Solicitation Amendment

Cascade Care Public Option Plans (to be offered on the Washington Health Benefit Exchange)

RFA No. 2020HCA1

Amendment No. 4

Date Issued: April 2, 2020

Purpose: Provide Answers to Questions received by the deadline stated in RFA Section 1.2, *Estimated Schedule of Solicitation* or at the Pre-Solicitation Conference.

The Amendment does not need to be submitted with Application. All other Terms, Conditions, and Specifications remain unchanged. The above referenced solicitation is amended as follows:

RFA 2020HCA1 - Cascade Care Public Option Plans			
Number	**RFA Section**	**Question**	**Answer**
1	Appendix 2	Since the HCA reserves the right not to award the contract to Applicants who do not meet any of the affordability options, what factors would preclude the HCA from disqualifying an Applicant not meeting any of the affordability options?	HCA reserves full authority to not award a contract if Applicants do not meet affordability standards. This authority is not precluded by any specific factor.
2	Appendix 4	In the Milliman Pricing Methodology, Appendix 4, Milliman states that Medicare incentive payments are not included in the Medicare pricing in the denominator. The report, however, does not specify whether incentive payments paid to providers under Cascade Care VBP arrangements will be included in the numerator when calculating the aggregate expenditures as a percentage of Medicare payment. Can HCA please explain if incentive payments will be included in the numerator and, if so, how that calculation will occur?	Given the time needed to process the incentive payments, the validation calculation for a percent of Medicare will not include the carrier incentive payments in the numerator. If the incentive payment is adjudicated and paid before the March 31st runout date and included within the validation claims file then the carrier will need to identify the incentive amounts for their removal from the numerator.
3	Exhibit C	Please confirm that carriers can indicate "maybe" in addition to "yes" or "no."	Please respond with either "yes" or "no" as indicated in Exhibit C to indicate the proposed service area. Exhibit C must be completed and submitted as part of the applicant's Phase 1 responses.
4	Exhibit C	In Exhibit C, HCA provides the “point awarded” for each county. Are those points awarded for responding positively to serving the county or based on the quality of the network? Will carries who choose fewer counties be excluded from participating?	As stated in Section 4.2, points are awarded based on confirming "yes" for the county and providing a description of experience building a network and working with providers in the network and providing the counties' estimated enrollment. Points are not specifically awarded for the network quality. (OIC determines whether a provider network is meeting access standards.) Also stated in Section 4.2, applicants must receive at least 1 point (for each question), to advance to Phase 2. A carrier will earn point(s) as long as at least one county is included in the proposed service area. Carriers will not be excluded from participation based on choosing fewer counties.

Number	RFA Section	Question	Answer
5	Exhibit C	Is there the possibility of modifying the service area (adding or exiting counties) in subsequent years beyond 2021?	Initial contracts will be awarded for a two year period, with ability to extend. HCA has not determined the cadence for a future procurements. Per 4.2.C, an Applicant's aggregate score in this RFA may be factored in to future Plan Years participation.
6	Exhibit D	Regarding Exhibit D, Item 7, please provide the template to be used for the Health Improvement activities report.	The template for Exhibit D, Item 7 for the Health Improvement activities report will be provided in the resulting final contract.
7	Exhibit D	Regarding Exhibit D, item 8, Affordability Standards, we can respond 'Yes' to this granted there is an NDA in place stating that the data will only be used for the purpose of demonstrating adherence to affordability requirements. Does the HCA plan to have an NDA place with this protection? Will answering 'Yes' with this caveat be acceptable to HCA?	Claims data required to demonstrate adherence to Exhibit D, item 8, Affordability Standards will be provided to an HCA-contracted actuary. Claims data will not be provided to HCA; data supplied to the actuary is subject to an NDA.
8	Exhibit F	Please clarify how HCA is evaluating 25% with respect to alignment with the HTCC Decisions Matrix.	Exhibit D, item 2, Health Technology Assessment Decisions outlines the reporting requirements to demonstrate adherence. The report anticipated in July, 2021 will cover progress on alignment beginning January 1, 2021 through June 30, 2021. The report anticipated in July, 2022 requires reporting on alignment for Plan Year 2021. <u>This report will be used to evaluate alignment to 25% of decisions.</u> Additional details regarding reporting requirements will be provided with the resulting final contract. Note: The HTCC Decisions Matrix must also be completed with the Phase 1 response to establish baseline levels of compliance as specified in Section 3, Application Contents.

Number	RFA Section	Question	Answer
9	Exhibit F	Will HCA please modify Exhibit F to allow Applicants to provide information in a single column indicating if they are or are not currently following each clinical decision, to reduce the administrative burden and establish the baseline compliance?	Exhibit F outlines the HTCC Decisions Matrix. For purposes of clarity, for each decision, please provide the Carrier's Current Coverage Policy (Link or Summary) in column F. The Carrier's Assessment indicating if they are following each clinical decision is required in column G. Please also refer to the answer provided in question 107.
10	Exhibit F	The HTCC Decisions Matrix identifies numerous HTCC Final Decisions that address services that are not covered benefits under the Public Option Plan. Does HCA want applicants to indicate adoption of the HTCC decision for all identified services or only for those that are covered benefits?	HCA is requesting applicants to indicate adoption of the HTCC decisions for all identified services in Exhibit F. If applicable, column G may include a "Not an Individual Market covered benefit"
11	General	Are there any updates on the review process for Cascade Care and if it is still planning to be implemented 1/01/2021? With the virus outbreak, there have been questions on prep and if there will be any pushback on dates.	While we recognize the significant impact of COVID-19 on health carrier and provider business operations, we will continue to monitor Covid-19 and adjust the RFA timeline accordingly. At this time implementation will begin on January 1, 2021.
12	General	Is this (Cascade Care Public Option Plans) a new requirement, or is there an incumbent currently providing these services? If so, may I have the vendor name, contract number and contract documents?	Cascade Care Public Option Plans are new requirements to be initially offered in 2021. Background on Cascade Care requirements is provided in section 1.4. Public Option Plan requirements have been developed by HCA in consultation with HBE and the OIC and will be initially offered in 2021. Cascade Care requirements originated through Engrossed Substitute Senate Bill (ESSB) 5526.

Number	RFA Section	Question	Answer
13	General	Given the intensity of the COVID-19 situation and almost hourly changes taking place at all levels across the state including entire health care delivery systems, are the three agencies reassessing their current decision? Would there be any additional consideration regarding a further delay or postponement of the RFA process or components of the RFA process? And if so, when might interested parties expect notification regarding this decision?	See answer to question 11.
14	General	In light of the WA state COVID-19 public health alarm and work safety issues, there are serious concerns with the need to negotiate contracts by meeting with providers and hospitals in these highly contagious areas for the upcoming RFA No. 2020HCA1 for the Cascade Care Public Option Plan. Is there the potential of postponing this RFA until a later date when the health crisis is under control?	See answer to question 11.
15	General	Please confirm that required Exhibits are not included in the page limits.	Per Sections 3.2 and 3.3 - Page limits exclude any requested charts, tables, samples, etc.
16	Section 1.10	Please confirm that the following language is applicable only to safe harbor, "invalidate the reimbursements and payment target thresholds provided through the safe harbor and will eliminate the option to participate" and does not eliminate an Applicant from offering in a county.	Yes, the information referenced in Section 1.10 is applicable to the safe harbor only.

Number	RFA Section	Question	Answer
17	Section 1.10	In Section 1.10, what is meant by “Safe Harbor?”	As stated in Section 1.10, safe harbor is an optional mechanism to facilitate health plan and provider participation in year 1 by removing uncertainty and maximizing opportunities bidding across geographic regions where costs vary. In other words, the safe harbor option is a mechanism to help applicants bidding across geographic regions – or bidding more than one county – to help off-set varying costs and achieve the affordability requirements of public option plans. The safe harbor provides additional protection for the Applicant if actual enrollment deviates from expectations (i.e. if more enrollees are from higher reimbursement rating areas), but does not change the requirement that a carrier has reimbursement of less than 160% of Medicare statewide in all other cases. If an Applicant chooses the safe harbor option for their proposed counties, Milliman will provide two Medicare adjusted reimbursement and payment target thresholds for provider payments in each area (one regular adjusted and the second VBP-adjusted). Applicants that choose the safe harbor will be required to attest that their projected reimbursement rates are equal to or below the target by OIC area provided by Milliman and will be required to provide sample provider contracts as part of their Phase 2 response to confirm VBP participation. Applicants that choose and agree to meet the safe harbor, but do not meet the statewide reimbursement requirement during validation, will not be required to submit a corrective action plan (after the validation process in 2021) if during validation the regional safe harbor amounts are satisfied.

Number	RFA Section	Question	Answer
18	Section 1.10	Safe Harbor Please provide the definition of "safe harbor"? Please provide specifics or examples of how the program and/or calculations will work as described. a. In the LOI, is there suggested language for Applicants that wish to participate in the optional safe harbor? b. The RFA states, "If an Applicant chooses the safe harbor, there is no penalty associated with retrospective review of the actual provider reimbursement." Are there scoring, other benefits or possible penalties for Applicants that do not participate in the safe harbor? c. Is there a different definition of safe harbor as described in Value-based Payments (1.11)? d. If an applicant declares in their LOI that they wish to participate in safe harbor, is the singular declaration applicable to both the "annual validation" and value-based payments? e. Is the definition of "safe harbor" consistent across the multiple references or are there multiple definitions of "safe harbor"? f. What will be deemed "Meaningful changes to the listing of the counties and/or enrollment information in which the applicant intends to participate, as provided through the LOI?" g. In addition to stating in the LOI a wish to participate in safe harbor. What are the requirements to qualify? Is the following the only requirement to qualify for safe harbor? "Applicants will qualify for the VBP-adjusted safe harbor reimbursement targets if at least thirty (30) percent of provider payments in each Public Option Plan are in CMS LAN Categories 2C to 4B as demonstrated	See answer to question 17. Example: If an applicant bid in King County and Yakima, which are in 2 different OIC rating areas, they would receive a total of 4 numbers, 2 for each OIC rating area. The safe harbor is not particularly meaningful for Applicants bidding in one county only or 2 counties in the same OIC rating area. If the carrier believes they are going to be able to achieve their attestation of 160% of Medicare for proposed counties offered through Cascade Care, regardless of membership mix by area, then there is little need to take the safe harbor option. a. No suggested language; simply indicate interest to participate in safe harbor. b. Please refer to first part of this answer. c. The safe harbor in 1.11 is related to the Safe Harbor in 1.10. The safe harbor in 1.11 gives Applicants an adjusted safe harbor reimbursement target for value-based payment contracts with providers. d. Yes, when an Applicant declares they will participate in the safe harbor (whether in the LOI or via email) it is applicable to the annual validation and value-based payment safe harbor. e. There is one definition for safe harbor and it applies to Sections 1.10 and Section 1.11. f. Meaningful changes are defined as changes in county offerings or significant changes in enrollment that would change the safe harbor calculation. Applicants must provide counties they intend to offer the public option product and project enrollment in order to qualify for the safe harbor outlined in Sections 1.10 and 1.11. g. Yes, the only requirement to qualify for the VBP-adjusted safe harbor is to provide evidence that at least thirty (30) percent of provider payments in each Public Option Plan are in CMS LAN Categories 2C to 4B as demonstrated through the sample contracts provided in the Phase 2 response."

		through the sample contracts provided in the Phase 2 response."	
19	Section 1.10	Bidder respectfully requests HCA's consideration in moving the Optional Safe Harbor declaration, described in section 1.10, from Letter of Intent to the Letter of Submittal as this would allow carriers time to request information during the formal Q&A period, the pre-selection bidders conference and make informed decision with regard to the Safe Harbor.	Please see Amendment 1, which removes the safe harbor declaration from the Letter of Intent. The new due date for Applicants to confirm their participation in the safe harbor is March 30, 2020.
20	Section 1.10	Within Section 1.10 Optional Safe Harbor to Facilitate Public Option Plan Offerings, the last paragraph indicates "Meaningful Changes" to the listing of counties and/or enrollment information as provided through the LOI. Please elaborate on the definition of "Meaningful Changes." In addition, within that same paragraph, if it is determined there are "Meaningful Changes," please confirm this would prohibit the Applicant from participating in Safe Harbor, and not prohibit participation in the Cascade Care Public Option.	Please see answer to question 18f for an answer for the first part of the question. Yes, participation in the safe harbor would be prohibited if meaningful changes were determined, as stated in Section 1.10; but Applicant would not be prohibited from participating in the Cascade Care Public Option. See answer to question 16.
21	Section 1.10	I'm trying to understand the optional safe harbor. Could you explain how it would operate in practice?	See answers to questions 17, 18 and 35.

Number	RFA Section	Question	Answer
22	Section 1.10	Do alternate reimbursement targets vary by carrier? If so, and they are determined based on existing reimbursement levels, carriers with higher reimbursements today will be more likely to achieve the necessary levels. This will bias selection toward carriers with higher reimbursements, and may result in HCA only approving plans with uncompetitive rates.	The alternative reimbursement target under the safe harbor will vary by carrier (Applicant). The comment is not correct. The safe harbor targets do not eliminate the responsibility of a carrier to work to achieve 160% of Medicare reimbursement, or less, on a statewide basis; they only provide regional protection if enrollment projections do not match actual enrollment. Even if the area targets are satisfied, the resulting reimbursement across the state could be more than 160% depending on actual enrollment levels. Secondly, the applicant comment assumes the "existing reimbursement levels" are based on the carriers own data. That is also not the case. The safe harbor targets are based on the average of all carriers who submitted data, and the necessary reductions to achieve a statewide 160% of Medicare reimbursement.
23	Section 1.10	Will only in-network reimbursements be used to determine aggregate reimbursement levels (we cannot control or reliably project OON reimbursement levels)? Does the primary care floor only apply to services that are provided by providers physically located in the counties where Cascade Care is offered (e.g. if we are approved for Cascade Care in Yakima, we are only required to satisfy reimbursement requirements for providers located in Yakima)?	Out-of-network payments will be included in the calculation to determine whether safe harbor targets or 160% of Medicare reimbursement (on a statewide basis) are satisfied. For the purposes of the safe harbor calculation, member location, not provider location, is used to evaluate if a carrier has met the target. The primary care floor is applicable statewide, and so if the carrier is only approved for Cascade Care in Yakima, they need to satisfy the reimbursement requirements for all providers of service to those members in Yakima.
24	Section 1.10	If targets are going to be provided on a service category level, does that mean carriers are required to meet the individual service category targets, rather than the aggregate medical target?	Per Amendment 1, targets will NOT be provided on a service category level; only for the aggregate (that includes inpatient, outpatient and professional).

Number	RFA Section	Question	Answer
25	Section 1.10	Is there a quantifiable defined penalty given for failing to meet the reimbursement target threshold in an area for any given year?	The quantifiable defined penalty is the requirement to submit a corrective action plan, as outlined in RFA Section 1.10. As a reminder, HCA can terminate contracts for non-performance (a contract requirement in all HCA contracts). At this time, it is not envisioned that termination would occur outside of a plan year cycle.
26	Section 1.10	The RFA states Carriers will not be required to submit a corrective action plan for failing to meet the reimbursement target threshold; how will carriers who participate in the safe harbor option be held responsible for modifying their network for the next year in order to meet the reimbursement target threshold?	Applicants will not be required to submit a corrective action plan for failing to meet the statewide 160% of Medicare as long as they satisfy the regional reimbursement target thresholds provided by Milliman, *if they participate in the safe harbor option.* Contracts resulting from this RFA may be amended in year 2 to adjust for year one experiences.
27	Section 1.10	This could negatively impact carriers with rates significantly lower than competitors. Will HCA consider awarding additional points to those carriers who participated in the voluntary data exercise in December 2019?	HCA will consider awarding additional points to carriers meeting affordability standards and provider reimbursement thresholds, and participating in the voluntary data exercise.
28	Section 1.10	Please define/clarify "meaningful changes." In the required LOI, Carriers were instructed to list the counties in which they intend to participate, but eventual participation is dependent on provider willingness/participation. If Carriers cannot contract with hospitals, they will not meet OIC network adequacy standards and will not qualify in that county. Does this mean if Carriers cannot get contracts with key providers to be able to offer Cascade Care in these counties, they would then no longer be eligible to participate in the safe harbor? Does this also eliminate the ability to offer Cascade Care plans?	Please see answer to question 18f and 20 for an answer for the first part of the question. Yes, per Section 1.11, Applicants are no longer eligible to participate in the safe harbor if there are meaningful changes in their bid, e.g., proposed counties and projected enrollment, as determined by HCA. Meaningful changes could also prohibit Applicants from offering Cascade Care Plans, per HCA's discretion.

Number	RFA Section	Question	Answer
29	Section 1.10	Under Section 1.10, Optional Safe Harbor to Facilitate Public Option Plan Offerings, there is a requirement that applicants “provide sample provider contracts as part of their Phase 2 response.” Please clarify what is meant by “sample provider contracts” as negotiations with providers are likely to continue through the end of the year.	The "sample provider contracts" are to be representative of the structure and considerations that are under negotiations with providers. The primary purpose of this request is to assess the level of Value Based Payments to providers that are being negotiated.
30	Section 1.10	If we participate in the Safe Harbor program, we receive the required threshold at the ACA geographic rating region level. If we do not participate in the entire region level, are we still required to meet the rating region threshold, or will we have to meet the individual county threshold?	Yes, Applicants are still required to meet the rating region level even if they do not participate in the entire region.
31	Section 1.10	Can HCA provide an overview and further detail on the Safe Harbor option, the opportunities, protections, risks?	See answers to questions 17, 18 and 35. The safe harbor option gives carriers protection against the corrective action plan if they fail to meet 160% of Medicare on a statewide basis. If the carrier believes they are going to be able to achieve their attestation of 160% of Medicare for proposed counties offered through Cascade Care, regardless of membership mix by area, then there is little need to take the safe harbor option.
32	Section 1.10	Does “… eliminate the option to participate …” eliminate the option to participate in the safe harbor, or eliminate the option to participate in Cascade Care?	See answers to questions 16 and 20.
33	Section 1.10	If a carrier is not afforded safe harbor, what is the penalty if the HCA assessment indicates that a carrier did not meet the 160% target, even if the carrier's assessment is that the carrier met the target?	All Applicants that choose to participate in the safe harbor option will be afforded the option of safe harbor. We are working on developing a dispute resolution process.

Number	RFA Section	Question	Answer
34	Section 1.10	Can HCA provide further detail on what is included in the amendment released on March 10 to the RFA specifically regarding the language updating the Safe Harbor section 1.10, including the option to answer Yes, No, or Maybe for Safe Harbor and the confirmation carriers need to send by March 30.	If an Applicant would like to participate in the safe harbor option, the Applicant must notify the RFA coordinator by the March 30th deadline. An email to the RFA coordinator will suffice.
35	Section 1.10	Using rating area 6 (i.e., Benton, Franklin, Kittitas, Yakima) as an example, let's say that a carrier has proposed to serve Benton and Franklin counties, and has noted "YES" for safe harbor for Benton and "NO" for safe harbor for Franklin. • Is a single alternative reimbursement target set for rating area 6, or is an alternative reimbursement target set for each of the two counties? • If a single alternative reimbursement target is set for rating area 6, does the alternative target apply to Franklin? • If the carrier decides not to serve Franklin, is that a meaningful change with respect to safe harbor?	The safe harbor is calculated on a rating area basis, not a county basis. The carrier must participate in the safe harbor for all areas and counties included in the application or not at all. In the example provided, if the only rating area in the bid is Rating Area 6, the carrier must have reimbursement below 160% of Medicare and the safe harbor provides no meaningful protection. Also see answers to questions 17 and 18.
36	Section 1.10	Can HCA provide further detail regarding the data and information that will be provided by Milliman to support the Safe Harbor provision?	See answer to question 35. Milliman will provide safe harbor targets by rating area, that are adjusted based on the carrier provided enrollment distribution. Based on the carrier supplied enrollment projection, the regional targets will aggregate across the state to 158% of Medicare for without VBP, and 160% of Medicare for with VBP. Depending on selected area, and the membership projected, Milliman may provide for rating region reimbursement targets that exceed 160% of Medicare as those are offset by rating regions that are below 160% of Medicare. The regional targets are supported by the market average level of reimbursement submitted during the December 2019 data exercise. Given that the participating carriers were provided their results, Milliman is not able to share the carrier average starting point. The safe harbor is not needed if the proposed rating regions are each individually able to satisfy the 160% of Medicare target.

Number	RFA Section	Question	Answer
37	Section 1.11	"Applicants will qualify for the VBP-adjusted Safe harbor reimbursement targets if at least thirty (30) percent of provider payments in each Public Option Plan are in the CMS LAN Categories 2C to 4B as demonstrated through the sample contracts provided in the Phase 2 response." Can HCA describe the "VBP-adjusted Safe Harbor" and how it will work?	Please see answer in number 36. For carriers which qualify for the VBP-adjusted safe harbor, the rating area targets will be increased to 160% of Medicare on a statewide basis. Based on the enrollment distribution provided by the carrier, the statewide total reimbursement of the rating region safe harbor targets will be 158% of Medicare if there is not sufficient VBP present.
38	Section 1.11	Will HCA define "additional flexibility?" What additional flexibility regarding the provider reimbursements will be given? Does that mean if we have 30% of our contracts with Cascade Care providers in value-based arrangements, then we will be given additional safe harbor/reimbursement flexibility (in addition to the safe harbor mentioned in the prior section?)	Please see answer to question 37.
39	Section 1.11	Is it HCA's intent that the threshold for value-based payments for Cascade Care be 50% of provider payments, but that Carriers will still qualify for the safe harbor with only 30% of payments in value-based arrangements? Or is there another minimum threshold for the plan vs. the safe harbor qualification?	Yes, that is HCA's intent. Per the HCA VBP roadmap, HCA's goal is for 50% of provider payments under commercial health care plans (non-state-financed health care) to be linked to value based payments in category 2C or higher. Public option plans that do not meet that goal will not be penalized.
40	Section 1.11	Can HCA provide more detail regarding the additional flexibility through adjusted safe harbor reimbursement targets to reward carriers with VBP arrangements? Can HCA provide an example?	See answer to question 37.
41	Section 1.11, 1.12, 1.13	Understanding that Applicants' Letter of Intent to Apply is based on best intention and that service area and enrollment projections may need to change, will HCA please confirm when carriers will have the opportunity to make changes to counties	See Amendment #2. This question is moot.

		and/or enrollment without voiding the safe harbor election?	
42	Section 1.12	"HCA will verify that the ASA's OIC final approved rates resulted in a premium savings as provided in the ASA's submission of planned premium rates." Please note, through the course of OIC's rate review, rates are always adjusted throughout the review process. What is HCA's expectation if the initially filed rates met the savings targets, but final approved rates do not?	HCA understands and expects that rates may change through the course of OIC's rate review with some potential for flexibility. Guidance on HCAs expectations are outlined in Section 1.12. "Following the verification, HCA will proceed with contract finalization of Public Option Plans resulting in premium savings, as solely defined by HCA."
43	Section 1.13	Validation In 1.13.3, the RFA states that "HCA may also explore other methodologies that demonstrate increased affordability. These methods may include, but are not limited to, offering Public Option Plans that provide actuarially sound premiums that are at least ten (10) percent lower than the previous Plan Year." In this instance, will the HCA and/or OIC waive requirements that a change larger than a 3% requires new filings?	HCA nor OIC are aware of any exception to filing if "the change" is 3% or larger.
44	Section 1.15	Will only incumbents be able to renew every 2 years?	Per Section 1.15, HCA reserves the right, in its sole discretion, to extend the contract for two (2) periods of two (2) years each. Existing contracts (with contract holders/incumbents), may be extended at HCA's discretion. HCA reserves the right to open future procurements as the need arises.
45	Section 1.15	Are the services described in this RFA continually needed, even beyond the stated term of the contract, and therefore may be bid out again?	Services described in this RFA are expected to be continually needed. Also, please refer to the answer to question 44.
46	Section 1.16	Please confirm Applicants should only provide the full history of current or former state employees for the past two years.	Applicants should provide the full history of current or former state employees for at least the past two years.

Number	RFA Section	Question	Answer
47	Section 1.2	At what point does the HCA anticipate answering Applicant questions about the Safe Harbor option, considering that Applicants must confirm participation in the Letter of Intent by March 13? Will any flexibility on the due date of the Letter of Intent be granted considering the time it may take to confirm whether or not Safe Harbor is something we will pursue?	Please see Amendment 1, which removes the safe harbor declaration from the Letter of Intent. The new due date for Applicants to confirm their participation in the safe harbor is March 30, 2020.
48	Section 1.4.3	Please confirm that OIC has regulatory authority over carrier network(s), not the HCA.	As stated in section 1.4.3, HCA receives final approval from the OIC for rates, forms and network access. The OIC has regulatory authority over health plan issuers, including provider network standards. OIC determines whether a provider network is meeting access standards.
49	Section 1.5	For the purposes of this application, does HCA regard the plans offered through the Health Benefits Exchange as "commercial health care arrangements," and is it HCA's intent that a minimum of 50% of provider payments in Cascade Care be linked to value payment in category 2C or higher?	See answer to question 39.
50	Section 1.6	How are value-based payments credited in the calculation of reimbursement level? For instance, if a value-based payment is contingent on the provider achieving a certain quality score, is it assumed that the provider meets the quality threshold, thereby including the payment in the reimbursement calculation?	See answer to question 2.

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51	Section 1.7	Is the requirement that carriers just have to offer a subcontracting agreement? How should carriers document that we have complied with this requirement?	The requirement is that "Applicants must recognize the sovereign status of the tribes that all Indian Health Care Providers (IHCPs) operate under and interact with all IHCPs in a manner that is respectful of this status and this responsibility." In 3.2 Phase 1 Response, Section 2.2.b, HCA requests that the applicant describe how you will reach out to every tribe, IHS facility, and UIHP that offers services in each county in Washington in which you plan to participate 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. The request also requires the applicant to include how you will maintain relationships with contracted and non-contracted IHCPs, obtain training on the Indian health care delivery system and comply with HBE's Sponsorship Policy as it applies to tribal sponsors.
52	Section 1.8	Will HCA clarify or describe how Public Option Plans, Standard Plans, and Non-Standard Plans will appear on the Exchange? Alternatively, will Public Option Plans be given preference in order of display on the exchange?	The Exchange is developing nomenclature for public option plans, standard plans, and non-standard plans which it will be discussing with carriers in meetings scheduled for March 26 and April 3.
53	Section 1.8	Does HCA plan to present the Public Option Plans, Standardized Plans, and Non-Standardized Plans to consumers at the same time (e.g., direct comparison)?	All available plans will be shown to consumers during open enrollment for 2021 and consumers will be able to compare public option plans, standard plans, and non-standard plans side-by-side. Public option plans, standard plans, and non-standard plans will be differentiated using logo and nomenclature distinguishers that are being developed by the Exchange and will be shared with carriers during meetings scheduled for March 26 and April 3.
54	Section 1.9	As stated in 1.9 Provider Incentives in the Request for Application, "Public Option Plan Carriers will be required to revise the enrollee's insurance card to include a specific prefix in the member identification number to support the tax exemption as a benefit to their provider network." Can HCA please clarify any additional benefits beyond tax exemption that providers and other stakeholders receive by	HCA has not identified additional benefits at this time but expects there may be unanticipated benefits in distinguishing Public Option Plans from other individual market health plans through use of the identifier on the insurance card.

		including a special prefix in the member identification number?	
55	Section 1.9	As stated in 1.9 Provider Incentives in the Request for Application, “Public Option Plan Carriers will be required to revise the enrollee’s insurance card to include a specific prefix in the member identification number to support the tax exemption as a benefit to their provider network, to be specified by HCA in the contract." At this time has HCA defined what a prefix will look like? If not, when will HCA be providing direction to the Public Option plans on the prefix?	In 3.2 Section 2, Item 3 requests the applicant to "Include a plan to revise the insurance card for enrollees to include a specific prefix in the member identification number." HCA will evaluate the applicant's plan with consideration of providing additional guidance on a standardized approach (i.e. specifying a single prefix).
56	Section 1.9	As stated in 1.9 Provider Incentives in the Request for Application, “Public Option Plan Carriers will be required to revise the enrollee’s insurance card to include a specific prefix in the member identification number to support the tax exemption as a benefit to their provider network, to be specified by HCA in the contract." Has HCA considered alternatives to using a prefix such as a group number or product name?	See answer to question 55.
57	Section 1.9	Is the specific prefix number required or if a carrier has another design/approach that makes sense, is that allowed?	See answer to question 55.
58	Section 2	For Carriers who do not have many provider contracts in place for public option, please confirm that HCA will award partial points if the applicant submits a sample contract.	See answer to question 83.
59	Section 2.12	Can HCA advise when Applicants can expect the sample contract to be provided? Will the sample contract be provided?	HCA anticipates to release the draft contract on or around April 10, 2020. It will be released via an amendment to the RFA.

Number	RFA Section	Question	Answer
60	Section 2.12	HCA states that the sample contract will be offered as an amendment to the RFA. Can HCA please identify the date by which the sample contract will be released?	See response to question 59.
61	Section 2.19	Upon initial review, the requirement listed in RFA §2.19.4.1, does not appear to follow standard insurance industry practice. If awarded a contract, is HCA willing to discuss this requirement with the awardee to determine an acceptable alternative?	Yes, HCA is willing to discuss these terms during the resulting contract negotiations.
62	Section 2.4	There appears to be some conflicting information between the due date for the NDA and requirements in Section 1.10 and Section 2.4 of Amendment 1. Based on the statement below "The sooner the Applicant returns the NDA, the sooner they may be provided access to the safe harbor information." We are submitting this document today. Please let us know when we can expect to receive the safe harbor information or if you have any questions of us.	HCA provided Milliman with the NDA in batch on Wednesday March 26th. Safe Harbor information will be issued starting April 1st and will be handled in order of t data submitted.

Number	RFA Section	Question	Answer
63	Section 2.4	Revised section 2.4, which indicates applicants interested in safe harbor provisions must submit their NDA "after Applicants have emailed the RFA Coordinator their confirmed participation (March 30) to use the safe harbor," appears to conflict with the indicated NDA deadline of March 20, making NDAs due after safe harbor confirmation submission on March 30. Will HCA confirm its intended timeline of LOI and NDA submission on March 20, followed by Applicant receipt of Milliman data, and subsequent submission of confirmation of participation in the safe harbor on March 30? Additionally, if Applicants which indicate YES or MAYBE for participation in the safe harbor by county will receive Milliman payment threshold prior to ultimate confirmation of participation March 30, can HCA clarify any detriment to the applicant for an indication of MAYBE in its LOI prior to an ultimate indication of YES or NO due to HCA March 30?	Please refer to the response to question 62. A carrier may, at any time up to final submission, choose to not participate in the safe harbor. The safe harbor provides additional protection for the carrier if actual enrollment deviates from expectations (i.e. if more enrollees are from higher reimbursement rating areas), but does not change the requirement that a carrier has reimbursement of less than 160% of Medicare statewide in all other cases. Since the safe harbor is dependent on the membership projection and the counties proposed under the service area, carriers should immediately update the intended service area before the safe harbors are delivered - if there have been any changes.
64	Section 2.5	What is the maximum file size that the HCA can currently receive via email?	The maximum size of the whole email (email, plus attachments) is 30Mb.
65	Section 2.5	In an abundance of caution, would HCA consider another delivery mechanism besides email such as uploading to an FTP or mailing a USB?	Per RFA Section 2.5, HCA will only accept email submissions as an attachment to the RFA Coordinator at the e-mail address listed in Section 2.1.
66	Section 2.5	Please confirm the incoming email size limit for Applicants submitting their submissions to HCAProcurements@hca.wa.gov. If an Applicant's submission exceeds the incoming email size limit, please confirm that the Applicant can submit their response/files in multiple emails.	The maximum size of the whole email (email, plus attachments) is 30Mb. Multiple emails are acceptable. It is not required, however HCA would prefer that anyone submitting their Application in multiple emails to number the emails accordingly in order to ensure a portion of their Application is not missed (e.g.: email 1 out of 3; email 2 out of 3; etc.)

Number	RFA Section	Question	Answer
67	Section 3.1	Former State Employees In 3.1.6 it asks that applicants “Identify any state employees or former state employees employed or on the firm’s governing board as of the date of the application.” Does this requirement also apply to subcontractors?	No, it does not apply to subcontractors.
68	Section 3.2	Regarding question 1.c.ii in Section 2 of Section 3.2, do you have a list of networks that meet your definition of clinically integrated networks? Do you have a list of integrated delivery systems that meet your definition?	There are a number of clinically integrated networks (CIN) operating in Washington State that meet the CIN definition, including but not limited to Embright, UW Medicine Accountable Care Network, and Puget Sound High Value Network.
69	Section 3.2	For Phase One Scoring, please explain the weighting of the points. For example, on page 32, Section 3.2.2.c., Value Based Payment and Integrated Care Strategies is worth 20 possible points. On page 36, the Evaluation Table weights the question at 2.0 with a maximum point value of 20. Is the maximum point value 20 or 40?	The maximum available points for Phase 1 Section 2 (Quality and Value Strategies - Value-based Payment & Integrated Care Strategies) is 20 points. The weight listed will be multiplied by the average score received by Evaluators as listed in Section 4.3, Scoring Methodology for Phase 1 - Section 2.
70	Section 3.2	Regarding Phase 1 Section 2.2.a, "Carriers must ensure that enrollees may obtain covered medical and behavioral health services from the Indian health care provider at no greater than in-network cost:” Bidder wishes to clarify that the “no greater than in-network cost” requirement applies to IHS providers in-network with the health plan in which member is enrolled consistent with existing ACA requirements.”	The “no greater than in-network cost” requirement referenced in 3.2 Phase 1, Section 2.2.a refers to IHCPs who chose to not sign a contract with the applicant, but could be seeing beneficiaries who choose that IHCP as their PCP. Though the IHCP is not in-network, the enrollee will not incur costs greater than if the IHCP was in-network.
71	Section 3.2	Regarding Phase 2, Section 2, is the “30% of the Applicant’s 2021 Plan Year provider contracts” by total contract volume or 30% of claims dollars tied to a Value-Based payment arrangement?	Please refer to the revised wording for Section 3.3 Phase 2 - Section 2, Value Based Payment Arrangements and Sample Contracts in Amendment 3.
72	Section 3.2	Please confirm "new technologies" refers to the procedures identified in the HTCC Decisions Matrix located in Exhibit F.	Yes, new technologies refers to the procedures identified in the HTCC Decisions Matrix located in Exhibit F. Note that the HTCC adds new technologies each year.

Number	RFA Section	Question	Answer
73	Section 3.2	Since the response to this RFA is electronic via email, please confirm that twenty (20) double-sided pages is the equivalent of 40 single-sided pages.	Section 3.2 has a max of 20 double-sided (or 40 single-sided) pages. Section 3.3 has a max of 10 double-sided (or, 20 single-sided) pages. Note: the maximum page count excludes any requested charts, tables, samples, etc.
74	Section 3.2	In Section 2, Q. 1 c. iii. HCA asks "Does your organization offer any health plans that are CMS-certified "Other Payer Advanced APMs" in 2018 or 2019? If so, how many?" Does HCA mean "provider contracts" rather than "health plans?"	This question refers to health plan offerings that have been certified by CMS as "Other Payer Advanced APMs".
75	Section 3.2 and 3.3	Can HCA confirm the page limit guidance: o Phase 1 response is 40 electronic pages o Phase 2 response is 20 electronic pages	See response to question 73.
76	Section 3.2 and 3.3	Please confirm that completed Exhibits A, B, C, D, and F do not count toward the page limit.	Any requested documents (including the completion of Exhibits A, B, C, D, and F) do not count towards the maximum page limits.
77	Section 3.2.1	In Section 3.2.1, how is the score for this section calculated?	Per RFA Section 4.2, Phase 1 Section 1 - Scoring: Applicants will receive the points associated with each county for which they confirm "Yes" within Exhibit C, *Applicant's Proposed Service Area* AND provide the associated county's description of building a network AND provide the enrollment data for the associated county. The points received will be summed to determine the Applicant's score.
78	Section 3.2.1	In Section 3.2. Phase 1 Response (p. 32), the instructions note to “limit responses to twenty (20) double-sided pages”. Please clarify if that means a total page count of 20 (i.e. 10 pages, double-sided, for 20 pages of content) or a total page count of 40 (i.e. 20 pages, double-sided, for 40 pages of content). The same question is relevant for the instructions for Section 3.3. Phase 2 Response (p. 33), which notes to “limit responses to ten (10) pages double-sided pages”.	See response to question 73.

Number	RFA Section	Question	Answer
79	Section 3.3	Regarding the Premium Rate section in Phase 2, if the Applicant can meet the 160% requirement for a particular county, does the Applicant still have to meet one or more of the affordability options in Phase 2 Section 1 for that county?	Yes. Applicants are requested to meet one or more of the affordability requirements in 3.3 section 1 Premium Rates independent of meeting the 160% reimbursement requirement.
80	Section 3.3	Since the response to this RFA is electronic via email, please confirm that ten (10) double-sided pages is the equivalent of 20 single-sided pages.	See response to question 73.
81	Section 3.3	What if a Carrier's Cascade Care plan is not 5% lower than their lowest-cost plan in the same metal tier? For example, if the Carrier's Silver non-standard QHP is cheaper than their Silver standard QHP and the Cascade Care silver QHP is higher, does that mean a carrier will not score any of the 90 points available in this section?	The scoring approach of premium relativities is not yet finalized.
82	Section 3.3	In previous sections, HCA refers to 30% of provider payments made as value-based payment. In this section, HCA indicates that 30% of contracts should include value-based payment arrangements. Are these requirements distinct and independently valid, or should either 30% of payments or 30% of contracts demonstrate value-based arrangements?	See answer to question 71.

Number	RFA Section	Question	Answer
83	Section 3.3	The requirement refers to “Sample Contracts” however it asks the applicant to provide 75% of “current” 2021 Public Option Plan Year provider contracts. It then later refers to these as “example” contracts. Given that applicants do not currently offer a public option plan, and will not be able to demonstrate OIC approval until after the application date (OIC filing date 5/21 and HCA application date 5/22), please confirm applicants are to provide “sample/example” contract templates - not executed contracts - for the public option plan.	Applicants are to provide sample contracts submitted to and approved by the OIC as requested in 3.3 Section 2. Contracts are not required to be executed at the time the Phase 2 response is due. Understanding that the number of contracts may vary, the 75% requirement refers to contracts currently available to provide.
84	Section 3.3	Phase 2, Section 1 - Please confirm that Applicant should submit rates in the same format/rate schedule table as filed with OIC.	The rates requested in 3.3 section 1 Premium Rates may be in the same format/rate schedule as filed with the OIC.
85	Section 3.3	Based on the complexity in establishing VBP contracts and needing enough enrollees in the pool to establish stable baseline data for both quality and medical cost measures, we recommend that the use of VPB contracts be optional for the first three years. This is precisely why to date we have not entered into VBCs at all for current Marketplace populations. The same reasoning applies to unit cost reductions as well. And finally, it does not seem feasible to have OIC approved contracts at the time of submission, since naming conventions and other necessary elements to structure contracts are not yet finalized by HBE/HCA, and once template contracts are established and filed, they require 30 day review and approval by OIC.	See answer to question 83.

Number	RFA Section	Question	Answer
86	Section 3.3	Section 2 asks applicants to "confirm whether at least thirty (30) percent of the applicant's 2021 plan year provider contracts for public option plans include VBP arrangements…" Elsewhere in the RFA and in other contracts, HCA refers to 30 percent of payments, not contracts. Can HCA please clarify if the requirement is 30% of provider contracts or 30% of provider payments?	See answer to question 71.
87	Section 3.3	Can HCA clarify how they will evaluate whether an applicant has provided "sample contracts demonstrating VBP arrangements" (worth 40 pts), separately from whether at least 30% of the applicant's applicable provider contracts include VBP arrangements (worth 20 pts)?	In 3.3 Phase 2 Response, Section 2, the applicant is requested to include an explanation of how the contracts demonstrate Value-Based payment arrangements and unit cost reductions in contracting with providers. Also, as stated in 4.2.B Phase 2 Section 2 Scoring, evaluation is "Subject to verification through requested sample contracts…". HCA will review sample/example contracts and explanations provided by the applicant to determine whether the contracts meet the required level of VBP arrangements.
88	Section 3.3	Can HCA provide clarity around how unit cost reductions with be measured if the applicant does not have prior individual market provider rates to compare?	For section 3.3, applicants with no previous individual market experience will be evaluated using the applicant's proposed premiums compared to premiums listed in Appendix 3. Please refer to the revised wording for Section 3.3 Phase 2 - Section 2, Value Based Payment Arrangements and Sample Contracts in Amendment 3.
89	Section 4.1	HCA states that "an evaluation team(s) made up of representatives from HCA and HBE designated by HCA" will evaluate and score the RFA responses. Will HCA please identify any other agencies that will be involved in the evaluation, indicate which staff by agency and title will be involved in the evaluation team, and explain the evaluation training that each member of the team has undergone to prepare them for evaluation of the RFA responses?	Creation of the solicitation evaluation team is an internal HCA decision and has not been finalized. Once finalized, HCA will reveal evaluation team participants and evaluator training only after announcement of Apparent Successful Applicant(s) (ASAs) and upon a properly made public records request.
90	Section 4.2	Regarding the incentives for being a top-scoring applicant (outlined in Section 4.2.C), please provide further detail on each of the incentives.	Section 4.2.C Total Score provides guidance on incentives that may be offered by HCA. Additional details are not available at this time.

Number	RFA Section	Question	Answer
91	Section 4.2	What is the proposed timing of the service area expansions referred to in Section 4.2.C?	Section 4.2.C includes a description of potential incentives including expansion in select counties and/or OIC geographic rating areas that may be available beginning in Plan Year 2022.
92	Section 4.2	Section 3.2. Section 1 How is the score for Section 1 calculated? In Exhibit C, HCA provides the "points awarded" for each county. Are those points awarded for responding positively to serving the county or will partial points potentially be awarded on factors such as the quality of the network? Will applicants still be considered if they apply for certain counties, but not all counties? Will applicants still be eligible for maximum points in Sections 2, 3 and 4 if they do not propose to participate in all counties? Will applicants still be eligible if they score below the maximum of 170?	Per Section 4.2, Phase 1 Section 1 - Scoring, Applicants will receive the points associated with each county for which they meet all three requirements (confirming "Yes" within Exhibit C, provide the associated county's description of building a network, and provide the enrollment data for the associated county. There will be no partial credit given if any of these three requirements is not met per county.
93	Section 4.2	Weighting of Phase One Scoring – Please explain the weighting of points. On pages 32-33, each Section 2 is listed with "maximum available" points (for example, c. Value Based Payment and Integrated Care Strategies lists "20 points maximum"). Then on page 36 (Evaluation Table – Phase 1) Section 2 questions are listed with a "Weight" (for example Value-based Payment & Integrated Care Strategies has a Weight of 2.0). Does this mean this question has a potential weighted maximum of 40? In addition, Sections 1, 3, and 4 do not list a weight.	Phase 1 Section 2 is the only section that is being evaluated using the scoring methodology described in Section 4.3. Value-based Payment & Integrated Care Strategies has a weight of 2.0. If an Applicant receives the highest available score, 10, (as described in Section 4.3) by totaling the scores from all evaluators and then averaging, the Applicant would receive 20 points for this question.

Number	RFA Section	Question	Answer
94	Section 4.2	Total Score 2022 Incentives Please provide additional information on the Plan Year 2022 incentives for the top two scoring Applicants. Please provide an example of “Special communications by HCA highlighting participation in Public Option Plans” as the HCA has done this for other carrier offerings. When will Applicants be allowed to “expand in select counties and/or OIC geographic rating areas,” and what is the “potential preference?”	See answers to question 90 and 91.
95	Section 4.2	Phase 2 Section 2 - The narrative describing this scoring on pg 34 does not match up with the chart on pg 37. How are the 20 pts evaluated for "demonstration of cost reductions?" Where is that described and detailed? Will HCA clarify the scoring methodology for this section?	Please see RFA Section 4.2, *Phase 2 Section 2 - Scoring* for the scoring outlined on pages 36 and 37.
96	Section 4.2	In 4.2 C. Total Score, HCA states that it may offer incentives including "special communications by HCA highlighting participation in the public option plans” and “potential preference to expand in select counties and/or OIC geographic rating areas” for the public option plans with the top two scores. Can HCA please describe what is intended by "special communications" and share additional information about preference to expand in select counties and OIC geographic rating areas?	See answers to question 90 and 91.

Number	RFA Section	Question	Answer
97	Section 4.2	Exhibit C, Applicant's Proposed Service Area(s), identifies the total points that can be awarded for each county. HCA explains that to receive full points, the applicant must identify the service area, projected enrollment, and describe experience building a provider network in that county. Will HCA please explain how the total points will be allocated for each component of the required response? For example, King County has a total of 1 point. Is the 1 point divided equally (.33, .33, .33) for each component? What is the objective in assigning a score based on projected enrollment? It is not clear what is being evaluated and what HCA's objective is with this component of the question. We seek clarity on how projected enrollment will be evaluated in the scoring process.	Per Section 4.2, Phase 1 Section 1 - Scoring, Applicants will receive the points associated with each county for which they meet all three requirements (confirm "Yes" within Exhibit C, provide the associated county's description of building a network, and provide the enrollment data for the associated county). There will be no partial credit given if any of these three requirements is not met per county.
98	Section 4.2	On pg. 36, HCA states that if only one of the three options are met, 45 points will be awarded. Can HCA confirm that, as a new carrier an applicant can only receive 45 out of 90 points? If this not the case, can HCA provide an example of how a new carrier might obtain 90 points? If it is not possible for a new carrier to receive the full 90 points, will HCA consider reframing the question to create equity across new carriers and current carriers on the exchange?	A new carrier will only qualify for Option 3 and thus the maximum points possible will be 45 points. Carriers with current investment in the individual market that demonstrate premium reductions based on historical trend and current offering could meet both options and be potentially eligible for 90 points.
99		If an Applicant is a corporate entity with multiple brands, will it be acceptable for the Applicant to propose offering one brand in certain counties and an alternate brand in other counties? Will it be	Yes, carriers may offer a public option plan under any of their individual market lines of business and they may be offered in the same or different counties.

		acceptable for the Applicant to offer both brands in one county?	
100	Section 1.1	Clinically Integrated Networks Does HCA have a list of networks that meet its definition of clinically integrated networks?	See answer to 68 and please refer to the definition provided in Amendment #3 in Section 1.1, Definitions.
101		Integrated Delivery Systems Does the HCA have a list of integrated delivery systems that meet its definition?	Kaiser Permanente is the only delivery system in Washington considered an integrated delivery system by HCA's standards.
102		Standard Plan – It is our understanding that "standardized plans" must be offered on the Exchange by carriers that will also offer "non-standardized" QHPs. Is the waiver for this requirement only for carriers that are new entrants to the Exchange.	All carriers that offer QHPs through the Exchange in 2021 must offer the silver and gold standard plans (and, if they offer bronze, the bronze standard plan) in any county they offer Exchange coverage. They may also offer non-standard plans through the Exchange in any counties they wish. There is no exception to this rule for new entrants to the Exchange. Note: A public option plan will be a standard plan, so if accepted, would meet the requirement for the standard plan offering.
103		Pursuant to the timeline posted in RFA 2020HCA1 Amendment 1, we had hoped to receive the revised Milliman rate schedule after submitting our Non-Disclosure Agreement, and prior to submitting safe harbor confirmation on Monday, March 30. Can you advise whether we will receive the revised rate schedule with enough time for consideration prior to submitting our safe harbor participation? Alternatively, is the safe harbor confirmation due March 30 not intended to reflect ultimate participation decisions?	Milliman anticipates to send the data associated with the Safe Harbor on or around April 3.

Number	RFA Section	Question	Answer
104	General	Throughout, the RFA provides for page limits and minimum font size. Does the HCA have a preferred font? Where page limits are provided, should the text be single spaced or does it need to be double spaced? Does the HCA prefer any particular headers, footers, or other formatting other than what's listed.	HCA does not have a preferred font. Text can be either single or double spaced. All headers, footers and formatting should be followed as described in the RFA.
105	Section 3.3	Calculating the % of Value-Based Payment - On page 37 of the RFA, it states that a yes answer means at least thirty percent of the Applicant's 2021 plan year provider contracts include value-based payment arrangements. Page 16 of the RFA (regarding the VBP Roadmap) speaks to the percent of provider payments linked to value, which is different from the percent of contracts that include VBP. Section 1.11 on page 20 of the RFA references thirty percent of provider payments. Please clarify how the HCA will measure the percentage of value-based payments. If the HCA intends to measure percentage of contracts, how will the HCA count a contract with multiple providers included, like an IPA contract?	See answer to number 39 and Amendment 3.
106	Appendix 2	CAHPS Survey - In Appendix 2, two of the Quality Metrics are tied to Patient Satisfaction with primary care, as measured by the CAHPS survey. We presume the HCA expect all payers to use the CAHPS survey. If an FQHC in network has survey results readily available, may we report their results for all of their patients? If CAHPS is indeed required, is it required for Year 1? Members will have little experience so it may not make sense to deploy at that time.	Public Option plans will be required to use the same measure specifications as outlined in Appendix 2.

Number	RFA Section	Question	Answer
107	Exhibit F	What kind of answers are sufficient in Column G of Exhibit F? May we reflect yes/no or additional text?	As stated in 3.2 Phase 1 Response Section 4, columns F and G are to be completed to establish baseline levels of compliance. The applicant is requested to provide the Carrier's Current Coverage Policy (Link or Summary) in column F. The Carrier's Assessment indicating if they are following each clinical decision is required in column G. Please limit the response to "Yes", "No" or "Not an Individual Market covered benefit". If additional comments are desired, please use a new column. Please also refer to the answer provided in question 9.
108	Appendix 2	Requirement 8, Part A - How will the reimbursement ceiling for providers and facilities be calculated for each carrier? Will it be retrospective based on claims experience within the Public Option Plan or can a carrier use its service mix from existing business to project the aggregate reimbursement?	See answers to questions 17, 18, and 35. The reimbursement ceiling will be calculated by repricing the carrier(s) claims to Medicare and comparing carrier reported allowed to this repricing. The Medicare Pricing Methodology Report (Appendix 4 of the RFA) describes this process in detail.
109	Appendix 2	Requirement 8, Part A - If aggregate reimbursement ends up exceeding the 160 percent ceiling (or Safe Harbor threshold) for providers and facilities, will the state impose penalties in addition to likely financial losses from high cost ratios?	See answers to questions 17, 18, and 35. The reimbursement ceiling will be calculated by repricing the carrier(s) claims to Medicare and comparing carrier reported allowed to this repricing. The Medicare Pricing Methodology Report (Appendix 4 of the RFA) describes this process in detail.
110	Section 1.6.1	Will the HCA provide the definition of “primary care services” as noted in the RFA below? Background pg. 18 Reimbursement for primary care services, defined by HCA, provided by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine, may not be less than one-hundred and thirty-five (135) percent of the amount that would have been reimbursed under Medicare for the same or similar services. Affordability Standards pg. 53 8. c. Reimbursement for primary care services, defined by HCA, provided by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine, may not be less than one-	HCA will provide the definitions of primary care services in the sample contract. The definitions will be the same or similar to the definitions of primary care services in the current primary care spend template (a contract requirement of all Medicaid MCOs, SEBB plans and most PEBB plans).

		hundred and thirty-five (135) percent of the amount that would have been reimbursed under Medicare for the same or similar services	
111		Plans need to update their systems to accommodate Cascade Care plans potentially: What is the timeline for requirements for reporting quality and other measures, since so much in a plan's IT system implementation depends on these data elements and related requirements? When will we know?	The reporting measures for year one were deliberately chosen to align with already existing, publicly published, community endorsed measures, that are currently required by HCA and other major purchasers. The templates for reporting quality and other measures for requirements outlined in Exhibit D will be provided in the resulting final contract.

Number	RFA Section	Question	Answer
112	Section 3.3	The RFA requirement refers to “Sample Contracts” however it asks the applicant to provide 75% of “current” 2021 Public Option Plan Year provider contracts. It then later refers to these as “example” contracts. Given that applicants do not currently offer a public option plan, and will not be able to demonstrate OIC approval until after the application date (OIC filing date 5/21 and HCA application date 5/22), please confirm applicants are to provide “sample/example” contract templates - not executed contracts - for the public option plan.	See answer to question 83.
113		Can HCA further expand on the example provided with King and Yakima rating areas and share how Milliman would provide the VBP rate?	See answer to questions 17, 18, 35 and 36.
114		If an Applicant is a corporate entity with multiple brands, will it be acceptable for the Applicant to propose offering one brand in certain counties and an alternate brand in other counties? Will it be acceptable for the Applicant to offer both brands in one county?	See answer to question 99.
115	Section 2.12	When will the contract be shared?	See response to question 59.
116	Section 1.10	Can you confirm whether applicants which submitted yes/no/maybe safe harbor participation via the LOI need to respond to the additional deadline Monday? And must applicants which respond ‘maybe’ confirm yes/no at some point in the application process?	If a Carrier has already indicated interest, they do not need to contact us again unless something has changed (specifically an issue affecting their ability to calculate Safe Harbor rates). "Maybes" should be strongly encouraged to move to a "yes". Milliman proactively calculated Safe Harbor enrollment for all "maybes", rolling up to the regional level. Milliman is considering potentially recasting the Safe Harbor provision at the end of the process.

Number	RFA Section	Question	Answer
117	Exhibit C	Exhibit C, Applicant's Proposed Service Area(s), identifies the total points that can be awarded for each county. HCA explains that to receive full points, the applicant must identify the service area, projected enrollment, and describe experience building a network.	See answer to question 4.
118	Section 1.10	If we take on Safe Harbor but technically the region is below 160% would the carrier be held to the rate below 160% or would it be 160% be the floor so to speak?	For the safe harbor protection, it will be the safe harbor regional threshold number. For compliance with the contractual requirement, the measure will be at the statewide level and is 160%.
119	Section 1.10	Are the safe harbor targets evaluated by region or statewide or both?	Safe Harbor targets are calculated at the regional level, based on the carrier provided enrollment projections and individual market average historical data on a statewide basis. Carrier(s) are evaluated, for safe harbor purposes, based on individual regional performance. In other words, carrier(s) must meet the Safe Harbor target in each and every region to avoid a corrective action plan in the case that the statewide percent of Medicare is greater than 160%.
120	Section 1.10	Due to the non-binding nature of the answers provided on bidders' call and the requirement of the March 30 confirmation of safe harbor, would HCA consider asking for confirmation after written answers to the questions are released on April 2nd?	HCA will take this under consideration.
121	Section 1.10	Will Milliman provide a detailed methodology document for determining safe harbor targets (both regular and vbp-adjusted), and when would that document be provided?	Milliman will provide a cover letter to explain the safe harbor targets as they are provided to Applicants. A detailed methodology is not anticipated.
122	General	Will HCA be hosting another Pre-Bidder Conference?	HCA has not scheduled another Pre-Bidder Conference. However, per RFA Section 1,2 HCA reserves the right to revise the schedule at any time. If HCA decides to host an additional Pre-Bidder Conference, HCA will release an amendment with indicating the date and time. Call-in information will be provided by the RFA Coordinator.

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