STATE OF WASHINGTON

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

AMENDMENT No. 7

1. Bidder Questions

SECTION 1 – GENERAL INFORMATION	
Q1	In terms of preparing a Response, should "Key Elements" be included in each exhibit response twice: once on a separate page, and again within the response? Or should they be included on a separate page, then addressed within the response without being explicitly called out the second time? Overall, we are trying to understand if the element must precede every response independently, or is a narrative following all elements desired.
A1	The HCA would prefer that each "Key Element" be included in the Proposal only once, with the Bidder's response to each immediately following. For example: A. [Text from "Key Element" A]. [Bidder's response to "Key Element" A]. B. [Text from "Key Element" B]. [Bidder's response to "Key Element" B].
Q2	Section 1.5 of the RFP outlines specific instructions on the number of copies required by each Bidder; however, there is no address or contact name for receipt of the Proposal. Please provide the contact name and address for delivery of Bidder Proposals.
A2	Proposals should be delivered to the following: James W. Gayton 626 8th Avenue SE P.O. Box 42702 Olympia, WA 98504-2702

EXHIBIT 1 – HCA HEALTH TRANSFORMATION VISION	
Q3	Regarding Key Element E of Exhibit 1.1, "Past and current experience working with other public and private payers to accelerate health care transformation," what does the HCA mean by "public and private payers"?
A3	The HCA is referring to the Bidder's clients that purchase medical insurance for their employees that are either governmental ("public") or non-governmental ("private"). A response to this "Key Element" would describe and distinguish Bidder's experience supporting these two types of organizations in their individual efforts to transform health care delivery and payment.
Q4	In Exhibit 1.2.1, what specific coordination with Virginia Mason and Premera in connection with the COE Program will be required of the ASB?
A4	The HCA has contractual agreements with both Virginia Mason and Premera to provide a COE Program for Total Joint Replacement for UMP Classic and UMP CDHP Members. Contracts with additional COEs are anticipated. The ASB must have the ability to provide Premera with claims history files when requested; information regarding member eligibility and enrollment; and other coordinating activities, when necessary, pertaining to administration, data and billing.
Q5	In Exhibit 1.2.2., "Key Element" A.1 asks for enrollment information as of 7/1/2016, while the "Required Accompanying Documents" item A asks for "most current year-end enrollment." Please clarify from what time period the HCA is looking for enrollment information. If such period is the "most current year-end enrollment," does that mean 12/31/2016 or 7/1/2016?
A5	The HCA is looking for enrollment information as of July 1, 2016 as stated in Exhibit 1.2.2, Key Element, A.1. To further clarify, item A. is deleted from the "Required Accompanying Documents" section of Exhibit 1.2.2.
Q6	The "Evaluation and Scoring Insight" for Exhibit 1.4 is identical to Exhibit 1.3. What is "Evaluation and Scoring Insight" specific to section 1.4?
A6	Please review Amendment 5 to the RFP. That section of Exhibit 1.4. was deleted and replaced.
EXHIBIT 3 – ADMINISTRATIVE SERVICES	
Q7	In "Key Element" C of Exhibit 3.6, does "the data inventory" and "such reporting" refer to the "current reporting the Bidder does for other ACN purchasers" referenced immediately above in "Key Element" B, or is it in reference to "Overview" item E.4.vi, which in turn appears to reference Exhibit 3.10?
A7	The phrase "such reporting" refers to the reporting in "the data inventory" in the same Key Element C. Key Element B is directing a Bidder to provide any current reporting done for other ACN purchasers. Key Element C is directing a Bidder to describe how it will comply with the data inventory and the amount of time needed to build such reporting.

	This data inventory is also the document referred to as “UMP Plus Data and Reporting Inventory” in item E.4.vi. of the “Overview” section of Exhibit 3.6.
Q8	With regard to Exhibit 3.8.2, please confirm the HCA’s banking arrangement. Does the HCA use: a. Customer-maintained banking, where the HCA opens a bank account at its relationship bank and manages the daily support of that account; or b. Custodial banking, where the ASB opens a bank account under the HCA name and TIN at the ASB’s relationship bank and manages the daily support of that account?
A8	The HCA does not use either of the options listed. Instead, the ASB will set up its own bank account to pay Claims. The HCA will then reimburse the ASB after it has been properly invoiced for such Claims.
Q9	With regard to Exhibit 3.8.3, Bidder’s policy is to provide our business continuity and disaster recovery plans to customers under supervision in lieu of providing electronic or paper copies. Is this policy acceptable to the HCA?
A9	The HCA can accommodate a request for the supervised review of a single document. This review will need to take place at the HCA’s headquarters in Olympia, WA at a date and time to be determined by the HCA in its sole discretion. The HCA will work directly with any Bidder wishing to follow this process. However, for the Bidder selected as the ASB, the HCA will need to conduct a security design review of their proposed solution. For that process, the HCA will need to review many of the ASB’s confidential documents and supervised access will not be manageable. For other Bidders, the HCA can sign nondisclosure agreements and mark these documents as “Proprietary – Not for Public Disclosure.” The HCA does not need hard copies, electronic is preferable.
Q10	Regarding “Key Element” C in Exhibit 3.10, “Provide standard eligibility and Claims reports separately for Non-Medicare and Medicare risk groups by Plans and network, as well as combined, within five (5) Business Days of the HCA’s request,” please define “Non-Medicare and Medicare risk groups.”
A10	Members are split into two risk groups: (1) “Non-Medicare” is comprised of all active, self-pay and retired Members that do not have Medicare as their primary health plan, and (2) “Medicare” which is all retired and other Members whose primary coverage is Medicare (including End Stage Renal Disease (ESRD) patients and others under age 65 that qualify for primary Medicare coverage).
Q11	Regarding “Key Element” C in Exhibit 3.10, the “Content” column in Line 12 of Table 3.10.1 reads “Separate and combined reports for Non-Medicare and Medicare risk groups; Correct reporting of Medicare risk group Members including those who have Medicare as their primary coverage, and all other Members included in the Non-Medicare risk group.”

	Are these the same reports referenced in Key Element C of Exhibit 3.10? If not, please explain the difference.
A11	Yes, but the table is a sample reporting inventory and provided for illustrative purposes only. While the "Key Elements" may include a number of the reports that are listed in Table 3.10.1, Bidders should respond to what is requested in the "Key Elements."
Q12	Table 3.16.2 requests that the ASB process 97% of Clean Claims within 15 Business Days of receipt, and 99.5% of all Claims within 30 Days. Please clarify if the "30 Days" is business days or calendar days.
A12	The definition of the term "Day" from Section 1.3 of the RFP is as follows: **"Day"** is calendar Day, including weekends and holidays. All statements referring to a number of Days mean calendar days, regardless of the number of Days, unless something different is explicitly specified. If the time when something must be performed falls on a weekend, a day observed as a holiday by the State of Washington as an employer, or a day when HCA is officially closed for other reasons, then that action is due on the next Business Day. Day one is the Day after receipt, unless something different is explicitly specified.
Q13	Regarding the calculation of the "Value-Based Performance Guarantee" listed in Exhibit 3.16.7, please respond to the following: a. Please confirm that the measure is medical cost only and does not include pharmacy expenses. b. Will the HCA consider the exclusion of Critical Access Hospitals in the numerator and denominator? c. Are there any other services, charges or provider types that should be excluded from the measurement? d. Is the performance guarantee a cliff or is penalty prorated for a shortfall on the measure?
A13	a. This Performance Guarantee will be based on a template survey (see, Appendix 6, Attachment 24) to report the percentage of total annual payments (medical and pharmacy) to providers in CMS LAN APM Categories 2c-4b for its Washington State Book-of-Business. More detailed instructions will be provided once the Contract has been executed. b. Critical Access Hospitals (CAHs) should be included in the numerator and denominator if CAHs are included in the Bidder's Washington State Book-of-Business. c. All services, charges and provider types should be including the measurement. d. There is no proration for failing to meet the annual performance targets.
EXHIBIT 4 – PROVIDER NETWORK	
Q14	We have noticed that counties and zip codes are mismatched in the census file. Which data point should be assumed as accurate?

A14	A Member zip code and county of residence are independent variables. For the provider network exhibits, the zip code should be used to determine distances and the county should be used for summarizing the results for that individual. Both of these data points should be considered accurate as a zip code can cover multiple counties.
EXHIBIT 5 – CONTRACT COSTS AND TREND GUARANTEE	
Q15	Do the possible negative points awarded in Exhibit 5 negatively impact all Exhibit points earned (Exhibits 1-7) or do these possible negative points just impact the potential Exhibit 5 points earned?
A15	The Cost and Non-Cost elements will be scored and summed to determine an overall score for the written Proposal. If a Bidder receives negative points for one or more of the Cost elements (Exhibit 5), then this would have an impact on the overall score for such Bidder. For example, if a Bidder is awarded 1,650 points on Non-Cost elements, and -200 on Cost elements, the total score for such Bidder would be 1,450 points (1,650 - 200) out of a possible 5,000. More information on scoring can be found in Section 3.2 of the RFP.
Q16	For responses to Exhibit 5, can Bidders provide additional financial commentary documentation with their Proposals?
A16	No.
Q17	For Exhibit 5.1, in the “Specific Instructions” section, one of the database fields listed is “Medicare Lite Claim Amount” (MedicareLite). Please provide clarification as to what the dollar amounts in the “Medicare Lite Claim Amount” represent. Does this need to be factored into the repricing?
A17	The Medicare Lite Claim Amount represents the amount of allowed cost determined under the Medicare Lite repricing process. These amounts are informational only and do not need to be factored into the repricing. The summaries that Milliman is preparing for the HCA will present the response amount for Allowed as a percentage of the Medicare Lite Claim Amount. There will be no summaries for the discount from billed charges.
Q18	Regarding the administrative fee PSPM development in Exhibit 5.2, it is our understanding that all fees shall be included in the PSPM except for subrogation recoveries. In order to confirm that understanding: a. Does this mean that shared savings or usage based arrangements, in lieu of fee being included under the PSPM, will not be accepted at any point during the contract period, with the exception of subrogation recoveries? b. Would the HCA consider select program costs (e.g., Vision Administration, Clinical Programs, etc.) to be included in a claims invoice rather than included in the PSPM fee? c. Would the HCA consider “Per Participant” fees for items such as clinical programs that would be outside of the PSPM fee? d. Please confirm that expenses associated with actual utilization costs of the ASB’s services (such as expert medical opinion and telemedicine) are billed as claim

	expenses and not part of the PSPM. Does the HCA have defined services that can be claim expenses versus part of the PSPM fee? e. Would the HCA consider alternative fees for delivery of Lab/Hi Tech Radiology services to be included in a claims invoice rather than included in the PSPM fee? f. How and when will the ASB be compensated if work (new, additional, and/or ongoing) beyond the scope of the contract are not addressed within Work Order and the Pooled Hours are exhausted?
A18	The HCA's answers to each of the subparts to this question are as follows: a. Alternative arrangements will not be considered as part of Bidder's written Proposal. b. Only the cost of health care services to or for a Member may be invoiced as Claim cost. c. All clinical programs must be included in the PSPM. d. Yes. Claim costs may only be attributed to the actual cost of health care services. Any fees for administration of any portion of the UMP Plans are administrative costs. If "expert medical opinion" means a second opinion examination of a Member, such examination would be a claim expense. However, an expert review of case material as part of Utilization Management would be an administrative cost. If a fee for telemedicine services is not the billable cost of direct contact with the Member, then costs to the ASB for administration of such a telemedicine program would be an administrative fee, not claim cost. e. See answer to subpart d., above. f. Under the Work Order arrangement, once all Pooled Hours are used, the HCA will pay the Blended Hourly Rate (see, "Other Proposed Fees" in Appendix 6, Attachment 27, *Administrative Fees*) for Work Orders for the number of hours in excess of the Pooled Hours worked for services, and/or actual costs paid by the ASB for any supplies provided under a Work Order.
Q19	Regarding the statement "Bids will be evaluated relative to the Target Trend of 20% and the Threshold Trend of 45%. The Unit Cost Guarantee Margin and the Utilization Trend Guarantee will be totaled for the ten (10) year initial term of the Contract" in the "Specific Instructions" section of Exhibit 5.3, in the scoring for the RFP, will the annual trend amounts be summed across the years, or multiplied? Would you please supply an example of the calculation with 10 years of annual trends broken out?
A19	The trend guarantee response is being evaluated as the sum across the years. The target trend of 20% is 2% per year target for each of the ten (10) years, and the threshold trend is 4.5% per year. In calculations relating to settlement of the guarantee, all proposed trends will be factors multiplied by cost to measure performance.
Q20	For "Key Element" A of Exhibit 5.3, please provide an example of "Claims with Coordination of Benefit amounts that exceed 1% above than the Claim line."

A20

First, there is an error in this "Key Element." The phrase "that exceed 1% above than the Claim line" should not have been included in the RFP. Accordingly, "Key Element" A of Exhibit 5.3 is deleted in its entirety and replaced with the following:

A. Claims with Coordination of Benefit amounts.

Here is an example claim with a Coordination of Benefit (COB) amount. There is no excess of "1% above than the Claim line" criteria to the Medicare Lite process. Under the Medicare Lite process all claims with a COB amount are excluded from repricing.

Masked_ClaimID	Linenum	Billed	COB	Removed?
10000823582	1	$1803.28	$0	Yes
10000823582	2	190.34	0	Yes
10000823582	3	136.14	0	Yes
10000823582	4	95.17	0	Yes
10000823582	5	96	0	Yes
10000823582	6	96	0	Yes
10000823582	7	4160	0	Yes
10000823582	8	1841	0	Yes
10000823582	9	164	0	Yes
10000823582	10	36	0	Yes
10000823582	11	36	0	Yes
10000823582	12	105	0	Yes
10000823582	13	105	0	Yes
10000823582	14	114	0	Yes
10000823582	15	114	0	Yes
10000823582	17	9537	651.41	Yes
10000823582	18	2439	0	Yes
10000823582	19	342.16	0	Yes
10000823582	20	272.16	0	Yes
10000823582	21	266.16	0	Yes
10000823582	22	175.8	0	Yes

Total Billed $22,124.21
COB % 2.9%

Q21

For "Key Element" B of Exhibit 5.3, are all claims for members with ESRD removed, or just the dialysis/ESRD specific claims removed? Are all dialysis claims removed, or just those related to ESRD? Are acute dialysis claims for members without ESRD included or excluded?

A21

All claims for members with ESRD are removed. Acute dialysis claims for members without ESRD are included.

Q22	For “Key Element” C of Exhibit 5.3, please provide a detailed definition of "Claims that cannot be priced for Medicare Lite." What makes a claim unable to be priced with Medicare Lite?
A22	There are several possible reasons that Claims cannot be priced with Medicare Lite: • Claim coding is missing or insufficient to determine a Medicare Lite payment amount. An example is a Physician claim missing the HCPCS procedure code. • Inpatient claims where the hospital Medicare identifier cannot be determined or where the hospital does not have Medicare payment information through IPPS or a Medicare cost to charge ratio available. • Inpatient claims with a missing DRG or DRG that cannot be grouped. • Outpatient claims missing both hospital location and hospital Medicare identifier, so that area based payment levels cannot be determined. • Services that are bundled within combined payments under Medicare Lite that do not have a primary procedure present on the claim. • Services where no Medicare Lite fee is available.
Q23	As a lot can change across the period of the contract, is the HCA open to alternative proposals to the Trend Guarantee in Exhibit 5.3 that may include a shorter duration, corridors, etc., in lieu of the exact approach requested? If so, how would those approaches be scored relative to the specific approach requested?
A23	No, not as part of the Bidder’s written Proposal.
Q24	Regarding the report titled “UMP Historical Unit Cost Analysis under Medicare Lite” referenced in the “Overview” section of Exhibit 5.3: a. How are Home Health and Hospice services priced in the model? b. How are Critical Access Hospital claims priced in the model? c. Regarding the statement “Gross up factors have been applied to the PMPMs in Table 1 and Exhibit 1 to adjust…,” will this gross up happen in the actual trend calculations? d. For the Medicare Lite calculation, will the “1st Year Medicare Schedule Basis UMP Plans Unit Cost Trend” or the “2nd Year Incurred Experience Basis Medicare Unit Cost Trend” be used? Will it be the minimum, maximum, or average of the two methods? e. How are new and deleted codes treated in the model? For instance, if a code is deleted and split into 3 new codes, how would the model treat this situation as the historical data would not have the 3 new codes, and the new Medicare schedules would not have the old code? f. The report references that “members whose primary coverage is not the UMP network were excluded,” but the RFP states “Claims with COB amounts that exceed 1% above

	than the Claim line" are to be excluded. How do these two statements differ? Please provide detailed claims examples of both these statements. g. How are "Claims with unreasonable, inconsistent, or problematic financial values are excluded" defined? Please supply examples. h. How are "unrecognized procedure codes" defined? Please supply examples.
A24	The HCA's answers to each of the subparts to this question are as follows: a. Home Health and Hospice services are excluded from this analysis. These services make up less than 1% of the allowed dollar volume in the analyzed claims. b. Inpatient facility Claims at Critical Access Hospitals are excluded from the pricing in the model. As with Home Health and Hospice, Claims at these hospitals make up a small portion of the overall Claims volume and therefore have a low impact on global unit cost trends. Outpatient facility Claims at such hospitals are priced under the standard area adjusted Medicare Lite fee schedule, consistent with general hospitals. Medicare reimbursement methodology specific to Critical Access Hospitals, such as reasonable cost based reimbursement, is not applied under Medicare Lite. c. Yes; however, applying this gross up adjustment does not have an impact on the calculated trends. The percent of Medicare values calculated in lines D and E of Table 1 apply the same gross up factor to both the numerator and denominator PMPMs. This causes the gross up factor to cancel out of the calculation so that the same percent of Medicare is produced whether or not the gross up factor is applied. Because the percent of Medicare values are unaffected by the gross up, the calculation produces the same unit cost trends that would be calculated without a gross up adjustment. d. For UMP Plans, the unit cost trend is the minimum of "1st year Medicare Schedule Basis (from Table 1)" and "2nd Year Medicare Schedule Basis (from Table 2)." This can be seen in Table 3, row C of the UMP Historical Medicare Lite Unit Cost Analysis report. For Medicare, the unit cost trend is the maximum of "1st year Incurred Claim Basis (from Table 2)" and "2nd Year Incurred Claim Basis (from Table 1)." This can be seen in Table 4, row C of the UMP Historical Medicare Lite Unit Cost Analysis report. The UMP Plans unit cost trend is compared to the Medicare unit cost trend to determine the actual UMP Plans unit cost trend margin which can be seen in Table 5. These values represent separate concepts, rather than two methods of the same calculation. The following describes these two concepts: i. The Medicare Schedule Basis for calculating the UMP Plans Unit Cost Trend represents the trend in the UMP Plans unit cost on a utilization case mix and severity normalized basis for the two years of consideration. This is the year-to-year unit cost trend in actual UMP medical reimbursement relative to the Medicare Schedule in effect for each of these years. ii. The Incurred Experience Basis for calculating Medicare Unit Cost Trend represents the cost trend in the Medicare Lite reimbursement, under the UMP

utilization, provider and service mix for the two years of consideration. This is the year to year unit cost trend in Medicare Lite would pay for the same UMP basket of services and is the benchmark basis for determining the UMP Plans Unit Cost Trend Margin in Table 5, line B.

Both items i. and ii. above are calculated under two separate years in Table 1 and Table 2. Table 1 reprices each year under the Prior Year and Same Year Medicare fee schedules. Table 2 reprices each year under the Same Year and Next Year Medicare fee schedules. The Medicare Lite reimbursement results for the Same Year Medicare fee schedules are repeated in both tables for convenience. Within Table 1 the Same Year results are in the denominator of the two trend calculations, while within Table 2 the Same Year results are in the numerator of the two trend calculations.

e. Cross year code mappings are not applied in the model. In this situation, the service would be unrecognized and excluded from the analysis in the year where it is not on the Medicare schedules. The calculations are performed with both the first year and second year Medicare Lite (as shown in Table 1 and Table 2), so in one estimate the single code would be included and the three codes excluded, in the second estimate the three codes would be included and the single code excluded. The final UMP unit cost trend uses the minimum of the two results under the two years as illustrated in Table 3.

f. The first statement is based on the Member's coverage, rather than the characteristics of an individual Claim and applies to Members with Medicare primary coverage. All Claims for these Members are excluded from the analysis regardless of whether COB appears on the Claim. Based on the Member's status as a Medicare primary Member, Medicare is expected to pay most of the cost of this care, so the claims experience for that Member is not representative of UMP payment levels. This corresponds to the line "Medicare Eligible" on Table 7.

The second statement is based on reimbursement for a specific Claim through COB, for a Member who is not eligible for Medicare. Please note that there is a typographical error in the RFP as the Medicare Lite process excludes all claims with COB payments (*see also*, A20 above). For example, if workers' compensation paid a claim for a Member whose primary coverage is a UMP Plan, that particular Claim is excluded from the analysis, but the rest of the Member's Claims are included. See A20 above for an example of a claim excluded due to a non-zero COB amount.

g. Claims with unreasonable, inconsistent, or problematic financial values are defined as follows:
   - Low Allowed Charges: Claims with absolute value of total allowed of less than $1.
   - Inconsistent Allowed and Billed: Claims where total allowed is more than double billed and allowed is over $100.
   - Inconsistent Allowed vs. Paid + Patient Pay: Claims where allowed dollars are significantly different from the sum of paid and patient pay.

	• Unreasonable Percent of Medicare: Medicare reimbursement for the claim is less than 5% of actual allowed or over 1500% of actual allowed at the claim level. Please check the Milliman SFTP site for example claims demonstrating these issues. h. These procedure codes are HCPCS codes that are unrecognized in the context of the Medicare Lite schedules, either as invalid codes or codes without associated Medicare Lite payment levels. Examples include: CPT: 90680 Rotovirus vacc 3 dose oral Certain immunizations and vaccines do not have Medicare payment levels. HCPCS: V2599 Contact lenses other type Some ancillary benefits do not have Medicare payment levels.
ATTACHMENTS	
Q25	In addition to the information provided in Appendix 1, please provide monthly medical claims and enrollment by plan for the last 24 months, including pharmacy claims.
A25	An historical experience summary was uploaded to the Milliman SFTP site which includes monthly medical Claims and enrollment by plan and risk pool covering a prior 24 month period. As retail pharmacy claims are not part of the procurement these have been excluded from the experience summary. All medical based pharmacy claims are included in the summary provided.
Q26	In addition to the information provided in Appendix 1, please provide UMP Plan changes made within the last 24 months
A26	Exhibit A to this amendment is a table containing the UMP Plan changes for benefit years 2017 and 2016.
Q27	Please provide large claims over $100,000 with diagnosis.
A27	Please check the Milliman SFTP site for a large claim summary for claimants with over $100,000 in costs in a calendar year. Condition categories associated with the claimant will be provided, but diagnosis codes are too numerous to list.
Q28	Please confirm policy for stale-dated checks. a. The Operations Manual (Appendix 6, Attachment 8) notes to contact the Member when a check is stale-dated. Should that also state “provider” or just “payee”? Does the Member need to be notified when it is a provider check? b. If a payee does not respond to a stale-dated search letter, please clarify to whom the funds will be turned over. Does “State” mean the HCA? Or escheatment to the state treasurer where the member/provider resides?

A28	a. Notice should be provided to the stale-dated check payee. The payee could be a Member, provider, or some other third-party paid by the ASB on behalf of the HCA. If the stale-dated check pays is a provider, then the Member would NOT have to be notified. b. The finds would not be turned over the HCA. Instead, there would be escheatment to the appropriate agency of the state where the Member resides. For Washington residents, that would be the Washington State Department of Revenue.
Q29	For Attachment 1 of Appendix 2, what is the current expatriate population?
A29	There are currently 78 Members who have an address outside of the United States.
OVERALL	
Q30	In several sections of the RFP, Bidders are asked to “include” reports. However, no specific reports are asked for in the “Required Accompanying Documents” section of the exhibits. Is it acceptable to provide sample reports as exhibits to a Proposal in support of the requested detail?
A30	If sample reports are requested, regardless of the section of the Exhibit where such request is made, then Bidders should provide those as part of the Proposal. These sample reports, just as any “Required Accompanying Documents,” would not be counted towards the page limit provide for any particular Exhibit.
Q31	When five years of reporting detail is requested, does the HCA want the reports on an annual basis, aggregate basis, or both?
A31	Annual.

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.