Management, Care Coordination, and Quality of Care Improvement Initiatives. What are the key performance indicators for those Clinical Management Services? Describe how providers and other interested parties, including Enrollees, are involved in the quality management program for Clinical Management Services.

5.6.2. [S, Max 8 points] Describe Bidder's role and responsibilities in ensuring providers are current on new dental procedures, program guidelines, and best practices.

5.6.3. [S, Max 8 points] Describe all recent Performance Improvement Projects (PIPs) from the last 12 months. What were the impetuses for these projects? What were the findings? How were they implemented? How will success be measured?

5.6.4. [S, Max 8 points] Please provide sample Enrollee materials Bidder has used in other Quality and Performance Improvement projects associated with delivery of services to Medicaid clients. If Bidder does not have current experience with the Medicaid population, how will Bidder tailor materials for the Medicaid population?

5.7. Clinical Management Innovation and Improvements (Page Limit: 5)

HCA is interested in an ASB that uses a systematic approach for identifying and implementing innovations in the delivery, management, and payment of dental health care services. HCA seeks an ASB who is committed to progressively identifying and implementing innovations, especially as they impact Clinical Management, in order to leverage technology, human resources, emerging financial reimbursement strategies, and evolving evidence-based care delivery models.

5.7.1. [S, Max 10 points] Describe Bidder's philosophy and guiding principles for dental health innovation, including promoting the use of evidence-based processes informed by peer-reviewed published literature, or other evidence sources.

5.7.2. [S, Max 10 points] Describe Bidder's experience with identifying and implementing dental innovations related to Clinical Management programs, including in Washington State. Include successes and lessons learned from previous innovation projects.

5.7.3. [S, Max 10 points] Describe any structures Bidder has in place, including staff and other resources, dedicated to dental health innovation.

5.7.4. [S, Max 10 points] Describe how Bidder involves providers, plan sponsors, patients, and other stakeholders in the development of dental health innovation initiatives.

5.8. Program Integrity (Page Limit: 10)

Program Integrity consists of initiatives to conduct activities that prevent, detect, and recover expenditures associated with fraud, waste, and abuse, and overpayments. Program Integrity also provides routine program oversight to ensure compliance with contracts, and state and federal regulations. The activities are meant to ensure that taxpayer dollars are spent appropriately on delivering accessible, high-quality, and necessary care.

5.8.1. [S, Max 8 points] What types of Program Integrity activities does Bidder perform to prevent, detect, and recover expenditures associated with Fraud, Waste, and Abuse?

5.8.1.1. Provide examples of Program Integrity activities, including risk or vulnerability assessments used to identify aberrant billing patterns or outliers.

5.8.1.2. Describe Bidder's payment system algorithms, audits, or edits that identify outliers or aberrant billing patterns.

5.8.1.2.1. Provide a sample of such with the associated effectiveness.

5.8.1.3. Provide copies of Bidder's policies to oversee contracted providers and entities, and identify improper payments.

5.8.1.4. Describe the number of Bidder staff, staff credentials, if any, and staff duties dedicated to Program Integrity and other associated activities.

5.8.1.5. What types of corrective action does Bidder employ when Fraud, Waste, and Abuse is identified?

5.8.2. [S, Max 8 points] What type of Program Integrity standards does Bidder adhere to?

5.8.2.1. Does Bidder have established written medical necessity and medical appropriateness criteria? Please describe.

5.8.2.2. Does Bidder have educational resources and training opportunities to inform providers about program guidelines and compliance requirements? Please describe.

5.8.3. [S, Max 8 points] Describe Bidder's dispute and appeal processes related to Program Integrity and Fraud, Waste, and Abuse.

5.8.4. [S, Max 8 points] Describe Bidder's erroneous payment identification and recovery services including:

5.8.4.1. How Bidder handles payments identified as improper.

5.8.4.2. Whether or not identified improper payments are reported and recovered and, if so, by what means and in what timeframe.

5.8.4.3. How Bidder collects other coverage information from members for Coordination of Benefits.

5.8.4.4. How Bidder will report to HCA: any improper payments or overpaid claims; and methods used to recover erroneous payments and the status of such efforts.

5.8.4.5. How Bidder will address submitted and accepted encounters for claims considered to be overpaid or paid improperly or erroneously.

5.9. Utilization Management (Page Limit: 4)

5.9.1. [S, Max 8 points] Describe the workflow, methodology, and performance measures for utilization, including identifying over- and under-utilization of dental services; program success (e.g. ensuring Enrollees receive preventative and restorative services); and

opportunities for improvement. Provide examples of quarterly reports and explain how the Bidder uses the information derived from the reports.

5.9.2. [S, Max 16 points] Describe how Bidder's Utilization Management program uses data to identify quality concerns that generate a referral to the Quality Assessment and Performance Improvement program for further investigation and action, ensure Program Integrity, and result in improvements to the dental program. Provide examples of quarterly reports and explain how the Bidder uses the information derived from the reports.

5.10. Prior Authorizations. (Page Limit: 10)

HCA requires the ASB(s) to meet the current timeliness requirements as defined in 42 C.F.R. § 438.210, and the Sample PAHP Apple Health Dental Services Contract, Section 11, Utilization Management Program and Authorization of Services, for authorization requests.

HCA also requires the ASB(s) to have a process for determining Medical Necessity that is comparable to the process described in WAC 182-501-0169. HCA has Enrollee notification letter requirements that must comply with WAC 182-501-0165, subsection 8. HCA uses National Electronic Attachment (NEA) to receive backup documentation for prior authorizations, and is interested in ASB(s) that use NEA, or similar electronic system(s) for backup documentation.

5.10.1. [S, Max 6 points] Describe Bidder's requirements and processes for referrals to oral health specialists, including prior authorization requirements, timeliness, and care management.

5.10.2. [S, Max 6 points] Describe Bidder's process for determining Medical Necessity, consistent with WAC 182-501-0169.

5.10.2.1. Describe Bidder's criteria, including source, for making prior authorization determinations.

5.10.2.2. Include required documentation to support a Prior Authorization request; and the submission and receipt processes for backup documentation.

5.10.3. [S, Max 6 points] Describe processes for receiving, processing, pending, rejecting, approving, and denying authorization requests.

5.10.3.1. Describe how Bidder ensures that the authorization process is not a barrier to receipt of services;

5.10.3.2. Describe how Bidder handles "expedited" authorization requests;

5.10.3.3. Describe how Bidder handles retro-authorizations related to retro-eligibility, urgent, and emergent office-based services that require Prior Authorization,

but timeliness requires Prior Authorization be retro (such as root canals, or crowns done on an emergency basis);

5.10.3.4. Describe Bidder's process for monitoring authorizations that are consistently approved, and the associated process(es) for removing them from Prior Authorization requirements and further monitoring.

5.10.4. [S, Max 6 points] If Bidder prior authorizes orthodontics, and the Enrollee changes providers, how will Bidder address this change consistent with your prior authorization process and in your reimbursement methodology?

5.10.4.1. How are orthodontics reimbursed?

5.10.4.2. What policies are in place for when treatment is not completed or discontinued?

5.10.4.3. How will Bidder treat continuity of care if an Enrollee switches plans in the middle of orthodontic treatment?

5.10.5. [S, Max 6 points] Describe how Bidder will comply with the intent of the Best Practices Guidelines (Pre-Authorization Administrative Simplification Best Practices Guidelines), (http://dev-www.onehealthport.com/best-practice-recommendations), into current processes.

5.11. Enrollee and Customer Services (Page Limit: 10)

HCA is interested in ASBs that have, or will, incorporate Culturally and Linguistically Appropriate Services (CLAS) and procedures into their internal operations, in compliance with Title IV and National CLAS standards for managed care programs. Please describe in your responses below, how CLAS is incorporated into call center and customer service daily functions and interaction with customers.

Call Center:

5.11.1. [S, Max 8 points] Describe Bidder's call center organization and processes, including hours of operation, and standard data collected, such as response time, first call resolution goals, etc.

5.11.2. [S, Max 8 points] Describe which processes, tools, and systems Bidder uses for monitoring call quality.

5.11.2.1. If call center functions are outsourced, how does Bidder monitor this contract to ensure compliance with contract requirements?

Enrollee and Customer Services:

5.11.3. [S, Max 8 points] Describe the Bidder's customer service center staffing. Include:

5.11.3.1. Size of support staff and duties, including other roles staff may perform in addition to customer service;

5.11.3.2. Current customer service staffing rationale and annual customer service staff turnover rate.

5.11.4. [S, Max 12 points] How does Bidder initiate contact with new Enrollees to ensure they have adequate information to enable them to participate successfully in the program? Include the purpose of the contact, how Bidder ensures Enrollees are connected with a dentist, know their benefits, and are able to get to their appointments.

5.11.5. [S, Max 8 points] Describe how Bidder notifies Enrollees and potential enrollees of the availability of interpreter services and how to access them.

5.11.6. [S, Max 8 points] Describe accommodations for Clients who need to access customer service and who are blind, or hearing and/or speech impaired, in accordance with the ADA.

5.11.7. [S, Max 8 points] Describe the Bidder's Enrollee feedback process, including processing of complaints about customer service staff.

5.11.8. [S, Max 8 points] Describe the Bidder's customer service training program, Quality Control monitoring, and auditing processes. Describe the onboarding process for customer service representatives.

5.11.9. [S, Max 8 points] Explain performance measures staff, supervisors, managers, and directors are expected to adhere to and how they have been met over the last two years.

5.12. Working with Indian Health Care Providers (IHCPs) (Page Limit: 4)

5.12.1. [S, Max 10 points] Describe how Bidder will ensure compliance with the federal requirements set forth in the Indian Addendum (https://www.medicaid.gov/medicaid/indian-health-and-medicaid/downloads/addendum-ihcps.pdf) in each of the following operational areas: 1) provider contracting; 2) credentialing; 3) referrals; 4) coordination of care; 5) prior authorization; 6) utilization management; 7) quality assurance; 8) claims adjudication; 9) payment; and 10) dispute resolution.

5.12.2. [S, Max 10 points] Describe how Bidder will engage with every tribe, IHS facility, and UIHP that offers dental services in Washington and in out-of-state bordering cities (as defined in WAC 182-501-0175), including tribes with Contract Health Service Delivery Areas in those cities, to offer subcontracting arrangements. Be sure to include how Bidder will maintain relationships with contracted and non-contracted IHCPs, and

obtain training on the Indian health care delivery system, particularly as it relates to dental care.

5.13. Working with Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs) (Page Limit: 4)

5.13.1. [S, Max 8 points] Describe how Bidder will communicate with FQHCs/RHCs that provide dental care to ensure appropriate rosters of assigned Enrollees are submitted to HCA.

5.13.2. [S, Max 8 points] Describe Bidder's experience with FQHC/RHC enrollment list (roster) submission and enhancement payments.

5.13.3. [S, Max 8 points] Describe Bidder's ability to accommodate changes in HCA's expectations with enrollment list (roster) submissions, and enhancement payments (i.e. paying claims with enhancement dollars to full encounter rate instead of passing enhancement dollars to providers).

5.14. Systems and Data Management (Page Limit: 12)

5.14.1. [S, Max 8 points] Describe how Bidder's system processes inbound and outbound HIPAA transactions, specifically 270 eligibility inquiries, 271 eligibility responses, 834 enrollment files, 820 payment files, 837D dental healthcare claim files, and 835 payment advice files.

5.14.2. [S, Max 8 points] Describe how Bidder will modify their information system to process dental service encounters via the HIPAA-compliant 837 transactions for encounter data reporting. Be sure to include:

5.14.2.1. Bidder's process for systematically applying claims data validations to ensure accurate claims submission, payment, and denials.

5.14.2.2. Bidder's ability to accurately process claims and submit the required data elements using 837D dental healthcare claim files within established timeframes for file submissions. Include any constraints.

5.14.2.3. Bidder's strategy for providing claims support to new providers who may be new to the Managed Care model.

5.14.3. [S, Max 8 points] Describe Bidder's reporting system and processes in place, including the approach to developing, testing, modifying, and finalizing reports.

5.14.4. [S, Max 8 points] Describe Bidder's ability to provide both standard and ad hoc customized reports to HCA on plan quality, cost and utilization performance, Enrollee reported outcomes, provider performance, and population health measures.

5.14.5. [S, Max 8 points] Describe the technology and core systems in place to accept, store, process, and validate data from various sources.

5.14.5.1. Describe Bidder's capacity and expertise in coordinating and integrating data sets across those sources (e.g., clinical, such as utilization or case management systems, and claims data).

5.14.6. [S, Max 10 points] Describe the process to implement changes to the Bidder's system. Include the average number of days to implement these changes. Please talk specifically about changes relating to:

5.14.6.1. benefit package and payment; and

5.14.6.2. implementation of a completely new benefit, which requires new policies for authorizing, paying claims, and encounter data reporting.

5.14.7. [S, Max 10 points] HCA is interested in Bidders using OneHealthPort to enroll providers. Bidders must have processes in place consistent with 42 C.F.R. § 455.436 for enrolling eligible providers, including screening the federal Office of the Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE), ownership and control checks, license validation, etc.

Bidders must have a process to ensure network providers are enrolled with HCA (42 C.F.R.§ 455.410). Bidders should be aware that HCA's current provider enrollment process may take approximately 30 days to complete. HCA processing times are subject to change.

5.14.7.1. Describe Bidder's enrollment process, including average enrollment time, any database support, how Bidder ensures that providers who apply are retroactively reimbursed for services provided during the delay, and how Bidder will incorporate confirmation of HCA enrollment.

5.14.7.2. Describe the criteria by which Bidder would exclude providers from being enrolled/credentialed with Bidder.

5.14.8. [S, Max 12 points] Federal regulations require members of the dental provider network be enrolled in HCA's ProviderOne system as either a billing or non-billing provider. What processes does Bidder have in place to ensure providers are enrolled with HCA as required as a billing or non-billing provider?

5.14.9. [S, Max 8 points] Propose how Bidder will ensure updated dental health information is available on Bidder's secure website to be utilized by enrollees, family members, providers, stakeholders, and state agencies. Include the following:

5.14.9.1. A searchable provider directory;

5.14.9.2. Educational materials and advocacy information and promotional holistic health and wellness information, taking into account culturally appropriate communication and resources; and

5.14.9.3. Contact information for Managed Care Entity.

5.14.10. [S, Max 8 points] Describe any mobile application(s) Bidder offers Enrollees, including secure instant messaging and chat functions.

5.15. Security (Page Limit: 20)

5.15.1. [S, Max 20 points] Describe how Bidder will meet the Security Requirements of OCIO Security Standard 141.10, Attachment 4, and pass the Security Design Review, Checklist Attachment 6. Attachment 5, Information Services Board (ISB) Identity Management User Authentication Standards is also attached for reference.

Describe how Bidder will meet the requirements in:

5.15.1.1. OCIO 141.10 Section 4.

5.15.1.2. OCIO 141.10 Section 5.

5.15.1.3. OCIO 141.10 Section 6.

5.15.1.4. OCIO 141.10 Section 7.

5.15.1.5. OCIO 141.10 Section 8.

5.15.1.6. OCIO 141.10 Section 10.

5.15.1.7. OCIO 141.10 Section 11.

5.16. HIPAA Compliance (Page Limit: 3)

5.16.1. [S, Max 10 points] Describe Bidder's policies and procedures for ensuring compliance with HIPAA Security, Privacy, and Breach Notification Rules.

5.16.2. [S, Max 10 points] Provide a detailed list and summary of any privacy breaches your organization has had in the last five (5) years, that affected more than 500 people. Describe any mitigation activities completed or ongoing, and any resulting technical assistance or corrective action, including penalties from the U.S. Department of Health and Human Services (DHHS), Office for Civil Rights (OCR).*This question will not count towards this section's page limit.*

6. Bonus Questions (OPTIONAL)

6.1. Experience with Providing Medicaid Managed Care Dental Services in Other States (Page Limit: 3)

Provide at least one example, of three or more years' experience, demonstrating Bidder providing Medicaid Managed Care Dental services in another state(s). Include: a summary of the project implementation, administration, and lessons learned; and a contact name, telephone number, and email address for Bidder's client(s).

Bidders that are able to provide a responsive demonstration to Question 6.1 will be awarded up to 40 bonus points.

6.2. Experience with Utilizing Reimbursement Methodologies Other Than Fee-For-Service (FFS) (Page Limit: 3)

Describe all other reimbursement methodologies Bidder has experience using. Provide a brief summary, lessons learned, and an example(s) of where the reimbursement methodology was used.

HCA will provide up to 20 bonus points for responsive demonstration to Question 6.2.

6.3. Treatment Plan Documentation and Provider Expectations (Page Limit: 2)

Does Bidder have expectations around documentation of treatment plan completion? For example, do providers document completion of a list of procedures planned at comprehensive and periodic oral evaluations? If yes, please describe the requirements.

HCA will provide up to 20 bonus points for responsive demonstration to Question 6.3.