



**STATE OF WASHINGTON
HEALTH CARE AUTHORITY
REQUEST FOR APPLICATION (RFA)
NO. 2520
RELEASE E for Coverage Area 3**

***NOTE:** If you download this RFA from the Health Care Authority website, you are responsible for sending your name, address, e-mail address, and telephone number to the RFA Coordinator in order for your organization to receive any RFA amendments or bidder questions/agency answers. HCA is not responsible for any failure of your organization to send the information or for any repercussions that may result to your organization because of any such failure.*

PROJECT TITLE: Qualified Managed Fee-for-Service Health Homes

INITIAL APPLICATION DUE DATE: November 8, 2017, 2:00 p.m.

HCA intends to leave this RFA OPEN until a sufficient number of Apparently Successful Applicants are awarded to serve all King County eligible clients

Coverage Area 3: King County

E-mailed bids will be accepted. Faxed bids will not.

EXPECTED PERIOD OF CONTRACT: February 1, 2018 through December 31, 2019. HCA will have the option, at its sole discretion, to extend the contract for two (2) additional 2-year terms.

CONSULTANT ELIGIBILITY: This procurement is open to those consultants that satisfy the minimum qualifications stated herein and that are available for work in Washington State.

CONTENTS OF THE REQUEST FOR APPLICATIONS:

1. Introduction
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1. INTRODUCTION

1.1 PURPOSE AND BACKGROUND

The Washington State Health Care Authority hereafter called "HCA," in conjunction with the Washington State Department of Social and Health Services, Aging and Long Term Services Administration (DSHS/AL TSA) is initiating this Request for Applications (RFA) to solicit applications for designation as a Managed Fee-for-Service (MFFS) Health Home in the jointly administered Health Home Program.

1.1.1. Background

Under Washington State's approach, Health Homes are the bridge to integrate care within existing health delivery systems. Health Home implementation is authorized by Section 2703 of the federal Patient Protection and Affordable Care Act and the Managed Fee-for-Service Demonstration model. A designated Health Home provider (Lead Entity) is the central point for directing person-centered care for high-risk, high-cost Beneficiaries in a specified geographic coverage area. Each designated Health Home provider is accountable for improving the Beneficiaries' self-management abilities and reducing future cost trends, or at the very least attain cost neutrality with improved outcomes, such as a decrease in institutional readmission rates. The hallmark of the Health Home program is a care coordinator, assigned to a Medicaid or Medicare/Medicaid Beneficiary embedded in community based settings to effectively manage the full breadth of Beneficiary needs.

A designated Health Home provider must be qualified by the state of Washington Medicaid program, and agree to comply with all Medicaid program requirements. Refer to Section 1.6, Definitions.

Only Lead Entities must apply to become a Qualified Health Home. Care Coordination Organizations qualify under a Lead Entity's application by virtue of their subcontracts with the Lead Entity.

1.1.2. Purpose

The purpose of this solicitation is to provide HCA with a limited number of geographically based qualified MFFS Health Home Lead Entities. Successful bidder(s) will provide intensive Health Home services to fee-for-service high-risk, high-cost Medicaid and Medicare/Medicaid Beneficiaries to ensure services delivered are integrated and coordinated across medical, mental health, substance use disorder, and long term services and supports.

HCA intends to award a limited number of contracts per coverage area to provide the services described in this RFA based on the results from this RFA and the amount of eligible Health Home Beneficiaries within the coverage area.

1.2 OBJECTIVES AND SCOPE OF WORK

The Health Home program is available statewide, by coverage areas, with dual goals to improve the delivery of health care and social services. Health Home services will be available to both managed care and Fee-for-Service clients. The Health Home program provides an opportunity to build a person-centered system that achieves improved outcomes for Beneficiaries and increases the quality and efficiency of the State’s Medicaid program. The program also provides targeted and intensive interventions that improve health outcomes, Beneficiary’s experience in accessing and navigating the care system, and helps reduce preventable hospitalizations, emergency department visits, and unnecessary institutionalizations.

With the Health Home program there are six specifically defined care coordination services:

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, which includes authorized representatives;
5. Referral to community and social support services, if relevant; and
6. The use of health information technology to link services, as feasible and appropriate.

For a detailed description of the six care coordination services, please see Exhibit C, Provider’s Qualifications and Standards.

COVERAGE AREA & COUNTY

Coverage Area	County
3	King

HCA will qualify Lead Entities who will be responsible for delivery of Health Home services in Coverage Area 3: King County. Applicants applying to become Lead Entities for Fee-for-Service (FFS) Beneficiaries must serve the entirety of King County.

HCA is responsible to enroll FFS eligible Beneficiaries into qualified Health Homes that provide Health Home services to FFS Beneficiaries.

Health Home Beneficiaries must have at least one (1) Chronic Condition and be at risk of a second with a minimum predictive risk score of 1.5. The Chronic Conditions covered are mental health conditions, substance use disorders, asthma, diabetes, heart disease, cancer, cerebrovascular disease, coronary artery disease, dementia or Alzheimer’s disease, intellectual disability or disease, HIV/AIDS, renal failure, chronic respiratory conditions, neurological disease, gastrointestinal, hematological, and musculoskeletal conditions.

The predictive risk score of 1.5 means a Beneficiary’s expected future medical expenditures are projected to be 50% greater than the base reference group, the Washington Supplemental Security Income (SSI) disabled population. The risk score is based on the Chronic Illness & Disability Payment System and Medicaid-Rx risk groupers developed by Rick Kronick and Todd Gilmer at the University of California, San Diego, with risk weights normalized for the WA Medicaid population. Diagnoses, prescriptions, age and gender from the Beneficiary’s medical claims and eligibility history for the past fifteen (15) months (twenty-four (24) months for children) are analyzed, a risk score is calculated and Chronic Conditions checked across those meeting the other eligibility criteria. A tool will be available to manually calculate Health Home eligibility for Beneficiaries with an electronic claims history of less than fifteen (15) months that may be referred to the HCA.

1.3 HEALTH HOME PROVIDER COMPENSATION

Consideration paid to successful Applicants for Health Home services provided under a resultant contract will be paid at a monthly encounter rate for FFS participating Beneficiaries.

Per Beneficiary Per Month FFS Program Payment Rates		
Stage of Care Coordination	Total Rate	Total Administrative costs allowed
<u>Tier 1: Outreach, Engagement, and Health Action Plan</u>	\$252.93	\$25.29
<u>Tier 2: Intensive Health Home Care Coordination</u>	\$172.61	\$17.26
<u>Tier 3: Low-Level Health Home Care Coordination</u>	\$67.50	\$6.75

For a detailed description of the tiers billing instructions, see Exhibit G, Health Home Tiers for Billing.

An opportunity for a quarterly performance payment is included in the contract, see Exhibit K.

Any contracts awarded as a result of this solicitation are contingent upon the availability of funding. The rates are subject to change based on legislative direction or appropriation.

1.4 PERIOD OF PERFORMANCE

The period of performance of any contract(s) resulting from this RFA is tentatively scheduled to begin on or about February 1, 2018 and to end on December 31, 2019. Amendments extending the period of performance, if any, will be at the sole discretion of the HCA.

HCA reserves the right to extend the contract for two, two-year periods.

1.5 CONTRACTING WITH CURRENT OR FORMER STATE EMPLOYEES

Specific restrictions apply to contracting with current or former state employees pursuant to chapter 42.52 of the Revised Code of Washington. Proposers should familiarize themselves with the requirements prior to submitting an application that includes current or former state employees.

1.6 DEFINITIONS

Definitions for the purposes of this RFA include:

Affordable Care Act – Public Laws 111-148 and 111-152 (both enacted March 2010). The law includes multiple provisions that are scheduled to take effect over a matter of years, including the expansion of Medicaid eligibility, the establishment of health insurance exchanges, and prohibiting health insurers from denying coverage due to pre-existing conditions.

Allied or Affiliated Staff – Health care staff, such as community health workers, peer counselors, or other non-clinical staff that support or facilitate the work of the Health Home Care Coordinator per formal or informal delegation agreements.

Apparently Successful Applicant – The consultant selected as the entity to perform the anticipated services, subject to completion of contract negotiations and execution of a written contract.

Applicant – Individual, company, or firm submitting a proposal in order to attain a contract as a Qualified Health Home Lead Entity with HCA.

Application – A formal offer submitted in response to this solicitation.

Area Agency on Aging (AAA) – A local agency that uses state and federal resources to help older persons and adults with disabilities live in their own homes and communities as long as possible, postponing or eliminating the need for residential or institutional care (such as nursing homes). AAAs were created under the Older Americans Act of 1965.

Assignment – The process used to determine which Health Home Care Coordination Organization is responsible for delivering the six Health Home care coordination services to the Beneficiary.

Authorizing Entity – Organizations contracted by the State to approve or disapprove covered benefits for Medicaid Beneficiaries following utilization guidelines. Examples include Managed Care Organizations, Behavioral Health Organizations, and Home and Community Based Service Providers.

Behavioral Health Organization – A county authority, or group of county authorities, or other entity recognized by DSHS to administer mental health and substance use disorder services in a defined region.

Behavioral Health Services – Services that address the promotion of emotional health; the prevention of mental illness and substance use disorders; and the treatment of substance use disorders, mental illness, and/or mental disorders.

Beneficiary – A person who is eligible for Health Home services.

Broad-based Regional Provider Networks – Community entities that are composed of a broad array of service providers that are responsible to serve all Beneficiaries in a defined geographical area.

Care Coordination Organization (CCO) – The organization, within the qualified Health Home network, responsible for delivering the six Health Home care coordination services to the participating Beneficiary.

Chronic Conditions – A physical or behavioral health condition that is persistent or otherwise long-lasting in its effects.

CMS – Centers for Medicare and Medicaid Services. The Federal Agency that regulates Medicare and Medicaid.

Consultant – Individual or company interested in the RFA and that may or does submit an application in order to attain a contract with HCA.

Contractor – Individual or company whose application has been accepted by HCA and is awarded a fully executed, written contract.

DSHS – Washington State Department of Social and Health Services.

Dual Eligibles – Individuals who are enrolled in Medicare Part A and B and eligible for and receiving Medicaid and no other comprehensive private or public health coverage.

Enrollment – A process used to assign Health Home eligible Beneficiaries into a Qualified Health Home.

Federally Qualified Health Center – Community based organizations that provide comprehensive primary and preventive care, including medical, oral, and mental health/substance use disorder services to people of all ages, regardless of their ability to pay or health insurance status. Examples are Community Health Centers, Migrant Health Centers, Public Housing, and Health Care for the Homeless Programs.

Fee-For-Service – A Medicaid delivery system that provides covered Medicaid benefits to eligible Beneficiaries through any willing and contracted provider.

HCA – The Health Care Authority is the agency of the state of Washington that is issuing this RFA.

Health Action Plan (HAP) – The plan created by the Beneficiary which identifies a plan to improve their health. The HAP includes: at least one Beneficiary prioritized goal, and identification of the actions the Beneficiary and the Health Home Care Coordinator will take, including use of health care or community resources and services, in support of the Beneficiary reaching their health goal.

Health Home Care Coordinator – Staff employed by the Health Home CCOs to provide the six pre-defined Health Home care coordination benefits. Benefits must be provided through high touch, in-person visits by trained and qualified Health Home Care Coordinators.

Health Home Participation Authorization and Information Sharing Consent Form – A Health Home form signed by the Beneficiary to confirm the Beneficiary's consent to participate in the health home program and to authorize the release of information to facilitate the sharing of the Beneficiary's health information.

Health Home (HH) Services – Intensive services that coordinate care across several domains, as defined under Section 2703 of the Affordable Care Act of 2010. The purpose is to coordinate the full breadth of clinical and social service expertise for high cost/high risk Beneficiaries with complex chronic conditions, mental health, substance use disorder issues, and/or LTSS. The six services are: 1. Comprehensive care management; 2. Care coordination and health promotion; 3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4. Individual and family support, which includes authorized representatives; 5. Referral to community and social support services, if relevant; and 6. The use of Health Information Technology (HIT) to link services, as feasible and appropriate.

HIPAA – Requirements established in the Health Insurance Portability and Accountability Act of 1969, and implementing regulations, as well as relevant Washington privacy laws.

Long Term Services and Supports (LTSS) – A wide variety of services and supports that help people with functional impairments meet their daily needs for assistance in community based settings and improve the quality of their lives. LTSS are provided either in short periods of time when recovering from an injury or acute health episode, or over an extended period of time.

Managed Care Organizations (MCOs) – Health insurance companies licensed to provide health insurance in the state of Washington.

Managed Fee-for-Service (MFFS) – A community based organization that provides Health Home services to Medicaid Fee-for-Service eligible and to the Medicaid/Medicare Dual eligible population.

Medicaid – Program of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and Waivers thereof.

Medicare-Medicaid Coordination Office – Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

Memorandums of Understanding (MOU) – A business agreement for partnerships that do not involve financial arrangement which describe the roles and responsibilities of each party to the agreement.

Multidisciplinary Teams – Allied health care staff, such as community health workers, peer counselors, or other non-clinical staff to facilitate work of the Health Home Care Coordinator. Additional members of the multidisciplinary teams can be primary care providers, mental health professionals, chemical dependency treatment providers, social workers, nutritionists/dietitians, direct care workers, pharmacists, family members, or housing representatives.

Predictive Risk Intelligence System (PRISM) – A web-based tool used for predictive modeling and clinical decision support that is refreshed on a weekly basis. PRISM provides prospective medical risk scores that are a measure of expected costs in the next twelve (12) months based on the Beneficiary's disease profiles and pharmacy utilization. PRISM identifies Beneficiaries in most need of comprehensive care coordination based on risk scores. The system integrates information from primary, acute, social services, behavioral health, and LTSS payment and assessment data systems, as well as displays health and demographic information from administrative data sources.

Proposal – A formal offer submitted in response to this solicitation.

Proposer – Individual or company that submits an application in order to attain a contract with HCA.

Qualified Health Home – An entity qualified by the state to provide Health Home services to eligible Beneficiaries. Each Health Home acts as the Lead Entity responsible for administrative and oversight functions and includes a broad network of community based organizations representing

primary, acute, mental health, substance use disorder, and LTSS that provide intensive care coordination to eligible Beneficiaries.

Readiness Review – Prior to implementation, a readiness review conducted to ensure the Health Home provider has the necessary infrastructure and capacity to implement and oversee the proposed model. If gaps in readiness are identified, the Health Home provider must address these for implementation to proceed.

Request for Applications (RFA) – Formal procurement document in which a service or need is identified and individuals and companies are invited to provide their qualifications to provide the services described.

State – The state of Washington.

1.7 ADA

HCA complies with the Americans with Disabilities Act (ADA). Consultants may contact the RFA Coordinator to receive this Request for Applications in Braille or on tape.

2. GENERAL INFORMATION FOR CONSULTANTS

2.1 RFA COORDINATOR

The RFA Coordinator is the sole point of contact in HCA for this procurement. All communication between Consultants or Applicants and HCA upon release of this RFA will be with the RFA Coordinator, as follows:

Name	Angela Hanson
E-Mail Address	contracts@hca.wa.gov
Phone Number	(360) 725-1683

Any other communication will be considered unofficial and non-binding on HCA. Consultants are to rely on written statements issued by the RFA Coordinator. Communication directed to parties other than the RFA Coordinator may result in disqualification of the Applicant.

2.2 ESTIMATED SCHEDULE OF INITIAL PROCUREMENT ACTIVITIES

Issue Request for Applications	September 27, 2017
Questions Due from Applicants	October 11, 2017, 2:00 p.m.
HCA Response to Applicant Questions	October 18, 2017
Complaint Deadline	November 1, 2017
Application Submission Deadline	November 8, 2017, 2:00
Evaluate Applications	November 9 – 30, 2017
Announce “Apparently Successful Applicant(s)” and send notification via e-mail to unsuccessful proposers	December 1, 2017
Debrief Request Deadline	December 6, 2017
Hold debriefing conferences (if requested)	December 4 – 8, 2017
Protest Period	December 11 – 18, 2017

Readiness Reviews	December 19, 2017 – January 30, 2018
Contract Signature	January 31, 2018
Projected Start Date of Contracts	February 1, 2018

If HCA does not receive enough applications in this initial schedule, HCA will amend the RFA to include additional application submission deadlines and scheduled procurement activities.

HCA reserves the right to revise the above schedule.

2.3 SUBMISSION OF APPLICATIONS

ELECTRONIC APPLICATIONS:

HCA intends to leave this RFA open until a sufficient number of Apparently Successful Applicants are awarded to serve all King County eligible clients. The application for the Initial Application Deadline must be received by the RFA Coordinator by email no later than 2:00 p.m., Pacific Time, in Olympia, Washington on November 8, 2017.

Applications must be submitted electronically as an attachment to an e-mail to the RFA Coordinator, at the e-mail address listed in Section 2.1. Attachments to e-mail will be in Microsoft Word format or PDF. Zipped files are not preferred. The cover submittal letter and the Certifications and Assurances form must have a scanned signature of the individual within the organization authorized to bind the Applicant to the offer. HCA does not assume responsibility for problems with Applicant’s e-mail. If HCA email is not working, appropriate allowances will be made.

Applications may not be transmitted using facsimile transmission.

Applicants should allow sufficient time to ensure timely receipt of the application by the RFA Coordinator. Late applications will not be accepted and will be automatically disqualified from further consideration, unless HCA e-mail is found to be at fault. All applications and any accompanying documentation become the property of HCA and will not be returned.

2.4 PROPRIETARY INFORMATION/PUBLIC DISCLOSURE

Applications submitted in response to this competitive procurement will become the property of HCA. All applications received will remain confidential until the Apparently Successful Applicant is announced; thereafter, the applications will be deemed public records as defined in Chapter 42.56 of the Revised Code of Washington (RCW).

Any information in the application that the Consultant desires to claim as proprietary and exempt from disclosure under the provisions of Chapter 42.56 RCW, or other state or federal law that provides for the nondisclosure of your document must be clearly designated. The information must be clearly identified and the particular exemption from disclosure upon which the Consultant is making the claim must be cited. Each page containing the information claimed to be exempt from disclosure must be clearly identified by the words "Proprietary Information" printed on the lower right hand corner of the page. Marking the entire application exempt from disclosure or as Proprietary Information will not be honored.

If a public records request is made for the information that the Consultant has marked as "Proprietary Information," HCA will notify the Consultant of the request and of the date that the records will be released to the requester unless the Consultant obtains a court order enjoining that disclosure. If the Consultant fails to obtain the court order enjoining disclosure, HCA will release the requested information on the date specified. If a Consultant obtains a court order from a court of competent jurisdiction enjoining disclosure pursuant to Chapter 42.56 RCW, or other state or federal law that provides for nondisclosure, HCA will maintain the confidentiality of the Consultant's information per the court order.

A charge will be made for copying and shipping, as outlined in RCW 42.56. No fee will be charged for inspection of contract files, but twenty-four (24) hours' notice to the RFA Coordinator is required. All requests for information should be directed to the RFA Coordinator.

2.5 REVISIONS TO THE RFA

In the event it becomes necessary to revise any part of this RFA, addenda will be provided via e-mail to all individuals, who have made the RFA Coordinator aware of their interest. Addenda will also be published on Washington's Electronic Bid System (WEBS). The website can be located at <https://fortress.wa.gov/ga/webs/>. For this purpose, the published questions and answers and any other pertinent information will be provided as an addendum to the RFA and will be placed on the website.

HCA also reserves the right to cancel or to reissue the RFA in whole or in part, prior to execution of a contract.

2.6 DIVERSE BUSINESS INCLUSION PLAN – Exhibit F

Applicants will be required to submit a Diverse Business Inclusion Plan with their application. In accordance with legislative findings and policies set forth in RCW 39.19, the state of Washington encourages participation in all contracts by firms certified by the Office of Minority and Women's Business Enterprises (OMWBE), set forth in RCW 43.60A.200 for firms certified by the Washington State Department of Veterans Affairs, and set forth in RCW 39.26.005 for firms that are Washington Small Businesses. Participation may be either on a direct basis or on a subcontractor basis. However, no preference on the basis of participation is included in the evaluation of Diverse

Business Inclusion Plans submitted, and no minimum level of minority- and women-owned business enterprise, Washington Small Business, or Washington State certified Veteran Business participation is required as a condition for receiving an award. Any affirmative action requirements set forth in any federal Governmental Rules included or referenced in the contract documents will apply.

HCA has the following agency goals:

10% participation by Minority Owned Business

6% participation by Women Owned Business

5% participation by Veteran Owned Business

5% participation by Small Businesses

2.7 ACCEPTANCE PERIOD

Applications must provide 180 days for acceptance by HCA from the due date for receipt of applications.

2.8 COMPLAINT PROCESS

Vendors may submit a complaint to HCA based on any of the following:

- a) The solicitation unnecessarily restricts competition;
- b) The solicitation evaluation or scoring process is unfair; or
- c) The solicitation requirements are inadequate or insufficient to prepare a response.

A complaint may be submitted to HCA at any time prior to 5 business days before the application response deadline. The complaint must meet the following requirements:

- a) The complaint must be in writing;
- b) The complaint must be sent to the RFA Coordinator in a timely manner;
- c) The complaint should clearly articulate the basis for the complaint; and
- d) The complaint should include a proposed remedy.

The RFA Coordinator will respond to the complaint in writing. The response to the complaint and any changes to the solicitation will be posted on WEBS. The Director of HCA will be notified of all complaints and will be provided a copy of HCA's response. The complaint may not be raised again

during the protest period. HCA's action or inaction in response to the complaint will be final. There will be no appeal process

2.9 RESPONSIVENESS

All applications will be reviewed by the RFA Coordinator to determine compliance with administrative requirements and instructions specified in this RFA Release. The Applicant is specifically notified that failure to comply with any part of the RFA may result in rejection of the application as non-responsive.

HCA also reserves the right at its sole discretion to waive minor administrative irregularities.

2.10 MOST FAVORABLE TERMS

HCA reserves the right to make an award without further discussion of the application submitted. Therefore, the application should be submitted initially on the most favorable terms which the Consultant can propose. There will be no best and final offer procedure. HCA does reserve the right to contact an Applicant for clarification of its application.

The Apparently Successful Applicant should be prepared to accept this RFA for incorporation into a contract resulting from this RFA. Contract negotiations will incorporate some, or all, of the Applicant's application. It is understood that the application will become a part of the official procurement file on this matter without obligation to HCA.

2.11 CONTRACT AND GENERAL TERMS & CONDITIONS

The Apparently Successful Applicant(s) will be expected to enter into a contract which is substantially the same as the sample contract and its general terms and conditions attached as Exhibit K. In no event is an Applicant to submit its own standard contract terms and conditions in response to this solicitation. The Applicant may submit exceptions as allowed in the Certifications and Assurances form, Exhibit E to this solicitation. All exceptions to the contract terms and conditions must be submitted as an attachment to Exhibit E, Certifications and Assurances form. If the Applicant fails to identify or object to any particular term or condition, that term or condition will be deemed agreed to by the Bidder and will not be further discussed by HCA. HCA reserves the right to discuss any Applicant proposed change to terms or conditions and to clarify and supplement such proposal. HCA will review requested exceptions and accept or reject the same at its sole discretion.

If, after the announcement of the Apparently Successful Applicant, and after a reasonable period of time, the Apparently Successful Applicant and HCA cannot reach agreement on acceptable terms for the Contract, HCA may cancel the selection, and Award the Contract to another qualified Applicant at HCA's sole discretion.

2.12 COSTS TO PROPOSE

HCA will not be liable for any costs incurred by the Applicant in preparation of an application submitted in response to this RFA, in conduct of a presentation, or any other activities related to responding to this RFA

2.13 NO OBLIGATION TO CONTRACT

This RFA does not obligate the state of Washington or HCA to contract for services specified herein.

2.14 REJECTION OF APPLICATIONS

HCA reserves the right at its sole discretion to reject any and all applications received without penalty and not to issue a contract as a result of this RFA.

2.15 COMMITMENT OF FUNDS

The Director of HCA or his/her delegate is the only individual who may legally commit HCA to the expenditures of funds for a contract resulting from this RFA. No cost chargeable to the proposed contract may be incurred before receipt of a fully executed contract.

2.16 ELECTRONIC PAYMENT

The state of Washington prefers to utilize electronic payment in its transactions. The Apparently Successful Applicant will be provided a form to complete with the contract to authorize such payment method.

2.17 INSURANCE COVERAGE

As a requirement of the resultant contract, the Apparently Successful Applicant is to furnish HCA with a certificate(s) of insurance executed by a duly authorized representative of each insurer, showing compliance with the insurance requirements set forth below.

The Apparently Successful Applicant must, at its own expense, obtain and keep in force insurance coverage which will be maintained in full force and effect during the term of the contract. The Apparently Successful Applicant will furnish evidence in the form of a Certificate of Insurance that insurance will be provided, and a copy will be forwarded to HCA within fifteen (15) days of the contract effective date.

Liability Insurance

1. Commercial General Liability Insurance: Apparently Successful Applicant will maintain commercial general liability (CGL) insurance and, if necessary, commercial umbrella insurance, with a limit of not less than \$1,000,000 per each occurrence. If CGL insurance

contains aggregate limits, the General Aggregate limit will be at least twice the “each occurrence” limit. CGL insurance will have products-completed operations aggregate limit of at least two times the “each occurrence” limit. CGL insurance will be written on ISO occurrence from CG 00 01 (or a substitute form providing equivalent coverage). All insurance will cover liability assumed under an insured contract (including the tort liability of another assumed in a business contract), and contain separation of insureds (cross liability) condition.

Additionally, the Apparently Successful Applicant is responsible for ensuring that any subcontractors provide adequate insurance coverage for the activities arising out of subcontracts.

2. Business Auto Policy: As applicable, the Apparently Successful Applicant will maintain business auto liability and, if necessary, commercial umbrella liability insurance with a limit not less than \$1,000,000 per accident. Such insurance will cover liability arising out of “Any Auto.” Business auto coverage will be written on ISO form CA 00 01, 1990 or later edition, or substitute liability form providing equivalent coverage.

Employers Liability (“Stop Gap”) Insurance: In addition, the Apparently Successful Applicant will buy employers liability insurance and, if necessary, commercial umbrella liability insurance with limits not less than \$1,000,000 each accident for bodily injury by accident or \$1,000,000 each employee for bodily injury by disease.

Cyber-Liability Insurance / Privacy Breach Coverage: For the purposes of this subsection, the following definitions apply:

Breach – means the unauthorized acquisition, access, use, or disclosure of Data shared under any resulting Contract that compromises the security, confidentiality, or integrity of the Data.

Confidential Information – is information that is exempt from disclosure to public or other unauthorized persons under 42.56 RCW or other federal or state laws. Confidential Information includes, but is not limited to, Personal Information and Protected Health Information.

Data – means information that is disclosed or exchanged between HCA and Apparently Successful Bidder. Data includes Confidential Information.

Personal Information – means information identifiable to any person, including but not limited to, information that relates to a person’s name, health, finances, education, business, use, or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver’s license numbers, credit card numbers, any other identifying numbers, and any financial identifiers.

Protected Health Information (PHI) – means information that relates to the provision of health care to an individual, the past, present, or future physical or mental health or condition of an individual, the past, present, or future payment for provision of health care to an individual. PHI includes demographic information that identifies the individual or about which there is reasonable basis to believe, can be used to identify the individual. PHI is information transmitted, maintained, or stored in any form or medium. PHI does not include education records covered by the Family Educational Right and Privacy Act, as amended.

For the term of any resulting Contract and 3 years following its termination or expiration, the Apparently Successful Applicant must maintain insurance to cover costs incurred in connection with a security incident, privacy Breach, or potential compromise of Data, including:

Additional Provisions

Above insurance policy shall must include the following provisions:

1. **Additional Insured.** The state of Washington, HCA, its elected and appointed officials, agents and employees must be named as an additional insured on all general liability, excess, umbrella and property insurance policies. All insurance provided in compliance with this contract must be primary as to any other insurance or self-insurance programs afforded to or maintained by the state.
2. **Cancellation.** State of Washington, HCA, must be provided written notice before cancellation or non-renewal of any insurance referred to therein, in accord with the following specifications. Insurers subject to 48.18 RCW (Admitted and Regulation by the Insurance Commissioner): The insurer must give the state 45 days advance notice of cancellation or non-renewal. If cancellation is due to non-payment of premium, the state must be given 10 days advance notice of cancellation. Insurers subject to 48.15 RCW (Surplus lines): The state must be given 20 days advance notice of cancellation. If cancellation is due to non-payment of premium, the state must be given 10 days advance notice of cancellation.
3. **Identification.** Policy must reference the state’s contract number and the Health Care Authority.
4. **Insurance Carrier Rating.** All insurance and bonds should be issued by companies admitted to do business within the state of Washington and have a rating of A-, Class VII or better in the most recently published edition of Best’s Reports. Any exception must be reviewed and approved by HCA Risk Manager, or the Risk Manager for the state of Washington, before the contract is accepted or work may begin. If an insurer is not admitted, all insurance policies and procedures for issuing the insurance policies must comply with Chapter 48.15 RCW and 284-15 WAC

5. **Excess Coverage.** By requiring insurance herein, the state does not represent that coverage and limits will be adequate to protect Apparently Successful Applicant, and such coverage and limits will not limit Apparently Successful Applicant's liability under the indemnities and reimbursements granted to the state in the resulting Contract.

Workers' Compensation Coverage

The Apparently Successful Applicant will at all times comply with all applicable workers' compensation, occupational disease, and occupational health and safety laws, statutes, and regulations to the full extent applicable. The state will not be held responsive in any way for claims filed by the Apparently Successful Applicant or their employees for services performed under the terms of this contract.

3. APPLICATION CONTENTS

ELECTRONIC APPLICATIONS:

Applications must be written in English and submitted electronically to the RFA Coordinator in the order noted below:

1. Letter of Submittal – Exhibit A
2. Certifications and Assurances – Exhibit E
3. Minimum Qualifications
4. Exhibit D, Care Coordination Organization Network Spreadsheet
5. Organizational Infrastructure and Provider Network
6. Core Health Home Requirements

Applications must provide information in the same order as presented in this document with the same headings. Do not use an alternate numbering scheme. Answer each question separately. Do not combine answers to items requesting information. The responses for each major section should stand on their own and not refer to the response in another section, unless otherwise noted in the RFA. This will not only be helpful to the evaluators of the application, but should assist the Consultant in preparing a thorough response.

Items marked “mandatory” must be included as part of the application for the application to be considered responsive; however, these items are not scored. Items marked “scored” are those that are awarded points as part of the evaluation conducted by the evaluation team.

3.1 LETTER OF SUBMITTAL (MANDATORY)

The Letter of Submittal (Exhibit A to this RFA) and the attached Certifications and Assurances form (Exhibit E to this RFA) must be signed and dated by a person authorized to legally bind the Consultant to a contractual relationship, e.g., the President or Executive Director if a corporation, the managing partner if a partnership, or the proprietor if a sole proprietorship. Along with introductory remarks, the Letter of Submittal is to include by attachment the following information about the Consultant and any proposed subcontractors:

A. Identifying information about the Prime Applicant to include the following:

1. Name, address, principal place of business, telephone number, and fax number/e-mail address of legal entity or individual with whom contract would be written.

2. Name, address, and telephone number of each principal officer (President, Vice President, Treasurer, Chairperson of the Board of Directors, etc.).
3. Legal status of the Consultant (sole proprietorship, partnership, corporation, etc.) and the year the entity was organized to do business as the entity now substantially exists.
4. Federal Employer Tax Identification number or Social Security number and the Washington Uniform Business Identification (UBI) number issued by the state of Washington Department of Revenue. If the Applicant does not have a UBI number, the Applicant must state that it will become licensed in Washington within thirty (30) calendar days of being selected as the Apparently Successful Applicant.
5. National Provider Identifier (NPI), if applicable.
6. Type of lead entity (for example, Managed Care Organization, Behavioral Health Organization, Community Mental Health Agency, Substance Use Disorder Treatment Agency, Area Agency on Aging, Federally Qualified Health Center, Rural Health Clinic, Accountable Care Organization, Regional Health Alliance, Hospital, Tribal Clinic, Primary Care Medical Home). A lead entity may be more than one type. If so, list all that apply including any that may not be one of the above examples. For example, a Federally Qualified Health Center may provide medical, mental health, and substance use disorder treatment.
7. Name of the person who will have primary contact with the Health Care Authority in carrying out the responsibilities of a resultant contract.
8. Name(s) and title(s) of all persons authorized to speak on behalf of the Applicant on matters related to this solicitation.
9. Name and address of the entity that receives legal notices for the Applicant.
10. If the Applicant or any major Subcontractor contracted with the state of Washington during the past twenty-four (24) months, indicate the name of the agency, the contract number, and a brief description of the purpose of the contract(s).
11. Provide a statement affirming that by submitting a response to this solicitation, the Applicant and its key Subcontractors represent that they are not in arrears in the payment of any obligations due to owing the state of Washington, including the payment of taxes and employee benefits, and that it will not become in arrears during the term of a resultant contract if selected for contract award.

B. Conflict of Interest Information:

1. Identify any state employees or former state employees employed or on the firm's governing board as of the date of the application. Include their position and responsibilities within the Applicant's organization.
2. Identify any owner, key officer, or key employee of the Applicant that is related by blood or marriage to any employee of HCA or has a close personal relationship to same. Identify all parties, their current or proposed positions, and describe the nature of the relationship.
3. If the Applicant is aware of any other real or potential conflict of interest, the Applicant must fully disclose the nature and circumstances of such potential conflict of interest.
4. If the Applicant is both a Lead entity and a Care Coordination Organization, the Applicant must describe their methods to ensure there is no conflict of interest when assigning Health Home Beneficiaries to the other Care Coordination Organizations in their network.

If following a review of this information, it is determined by HCA that a conflict of interest exists, the Applicant may be disqualified from further consideration for the award of a contract.

Failure to disclose any real or potential conflict of interest may result in the disqualification of the Applicant or the termination for default of any contract with the Contractor resulting from an Application submitted by the Applicant.

C. References

List names, titles, addresses, telephone numbers, and e-mail addresses of three (3) business references for which contract work similar to the care coordination services proposed in this solicitation has been accomplished and briefly describe the type of service provided. The Applicant must grant permission to the HCA to contact the references. Do not include current HCA staff as references. References will be contacted for the regionally top-scoring proposal(s) only.

D. Debarment

The Applicant must certify that the Applicant, and all Subcontractors proposed to perform work under a resultant contract are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency from participating in transactions (Debarred). The Applicant also agrees to include this requirement in any and all Subcontracts into which it enters to perform work under a resultant contract. The Applicant agrees to immediately notify the Agency if, during the term of any resultant contract, the Contractor becomes debarred. The names of providers who have been debarred can be found at <http://www.epa.gov/ogd/sdd/espl.htm>.

E. Compliance with Provider Disclosure Requirements

The Applicant may be required to comply with subcontractor ownership disclosure requirements of 42 C.F.R. § 455.106, so state willingness to comply if required.

F. Prior Terminations for Default

1. Applicants must indicate whether they have had a contract terminated for default in the last five (5) years. Termination for default is defined as a notice to stop work due to the Applicant's nonperformance or poor performance, where the issue of performance was either, litigated or not litigated due to inaction on the part of the Applicant, or litigated and determined that the Applicant was in default.
2. If the Applicant has had a contract terminated for default in the last five years, the Applicant must submit full details including the other party's name, address, and telephone number. The Applicant must specifically grant HCA permission to contact any and all involved parties and access any and all information HCA determines is necessary to satisfy its investigation of the termination. HCA will evaluate the circumstances of the termination and may at its sole discretion, bar the participation of the Applicant in this solicitation.

G. Declaration of Parts of Proposal Marked as Proprietary or Confidential

The Applicant must list the page numbers and names of any proposal elements being claimed as "Proprietary" or "Confidential" (see Section 2.4). Include an explanation for each claim of confidentiality.

H. List of RFA Amendments Received

The Applicant will list all RFA amendments received by amendment issue date. If no RFA amendments were read or downloaded, write a statement to that effect. Applicant questions/HCA responses are considered an amendment to the RFA.

I. Attachments

The Applicant must include a detailed list of all materials and enclosures being sent in the proposal.

J. Certifications and Assurances

The Applicant must attach a copy of the Certifications and Assurances (Exhibit E) signed by a person authorized to bind the Applicant to a contract.

3.2 MINIMUM QUALIFICATIONS SECTION (MANDATORY)

This application is open to those public or private organizations that satisfy the minimum qualification requirements contained in this Section. The Applicant must provide evidence of a community based network that can deliver the care coordination functions and the six (6) Health

Home services, as described in Exhibit B, Essential Requirements, and Exhibit C, Provider Qualifications and Standards.

A. Assurances – The Applicant must attest that the requirements specified below are met:

1. The Applicant is currently licensed as a business in the state of Washington.
 Yes No

2. Only answer this question if your answer to number one (1) is “no.” If the Applicant is not currently licensed in the state of Washington, will the Applicant get a Washington State Business License in the next thirty (30) days?
 Yes No

3. The Applicant is a Medicaid provider in good standing.
 Yes No

 Not Applicable (for non-profit organization not currently providing Medicaid services)

4. The Applicant has completed and returned Exhibit D, Care Coordination Organization Network spreadsheet electronically.
 Yes No

5. The Applicant assures when providing Health Home services for FFS Beneficiaries, all counties in the coverage area(s) are served.
 Yes No

 Applicant is not providing Health Home services to FFS Beneficiaries

6. The Applicant assures when providing Health Home services for managed care Beneficiaries, all counties in the coverage area(s) are served, as specified by their State Apple Health managed care contract.
 Yes No

 Applicant is not providing Health Home services to managed care Beneficiaries

7. The Applicant and their subcontracted CCOs will document Beneficiary consent for Health Home participation and will share Beneficiary and treatment information in accordance with HIPAA requirements.

Yes No

8. The applicant has capacity to provide the six (6) Health Home services for no less than 300 Beneficiaries within their Health Home provider network.

Yes No

9. The Applicant assures they can provide the following services:

- a) Coordination of care and services after critical events, such as emergency department use and hospital inpatient admission and discharge;

Yes No

- b) Language access/translation capability;

Yes No

- c) Links to acute and outpatient medical, mental health, substance use disorder services and long term services and supports.

Yes No

- d) Links to community-based social support services, including housing.

Yes No

10. The Applicant assures they will subcontract with a variety of community based CCOs outside of their organization that may include Federally Qualified Health Centers; Community Mental Health Agencies and/or Substance Use Disorder Treatment Centers.

Yes No

11. The Applicant assures that if selected as a successful Health Home Lead contractor, the applicant will be able to submit Health Action Plans electronically in the specified format to OneHealthPort.

Yes No

12. The Applicant assures that if selected as a successful Health Home Lead contractor, the applicant will obtain all necessary licenses to use the Insignia Health Patient Activation tools. <http://www.insigniahealth.com/products/pam-survey>

Yes No

Applicants who do not meet the above minimum qualification will be rejected as non-responsive and will not receive further consideration. Any proposal that is rejected as non-responsive will not be evaluated or scored.

3.3 CARE COORDINATION ORGANIZATION NETWORK SPREADSHEET (SCORED)

MAXIMUM POINTS: 100

The intent of this section is to assess the Applicant’s Care Coordination Organization (CCO) network. Networks will be scored based on the data contained in Exhibit D, Care Coordination Organization Network Spreadsheet. The spreadsheet must be submitted in an electronic format in accordance with the instructions in Section 2.3, Submission of Proposals.

The spreadsheet has four (4) sections – Instructions, Definitions, Proposed CCO Network, and County Coverage Area References. Data must be entered in the correct section and clearly labeled or it will not be included in the score.

3.4 ORGANIZATIONAL INFRASTRUCTURE (SCORED)

MAXIMUM POINTS: 140

The intent of this section is to provide the Applicant with the opportunity to describe their organizational infrastructure. In order to be approved as a Qualified Health Home, the applicant must demonstrate the necessary infrastructure to administer the program and an adequate community based network to provide Health Home services. For additional information on organizational infrastructure and provider networks, review Exhibit B, Essential Requirements and Exhibit C, Provider Qualifications and Standards. *Limit twelve (12) pages total, excluding organizational chart listing/description of management staff.*

Items and Questions for Response

1. Which population(s) is the Applicant proposing to cover: (Unscored)
 - a) Medicare/Medicaid (dual eligible) fee-for-service Beneficiaries
 - b) Medicaid Fee-for-Service Beneficiaries

2. Is the Applicant proposing to be an internal CCO as well as a Lead Entity? If the Applicant is proposing to be an internal CCO, they must also agree to subcontract with external CCOs. *Checking “Yes” indicates Applicant’s intention to be an internal CCO **and** agreement to subcontract with external CCOs.* (Unscored)
 Yes No

3. Provide a complete description of your organization, including a list and description of management staff responsible for Health Home services and organizational structure. Include an organizational chart as an attachment. The list and description of management staff and the chart will not count against the required amount of pages.
4. Describe how the administrative functions will be operationalized within the Applicant's organization and the CCOs.
5. Describe your experience operating broad-based regional provider networks, such as Behavioral Health Organizations, Area Agencies on Aging, Managed Care Organizations, Hospitals, Rural Health Clinics, Federally Qualified Health Centers, Substance Use Disorder Agencies, etc.
6. Describe the process and timeline for bringing additional CCOs and Health Home Care Coordinators into the Health Home provider network to ensure the integrity of face-to-face Health Home care coordination activities.
 - a) What event would trigger the addition of CCOs or the addition of Health Home Care Coordinators?
7. Describe the process to assign and track Health Home Beneficiaries to CCOs.
8. Describe how the Applicant will ensure that hospitals have procedures in place for referring Health Home eligible Beneficiaries who seek or need treatment in a hospital emergency department for Health Home enrollment.
9. Describe how the Applicant would use Allied Staff to support Health Home activities.
10. Describe the Applicant's experience in performing administrative functions for:
 - a) Receiving enrollment and submitting encounter data in HIPAA compliant transaction formats;
 - b) Making timely payments to subcontractors;
 - c) Providing quality assurance and performance monitoring;
 - d) Subcontracting;
 - e) Analysis of Beneficiary utilization, claims, billing, and/or encounter data to detect overpayments;
 - f) Performing and tracking training and background checks of all employees, volunteers, and subcontractor staff who many have unsupervised access to children and/or vulnerable adults; and

- g) Ensuring data security requirements.
11. Describe how the Applicant will refer and ensure access for Beneficiaries who seek or need treatment/services to a Medicaid or Medicare provider.
 12. How will the Applicant ensure that roles and responsibilities for Health Home Beneficiaries are not duplicated when providing comprehensive or intensive care management?
 13. Describe the process used when a Health Home Beneficiary is moved to another Health Home or CCO:
 - a) How will the Applicant ensure continuity of the Health Home Care Coordinator and Beneficiary relationship?
 - b) How will the Applicant and CCO ensure a seamless transition when a Beneficiary moves or requests a transfer to an alternate Lead Entity or CCO?
 14. Describe the Applicant's experience with handling Beneficiary grievances and appeals.
 15. Describe how the Applicant will ensure equal access to Beneficiaries with communication barriers.
 16. Describe how the Applicant will ensure that Health Home Care Coordinators have satisfactorily completed Health Home training requirements. Health Home training requirements are listed in Exhibit K, Service Contract Format including General Terms and Conditions (GT&Cs).
 17. What data, data sources, and management systems will be used to monitor the subcontracted CCOs?
 18. The Applicant must have a designated incident manager on staff to report all instances of suspected abuse, abandonment, neglect, and/or exploitation of Beneficiaries. How will the Applicant collect and report this information to HCA?

3.5 CORE HEALTH HOME REQUIREMENTS (SCORED)

MAXIMUM POINTS: 225

The six (6) services provided under the Health Home program are non-duplicated care coordination functions. For a detailed description of the six care coordination services, please see Exhibit C, Provider's Qualifications and Standards.

Items and Questions for Response

In this section of the proposal, the Applicant should describe their organization's capabilities and capacities to meet each core requirement included in Exhibit C, Provider Qualifications and Standards. *Limit 20 pages.*

1. Comprehensive Care Management

- a) Describe how the Applicant will provide quality driven, cost effective, and culturally appropriate Health Home services.
- b) Describe how the Applicant will develop a person-centered Health Action Plan (HAP) that coordinates and integrates clinical and non-clinical health care related needs and services.
- c) Describe how the Applicant will engage Beneficiaries in establishing individualized health action goals, action steps, making behavior changes, and skills building to help manage chronic conditions when creating the HAP.
- d) How will the Applicant demonstrate a strong integrated system that is capable of providing face-to-face services in the Beneficiary's home or location of choice?
- e) What kind of preparation will take place before the Health Home Care Coordinator visits the Beneficiary?
- f) What methods will be used to guarantee cultural competency?
- g) Describe how the Health Home Care Coordinator will use the mandatory Patient Activation Measure (PAM[®]) and other screening tools when establishing a HAP.
<http://www.insigniahealth.com/products/pam-survey>
- h) Describe the process used to identify the Beneficiary's use of services including gaps in meeting Beneficiary needs. For example, describe how mandatory and optional standardized screening takes place which will inform the development of the HAP and possible referrals for additional services and supports.

2. Care Coordination and Health Promotion

- a) Describe the process that will be used to talk to the Beneficiary's treating/authorizing entities or providers when there are changes to the Beneficiary's circumstances, or conditions.
- b) Provide an example of when the Health Home Care Coordinator would need to pull together a multidisciplinary team to ensure coordination of care and achievement of Beneficiary HAP goals.

- c) Describe the process that will be used to arrange for and coordinate Beneficiary medical, behavioral health, and LTSS appointments.
- d) Describe the processes that will link Beneficiaries to community resources that will promote a healthy lifestyle.

3. Comprehensive Transitional Care

- a) Describe the Applicant's approach to providing transitions in care. Include a description of activities from admission through discharge to home or residential setting.
- b) Describe the information that will be provided to Beneficiaries that promote successful transitions.
- c) Describe the process that will be used to assure Beneficiaries have prescribed medication upon discharge and follow-up with pharmacy to get scripts filled and reconciled.
- d) Describe the process that will be used to assure timely access to follow-up care post discharge.
- e) Describe the process the Applicant would use to refer the Beneficiary for additional services when needed, such as mental health, substance use disorders, or LTSS and assurance the services were received.

4. Individual and Family Support Services (including authorized representative and identified decision makers)

- a) How will the Applicant provide education and information about applicable Chronic Conditions?
- b) How will the Applicant communicate and share information with the Beneficiary, family, and caregivers with consideration of language, activation level, literacy, and cultural preferences?
- c) How will the Applicant engage families, informal supports, and caregivers to support the Beneficiary in achieving self-management and optimal levels of physical and cognitive function?
- d) Describe the process for documenting and discussing advance directives with the Beneficiary.

5. Referral to Community and Social Support Services

- a) Describe the process for identifying community-based resources for Beneficiaries with chronic, complex health care needs.
- b) How will the Applicant actively manage applicable Beneficiary referrals and assist with access to care and services?
- c) Describe the process for assisting the Beneficiary to obtain and maintain health care services, disability benefits, housing, personal needs, and legal services.

6. Use of Health Information Technology (HIT) to Link Services

- a) How will the Applicant use health information technology to track Beneficiary assignment to CCOs?
- b) Describe the process that will be used to share the Beneficiary HAP with providers, team members, families, and caregivers.
- c) Describe how the Applicant will communicate real time use of the emergency department and inpatient hospitalizations discharge to the Health Home Care Coordinator, i.e. EDIE or Pre-Manage.

3.6 Office of Minority and Women’s Business Enterprises (OMWBE) CERTIFICATION (OPTIONAL and NOT SCORED)

Include proof of certification issued by the Washington State OMWBE if certified minority-owned firm and/or women-owned firm(s) will be participating on this project.

4. EVALUATION AND CONTRACT AWARD

4.1 EVALUATION PROCEDURE

Responsive Applications will be evaluated strictly in accordance with the requirements stated in this solicitation and any addenda issued. The evaluation of Applications will be accomplished by an evaluation team(s), to be designated by HCA, which will determine the ranking of the applications submitted for the same covered service area. Evaluations will only be based upon information provided in the Application

HCA, at its sole discretion, may elect to select the top-scoring Applicants as finalists for an oral presentation.

The RFA Coordinator may contact the Consultant for clarification of any portion of the Consultant's application.

4.2 EVALUATION WEIGHTING AND SCORING

The following weighting and points will be assigned to the application for evaluation purposes:

Care Coordination Organization Network Spreadsheet (20%)	100 points
Organizational Infrastructure and Provider Network (28%)	140 points
Core Health Home Requirements (46%)	225 points
References (06%)	30 points
MAXIMUM TOTAL POSSIBLE POINTS (100%)	495 POINTS

HCA reserves the right to award the contract to the Applicant whose Application is deemed to be in the best interest of HCA and the state of Washington.

4.3 NOTIFICATION TO APPLICANTS

HCA will notify the Apparently Successful Applicant(s) of their selection in writing upon completion of the evaluation process. Individuals or firms whose applications were not selected for further negotiation or award will be notified separately by e-mail.

4.4 DEBRIEFING OF UNSUCCESSFUL APPLICANTS

Any Applicant who has submitted an application and been notified it was not selected for contract award may request a debriefing. The request for a debriefing conference must be received by the RFA Coordinator no later than 5:00 p.m., local time, in Olympia, Washington within three business days after the Unsuccessful Applicant Notification.

Discussion at the debriefing conference will be limited to the following:

- Evaluation and scoring of the firm's application;
- Critique of the application based on the evaluation;
- Review of Applicant's final score in comparison with other final scores without identifying the other firms.

Comparisons between applications or evaluations of the other applications will not be allowed. Debriefing conferences may be conducted in person or on the telephone and will be scheduled for a maximum of 30 minutes.

4.5 PROTEST PROCEDURE

Applicants protesting this procurement will follow the procedures described below. Protests that do not follow these procedures will not be considered. This protest procedure constitutes the sole administrative remedy available to Applicants under this procurement.

Protests may be made only by Applicants who submitted a response to this solicitation document and who have participated in a debriefing conference. Upon completing the debriefing conference, the Applicant is allowed five (5) business days to file a protest of the acquisition with the RFA Coordinator. Protests must be received by the RFA Coordinator no later than 4:30 p.m., local time, in Olympia, Washington on the fifth business day following the debriefing. Protests may be submitted by e-mail or by mail.

All protests must be in writing, addressed to the RFA Coordinator, and signed by the protesting party or an authorized agent. The protest must state the RFA number, the grounds for the protest with specific facts and complete statements of the action(s) being protested. A description of the relief or corrective action being requested should also be included.

Only protests alleging an issue of fact concerning the following subjects will be considered:

- A matter of bias, discrimination or conflict of interest on the part of an evaluator;
- Errors in computing the score; or

- Non-compliance with procedures described in the procurement document or agency protest process or HCA requirements.

Protests based on anything other than those items listed above will not be considered. Protests will be rejected as without merit if they address issues such as: 1) an evaluator's professional judgment on the quality of an application, or 2) HCA'S assessment of its own and/or other agencies needs or requirements.

Upon receipt of a protest, a protest review will be held by HCA. The HCA Director, or an HCA employee delegated by the HCA Director who was not involved in the procurement, will consider the record and all available facts. If possible, a final decision will be issued within ten (10) business days of receipt of the protest. If the HCA Director delegates the protest review to an HCA employee, the Director nonetheless reserves the right to make the final agency decision on the protest. If additional time is required, the protesting party will be notified of the delay.

If HCA determines, in its sole discretion, that a protest from one Applicant may affect the interests of another Applicant, then HCA will invite such Applicant to submit its views and any relevant information on the protest to the RFA Coordinator. In such a situation, the protest materials submitted by each Applicant will be made available to the other Applicant upon request.

The final determination of the protest will:

- Find the protest lacking in merit and uphold HCA'S action; or
- Find only technical or harmless errors in HCA'S acquisition process and determine HCA to be in substantial compliance and reject the protest; or
- Find merit in the protest and provide options which may include:
 - --Correct the errors and re-evaluate all applications, or
 - --Reissue the solicitation document and begin a new process, or
 - --Make other findings and determine other courses of action as appropriate.

If HCA determines that the protest is without merit, HCA will enter into a contract with the Apparently Successful Applicant(s), assuming the parties reach agreement on the contract's terms. If the protest is determined to have merit, one of the alternatives noted in the preceding paragraph will be taken.

5. RFA EXHIBITS

Exhibit A Letter of Submittal

Exhibit B Essential Requirements

Exhibit C Provider Qualifications and Standards

Exhibit D Care Coordination Organization Network Spreadsheet

Exhibit E Certifications and Assurances

Exhibit F Diverse Business Inclusion Plan

Exhibit G Health Home Tiers for Billing

Exhibit H Guidelines for HH Staff Roles and Responsibilities

Exhibit I Health Action Plan

Exhibit J Health Action Plan Instructions

Exhibit K Service Contract Format including General Terms and Conditions (GT&Cs)