STATE OF WASHINGTON

WASHINGTON STATE HEALTH CARE AUTHORITY
REQUEST FOR PROPOSAL (RFP)
NO. K1807

AMENDMENT No. 3

1. Bidder Questions

SECTION 1 – GENERAL INFORMATION	
Q1	Item L, Other Contractors and Partners, in Section 1.2, Background, provides a list of contractors the ASB will be required to work with. Please confirm that the list provided is a complete list of all vendors and contractors that the ASB will be required to work with.
A1	The list is provided for illustrative purposes only as (a) it may change between the publication of the RFP, the start of implementation services, and the start of administrative services; (b) the ASB may not have to engage with all of the contractors listed; and (c) this list may also change throughout the life of the Contract as HCA changes vendors. In short, this list is not meant to be an all-inclusive list for the life of the Contract. If there are any known barriers or issues relating to a Bidder's cooperation with any of the current contractors listed, please note this in the Master Letter of Transmittal.
Q2	Regarding coverage of ancillary services in UMP Plus, the Provider Networks column of the UMP Plus table in Section 1.2 (p. 14) states the following: • "Networks are specific to UW and PSHVN providers except for ancillary services (currently UMP TPA network)." • "ACN Ancillary Providers in the UMP Plus Service Area are covered as network for both UMP Plus networks." When are ancillary services considered in-network, and when they are considered out-of-network?
A2	Please refer to the definition of "ACN Ancillary Provider" in Section 1.3. Any provider contracted to perform services for the UMP Plans that falls within a provider type listed as ancillary is an ancillary provider. The provider may also be a contracted provider with the ACN. Any service provided to a UMP Plus Member by an ACN Ancillary Provider for a UMP Plus covered benefit is an in-network ancillary service.

	This definition and types of providers may change with updates and amendments to the ACN contracts. As the definition changes, the TPA administration of the Ancillary Network will need to change and be updated as well. Below is the current list of ancillary provider types: **Ancillary Facilities** □ Birth Centers □ Chemical dependency facilities □ Dialysis □ Durable Medical Equipment suppliers □ Hearing aid dispensary □ Home Health providers □ Hospice □ Laboratories (lab testing) □ Mental health facilities □ Rehabilitation, Inpatient □ Skilled nursing facility □ Urgent care centers □ Emergency departments **Ancillary Professional Providers** □ Acupuncturists □ Anesthesiologists □ Audiologists □ Chemical dependency providers □ Chiropractors □ Christian science practitioners □ Massage therapists, licensed □ Maxillofacial surgeons □ Mental (behavioral) health providers (including M.D.s, such as psychiatrists) □ Midwives, licensed □ Naturopaths □ Occupational therapists □ Pathologists □ Physical therapists □ Registered dieticians □ Speech therapists
Q3	In Section 1.2, how is statewide being defined for UMP Plus? Is this by major metropolitan area or is the HCA truly seeking UMP Plus in every location for which Members reside in the State?
A3	The HCA wants to offer UMP Plus in every Washington State county where a Member resides. Members currently reside in all 39 Washington counties.
Q4	Outside of the potential K-12 enrollment, are there any other material changes to the membership for both non-Medicare and Medicare populations?
A4	To be clear, it is not certain that K-12 active employees will need to be included under the UMP Plans. Their eligibility will be, in part, established by the Washington State Legislature. Similarly, it is not known that there will be any material changes to either the non-Medicare or Medicare Member populations during the life of the Contract.
Q5	Can the HCA provide the number of Members who qualified for the $125 incentive last year? How many Members qualified for deductible credits and how many for HSA deposits?
A5	For activities during 2016, a total of 16,613 Members qualified and earned the incentive for 2017. Of those, 14,456 will receive the deductible credit, and 2,157 will have a deposit made in their HSA.

Q6	Please confirm that Bidders are not being asked to provide any Health & Wellness online website/portal access to Members, and that Limeade will administer the SmartHealth website, as well as all reasonable alternatives.
A6	The HCA Confirms that Bidders are not currently being asked to do this. Limeade administers the SmartHealth website or any reasonable alternative.
Q7	Regarding the definition of “Ancillary Provider” in Section 1.3, does the term include MDs, DOs, and specialists who are neither MDs nor DOs?
A7	It depends on the type of a provider, such as anesthesia or pathology. Please refer to A2, above.
Q8	Section 1.8 states that “the initial term of this Contract will expire December 31, 2029, and that, “thereafter, the Contract may be extended for increments of one (1) year or more for no more than seven (7) additional years.” Exhibit 3.17 states that “on an annual basis, the HCA conducts a Request for Renewal (RFR) process for both fully insured and self-insured Health Plans.” How will the extension process referenced in Section 1.8 differ from the RFR process described in Section 3.17?
A8	The purpose of RFRs is not to extend or re-negotiate the Contract, but for both parties to determine resources necessary to implement possible benefit changes, changes in administrative services, or changes in third-party business associates with whom the ASB will have to work. These changes may occur as a result of a mandate from either within or outside the HCA. As a result, certain changes may be made to the Contract in order to provide these revised benefits. Since the extension of the Contract term is not strictly associated with benefit changes, the HCA expects that this will be accomplished with a simple amendment changing the expiration date. Bidders should not expect that this extension process will be an opportunity to re-negotiate substantive terms of the Contract.
Q9	Under Section 5.F.3., the Master Letter of Transmittal requires that Bidders provide a copy of the AM Best report that does not bear a date not more than 90 days prior to the submittal date of the Proposal. Due to rules on use of the report and annual rating, can a Bidder’s most current AM Best Rating for 2016 be provided in the AM Best compliant press release form to comply with this item?
A9	Bidders should provide the most recent A.M. Best annual report.
Q10	Can the HCA please confirm if it wants Bidders to include both the submitted Letter of Intent and the Master Letter of Transmittal within the proposal binder, and where in the order of the items they should fall?
A10	There is no need to re-submit the Letter of Intent. The Master Letter of Transmittal should be placed at the beginning of the Bidder’s Proposal.

EXHIBIT 2 – CLINICAL MANAGEMENT	
Q11	How does HCA define complex case management (Exhibit 2.3) and chronic condition management (Exhibit 2.4)? It would be helpful to understand the distinction between the two since both sections contain several of the same or similar questions.
A11	The definition of "Case Management" is listed in Section 1.3 on page 19 of the RFP: "'**Case Management**' is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes." Complex Case Management refers to the provision of Case Management services aimed at coordinating care for an individual with a catastrophic, traumatic injury or illness. "Chronic condition management" involves the provision of services for chronic conditions that make them suitable for intervention (such as the disease remains with the patient for the rest of the patient's life); the costs for the chronic condition(s) is sufficiently high to warrant further resources and interventions; and the disease is often manageable through therapeutic interventions, patient self-management strategies, and lifestyle changes by the patient. "Chronic condition management" is sometimes called "disease management."
Q12	The "Overview" of Exhibit 2.4, Chronic Condition Management, states "The HCA requires the ASB to provide . . . [a] process for designing and implementing individualized treatment plans and distributing those plans within thirty (30) Days of initial contact with the Member." What is the HCA's definition of "individualized treatment plans" in this context? Is the HCA referring to the treatment plans provided by the provider or individualized treatment plans from the case managers?
A12	What the HCA is referring to by "individualized treatment plans" are plans from the ASB's case manager that are created based on patient needs and information from the treating provider in order to document the appropriate course of treatment. The plan may include type and intensity of services, benchmarks or milestones, goals of the treatment, and roles and responsibilities of individuals and entities involved in delivering care.
Q13	For Exhibit 2.2, will the HCA accept a Book-of-Business quality program description, work plan, and evaluation that includes the Washington market?
A13	Yes. The HCA prefers a Book-of-Business quality program description.
EXHIBIT 3 – ADMINISTRATION SERVICES	
Q14	Considering that retail pharmacy services are out of scope for this RFP, was it the HCA's intention to remove "Key Element E" in Exhibit 3.1, *Medical Benefit Drug Management Program*?
A14	The pharmacy benefits management for retail, mail order and specialty pharmacy administration is outside the scope of this RFP. There are however, many drugs that are covered under the medical benefit plans, such as infusion drugs administered in a facility or provider office setting. It is the HCA's expectation that the medical benefits provider coordinate with the provider of the retail pharmacy benefit with regard to managing the use of

	preferred and non-preferred drugs within the medical benefit. For example, Remicade is a non-preferred drug. The HCA would expect the medical benefit provider to require trial of the two preferred agents, Enbrel and Humira, prior to authorizing Remicade. As another example, the HCA would expect the medical benefit provider to ensure the most cost effective products are used when there are multiple products with the same ingredient (e.g., IVIG, Growth Hormone, etc.).
Q15	Regarding Exhibit 3.1, should the Bidder respond as if the Bidder is providing an integrated pharmacy solution, or as if the Bidder is working with the current UMP PBM?
A15	The Bidder should respond as if it is required to coordinate with the current UMP PBM. This RFP is not seeking an integrated pharmacy/medical plan administration and the current UMP PBM will continue to provide the retail pharmacy benefit. It is the expectation of the HCA that the ASB will coordinate with the current UMP PBM to provide a cost-effective medical drug benefit that is both consistent with the Washington preferred drug list and complements the retail pharmacy benefit.
Q16	In Exhibit 3.13.E., some of the content listed (e.g., personal health record) would require authentication as it would reference specific patient information. May Bidders provide links to the tools to authenticate and samples of the content sufficient to meet this Key Element?
A16	Yes.
Q17	With regard to the UMP Plus ACNs in Exhibit 3.6, does the HCA expect the ASB to build a customized network including reimbursement arrangements?
A17	The HCA is interpreting the terms “customized network” and “reimbursement arrangements” as used in this question to be asking if the HCA expects a specific ACN network with reimbursement arrangements specified just for that particular ACN. Accordingly, the HCA’s answer is no, it is not necessary for an ASB to develop a customized network with reimbursement arrangements tailored just for that network to fulfill the requirements presented in Exhibit 3.6, ACN Administration. Beginning in 2017, the HCA began paying a bundled amount for total joint replacements through a center of excellence. The bundled payment and center of excellence were not implemented within the Accountable Care Program. In the future, HCA may consider implementing bundled payments within the Accountable Care Program.
Q18	Will the HCA continue to directly contract with the ACN, or is it the HCA’s expectation the ASB will contract directly with the ACN?
A18	For the purposes of Exhibit 3.6, ACN Administration, the HCA will continue to directly contract with the ACNs. Please refer to Exhibit 1.2.2 of the RFP for requirements of an accountable care product to be offered by the ASB.

Q19	What is the expectation of the ASB with regard to implementation of the UMP Plus ACN plan and how we are to work with the providers in the ACN?
A19	The HCA contracts with the ACN for providers and the ASB implements the network of providers and the corresponding administrative activities as specified in Exhibit 3.6, ACN Administration.
Q20	Please clarify the expectations of the ASB regarding future state with ACNs and future contract improvements with an effective date of service January 1, 2020?
A20	Both of the current ACN contracts in the HCA's Accountable Care Program have a term that extends to December 31, 2019. Both ACN contracts could be extended with a January 1, 2020 effective date. At that time, each ACN may add or remove providers or HCA and the ACN may agree to add or remove a county or counties in the ACN's service area. This may also change during the course of the year through an amendment to the ACN contracts. HCA and an ACN may also agree to additional or modified data reporting. The Accountable Care Program contract is between the HCA and the ACN. However, the ASB would provide HCA with technical support in the contract negotiations and support the development and implementation of the Accountable Care Program changes administered by the ASB.
EXHIBIT 4 – PROVIDER NETWORK	
Q21	Is Milliman willing to sign a non-disclosure agreement from the Bidder for release of network data?
A21	Yes. Bidders should work directly with Milliman on this.
EXHIBIT 5 – CONTRACT COSTS AND TREND GUARANTEE	
Q22	(a)Based on the target for an annual average allowed trend of no more than 3.8% above "Medicare Lite," with a desired goal of less than 2% annually above Medicare, what tactics to control trend (e.g., programs, plan design, etc.) will be considered to support these goals and associated claim guarantees? (b)Will the HCA allow the cost of programs that increase administrative fees but lower the overall claim spend and thus necessary to achieve desired claim targets?
A22	(a)The HCA is open to considering Utilization Management and Care Management programs that may be implemented to control trend. The HCA will retain the decision authority over plan design, benefits and covered services. Network adequacy cannot be compromised. (b) No, any such increased administration fees are to be included in the proposed Administrative Fee PSPM.
Q23	Is the requested initial repricing based on what is in place today for the HCA? Please clarify if Bidders should use current network contracts to respond?
A23	Each Bidder must respond using its own current contract pricing, not past or anticipated future contract pricing.

Q24	Please confirm the data from Milliman will contain 24 months of claims and enrollment detail.
A24	Yes. These details will be uploaded and accessible by Bidders through the Milliman SFTP site in the same manner as the other claims information.
EXHIBIT 6 – TECHNICAL DATA REQUIREMENTS	
Q25	With regard to Service Organization Control (SOC) report sample requested in Exhibit 6.1, is it required the ASB have a SOC2 audit or is a SOC1 audit acceptable?
A25	A SOC 2, Type II report is not strictly required, but does contain much of the information needed to complete a full security design review. A SOC 1 Type II report does contain some security-related information as its focus is on financial controls. In the absence of a SOC 2 Type II report, HCA will need to gather required security information from other Bidder-provided source documents. The availability, quantity, and quality of those documents may affect the timing of the required security design review.
Q26	Under Exhibit 6.2, what data feeds are required from the ASB, if any, to support the OneHealthPort – Online member claim and eligibility portal for providers?
A26	No eligibility or claims data is being sent to OneHealthPort. The online claim and eligibility portals created by the ASB must be accessible by both network and non-network providers using OneHealthPort Single Sign-On authentication. The ASB will be responsible for coordinating with OneHealthPort to ensure access credentials work appropriately.

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<table>
<tr><td>Q27</td><td>In Exhibit 6.3, existing ID numbers were outlined for Bidders to reference. Please define the calculated check digit in the assigned member ID. How is this determined?</td></tr>
<tr><td>A27</td><td>The calculated check digit is determined as follows:

First, a sequential 7-digit number is assigned to a Member. The constant and check digit places in the final 9-digit Member number are added, with zero initially being used in place of the check digit. Starting from the right-most position, multiply each digit with either a 2 or 1. Multiply the right-most (last) digit by 2, the next to last by 1, and keep alternating the 2 and 1 until the sequence number is processed. As each digit is multiplied, add (accumulate) the result of each calculation. If the result of a calculation is greater than 9, the numbers in the two-digit result are added. Subtract the final accumulated total from 1,000 and use the “ones” digit as the check digit.

Example:

<table>
<tr><td>Sequence Number</td><td>8912345</td></tr>
<tr><td>Constant & Check No. Added</td><td><u>70</u>8912345</td></tr>
<tr><td>Calculation</td><td>Accumulation</td></tr>
<tr><td>5 x 2 = 1 + 0 = 1</td><td>1</td></tr>
<tr><td>4 x 1 = 4</td><td>1 + 4 = 5</td></tr>
<tr><td>3 x 2 = 6</td><td>5 + 6 = 11</td></tr>
<tr><td>2 x 1 = 2</td><td>11 + 2 = 13</td></tr>
<tr><td>1 x 2 = 2</td><td>13 + 2 = 15</td></tr>
<tr><td>9 x 1 = 9</td><td>15 + 9 = 24</td></tr>
<tr><td>8 x 2 = 1 + 6 = 7</td><td>24 + 7 = 31</td></tr>
<tr><td>0 x 1 = 0</td><td>31 + 0 = 31</td></tr>
<tr><td>7 x 2 = 1 + 4 = 5</td><td>31 + 5 = 36</td></tr>
<tr><td>Subtraction</td><td>1000 – 36 = 96<u>4</u></td></tr>
<tr><td>Final Check Digit</td><td><u>4</u></td></tr>
<tr><td>Final Member #</td><td>W7<u>4</u>8912345</td></tr>
</table>
</td></tr>
</table>

All other terms and conditions of the RFP remain in full force and effect. Capitalized terms not defined in this amendment have the meaning provided in the RFP.