Washington State Health Care Authority

# Solicitation Amendment

## SEBB Program Fully Insured Medical Plans

## RFP No. 2716

## Amendment No. 2

**Date Issued:** June 14, 2018

**Purpose:** Revise Exhibit G – Clinical Management and Exhibit H – Operations

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

**1.** Exhibit G, **Clinical Management**, Section 2, *Clinical Management*, is hereby amended to add the following question:

b. How does the Bidder manage prescription drug coverage when transitioning members from a previous Carrier's drug formulary? The Bidder's answer should address the following:

i. The process, in detail, for transitioning members to the Bidder's formulary;

ii. Any timelines associated with honoring previous prescriptions, authorizations, or exceptions;

iii. Whether or not there is any "grandfathering;" and

iv. Communications Members receive regarding their prescription drugs.

**Please replace the original Exhibit G with the updated Exhibit G included with this amendment.**

**2.** Exhibit H, **Operations**, Section 1, *General Operational Services*, is hereby amended as follows:

<u>The following item has been deleted:</u>

k. Appeals and Complaints management process. Provide a flow chart.

<u>The following item has been added</u>:

g. Preferred Coordination of Benefits payment method (i.e., full COB, non-duplication of benefits, etc.).

**Please replace the original Exhibit H with the updated Exhibit H included with this amendment.**

**Exhibit G – Clinical Management**

## 1. Clinical Objectives

Please limit response to two (2) pages.

a. Indicate whether the outcomes for the Bidder's clinical improvements are centered around cost savings and/or increases to quality of care, and how it envisions these outcomes benefiting the SEBB Program (e.g., cost efficiency, healthier population with fewer lost workdays, long-term savings, etc.)

b. Describe how the Bidder analyzes and measures outcomes obtained from all the Clinical Management operations listed below (2-8). Provide specific examples.

## 2. Clinical Management

Please limit response to seven (7) pages.

a. The Bidder will be required to provide a certain level of care transition beginning January 1, 2020 when Members are moving from their previous Carrier's coverage to the Contractor(s) coverage. Describe how the Bidder will facilitate transitions of care for individuals with complex health conditions, or have a current active treatment plan or prior authorization, or will be hospitalized between January 1, and March 31, 2020.

    i. How will out-of-network facilities be covered if the Member cannot be transferred prior to discharge to an in-network facility of the Bidder?

    ii. How will previously approved prior authorization requests be handled? Will the Bidder "honor" the original prior authorization request so long as the service(s) or treatment plan falls between January 1, 2020 and March 31, 2020? What if the prior authorization request is with an out-of-network provider or facility?

    iii. What kind of information or data will the Bidder need from HCA to help facilitate these transitions?

b. How does the Bidder manage prescription drug coverage when transitioning members from a previous Carrier's drug formulary? The Bidder's answer should address the following:

    i. The process, in detail, for transitioning members to the Bidder's formulary;

    ii. Any timelines associated with honoring previous prescriptions, authorizations, or exceptions;

    iii. Whether or not there is any "grandfathering;" and

    iv. Communications members receive regarding their prescription drugs.

c. The Bidder will be required to report annually on its primary care spend, broadly defined as the percentage to total cost of care devoted to primary care services. Does the Bidder currently measure primary care spend?

    i. If yes, how does the Bidder measure it? Does the Bidder have a target?

    ii. If no, is the Bidder willing to start measuring it in order to provide such reporting to HCA, if awarded a Contract.

d. How does the Bidder identify specialists who provide appropriate, high quality care?

    i. How does the Bidder weigh cost relative to quality with respect to specialty care (i.e., how does the Bidder define "value" in this case)?

    ii. How does the Bidder help primary care physicians connect their patients to high quality specialists?

e. How does the Bidder work with practices to improve the practices' use of clinical data to address gaps in care or to provide optimal care management?

f. Does the Bidder collaborate with local medical and health care communities, associations, and societies during the development and implementation of medical policies? If yes, which ones?

g. What strategies has the Bidder undertaken to promote the integration of behavioral health into primary care?
    i. How has the Bidder used payment structures to support behavioral health integration (BHI) (e.g., has the Bidder created a per member per month (PMPM) methodology to support BHI in primary care)?
    ii. Does the Bidder reimburse for collaborative care codes (as defined by Medicare)?
    iii. What technical support does the Bidder provide to practices to develop integrated models?
    iv. How does the Bidder track behavioral health outcomes?
    v. Does the Bidder, or will the Bidder, implement BHI as described in the Bree Collaborative's BHI recommendations?

h. What Patient Reported Outcomes does the Bidder currently collect and report on?

i. How does the Bidder coordinate with clinics to contract for improved clinical quality, member experience, and patient outcomes?

j. Does the Bidder have an EHR system/software? If yes:
    i. What EHR does the Bidder use?
    ii. How long has the Bidder used this EHR?
    iii. Is there any intent to change EHRs in the next 3-5 years?
    iv. Is the same EHR used across all providers in the Bidder's network? Are there any exceptions or exclusions?
    v. How do providers access and make changes to Patient records? Are all changes/updates to a Patient's records made in real time and saved in real time?
    vi. Is the EHR a certified EHR system as defined by the Office of the National Coordinator?
    vii. What number and percent of clinical, subcontracted health care systems do you have an IT interoperability arrangement with to facilitate data sharing for the calculation of clinical performance measures?

k. Describe the Bidder's process and timelines for notifying providers of changes in the Bidder's medical policy that materially affects the way the plan pays for services.

l. Describe how the Bidder uses evidence-based medicine.
    i. What guidelines for evidence-based clinical practices does the Bidder use (i.e. internally developed guidelines, Bree Collaborative, American College of Physicians®)?
    ii. Has the Bidder implemented any of the Bree Collaborative best practice recommendations? If yes, please describe which ones and include any modifications made to the Bree Collaborative recommendations during implementation.

m. Does the Bidder have any condition-specific Clinical Management Services and programs, for example: maternity and high-risk pregnancies, opioid use disorder, radiology, medical infusion, Autism/ABA therapy, transgender, and other programs offered in the Bidder's Book-of-Business to other large employer group health plans?

n. What is the Bidder doing to address the opiate epidemic? Also address the following:
    i. Is the Bidder, or does the Bidder have any intent to use the Bree opiate metrics to track use of prescription opiates?
    ii. How is the Bidder working with the provider community to improve opiate prescribing?
    iii. What is the Bidder doing to provide and pay for evidence-based non-pharmacologic options for pain management?

o. How is the Bidder increasing access to Medication-Assisted Treatment (MAT) in their provider network and ensuring that providers are offering MAT to members diagnosed with opioid use disorder.

p. How do the Bidder's business practices align with:
    i. NCQA or URAC standards?

ii. HEDIS standards?

## 3. Utilization Management (UM)

Please limit response to sixteen (16) pages. Describe the Bidder's:

a. Clinical leaders responsible for the UM program, such as Medical Director/Clinical Director and Operational Director of Utilization Management, by providing a professional biography.

b. Clinical and non-clinical UM team members. How many team members are there, and what are their qualifications, roles, and functions?

c. Clinical peer reviewers. Provide the number of reviewers and their qualifications.

d. Credentialing process for clinical/medical directors, clinical peer reviewers, and all other licensed clinical reviewers.

e. Specific location (city and state) of UM operations, if any, including the identification of U.S.-based and any offshore based operations.

f. Use of Subcontractors for UM, if applicable.

g. Years of experience in providing UM.

h. Process for utilization review, including prior authorization, concurrent review, retrospective review, etc. Please address the following in your response:

   i. Process for how a provider submits a prior authorization or concurrent review request to the Bidder.

   ii. Process for determining medical necessity. Include the source of clinical guidelines and criteria the Bidder uses in UM decision making.

   iii. Process for reviewing health care services when there are no clinical guidelines/criteria (e.g. potentially experimental or investigational health care services).

   iv. Process and timeframe when a case does not meet clinical review guidelines/criteria.

   v. Specific processes for the review of behavioral health services.

   vi. Specific processes for the review of inpatient/acute health care services.

   vii. Specific processes for the review of ambulatory healthcare services.

   viii. Specific processes for the review of ambulatory healthcare services.

   ix. Specific processes for the review of services provided by Centers of Excellence (COEs) (if used by the Bidder). (If applicable.)

   x. Process for notifications when there is a denial.

   xi. Process for notifications when there is an Appeal.

   xii. Preadmission counseling process.

   xiii. Discharge planning process.

   xiv. Post-discharge follow-up process.

   xv. Process for referrals to other services, such as complex Case Management and EAP services.

i. Approach to minimizing the administrative burden of UM?

j. Systems and/or reporting integrate with other health management programs.

k. Quality Assurance and Quality Improvement processes.

l. Organizational approach, philosophy and process for UM and address the following:

   i. Process through UM to reduce medically unnecessary care.

   ii. Ability to use UM to support timely and appropriate health care services for the right care for the right patient at the right time at the right level of care.

   iii. How does the Bidder's UM facilitate appropriate and timely referrals to other benefit programs (e.g., complex Case Management)?

iv. How does the Bidder's UM support patient safety and quality of care?

v. How does the Bidder's UM support Shared Decision Making?

vi. How does the Bidder's UM improve patient and provider satisfaction?

vii. Process for analyzing utilization trends in health care services. What steps has the Bidder taken in the last five (5) years to manage patters of over- and under-utilization?

viii. Vision for the future of UM, including the roles of providers in optimally managing utilization and promoting the delivery of evidence-based care.

m. Volume of reviews for the last five (5) years, including types of reviews (i.e., prospective, concurrent, retrospective, etc.), health care services reviewed, and review outcomes (i.e., approved, denied, partial approval/partial denials) for UM.

n. Volume of Appeals for the last five (5) years, including percentage of denials appealed, and number and percentage of Appeal outcomes (upheld, overturned or partially upheld/partially overturned).

o. Volume of Independent Review Organization (IRO) cases for the last five (5) years, including percentage of outcomes (upheld, overturned or partially upheld/partially overturned).

p. Percentage of reviews completed within the OIC specified timeframes for the last five (5) years.

q. Percentage of reviews denied for medical necessity for the last five (5) years.

r. Percentage of reviews denied for reasons other than medical necessity (e.g., lack of information, administrative denials, etc.) for the last five (5) years.

s. Percentage of cases referred for other health management programs, including complex Case Management, EAP, etc., for the last five (5) years.

## 4. Quality Management (QM)

Please limit response to seven (7) pages. Describe the Bidder's:

a. Quality committees responsible for overseeing and ensuring high quality health care services to members.

b. Clinical leader's role in promoting optimal health care service delivery to members. What specific authority and assignments are within the jurisdiction of the clinical leader?

c. QM work, including its governance, scope, measurable goals and objectives, staffing structure, and staff responsibilities.

d. Specific QM efforts related to non-clinical administrative services, such as Claims administration, provider contracting, and customer service.

i. What are the key performance indicators for those non-clinical administrative services?

ii. Are any suppliers or Subcontractors involved in the QM for non-clinical services.

e. QM process results by providing a summary of the Bidder's QM activities in the Washington market, or one alternate similar market, that demonstrates improvement in coordination or management of individuals with chronic medical and Behavioral Health care conditions as a result of the Bidder's QM process.

i. What data, information, or deficiencies supported the change effort?

ii. What actions were taken to address data, information, or deficiencies?

iii. What were the structural changes, quantitative and qualitative process improvements?

iv. What were the member outcomes from these change efforts?

v. What additional actions were taken to reinforce change (both structural and procedural) once outcomes were achieved?

vi. What is the Bidder's role in relation to providers?

## 5. Complex Case Management

Please limit response to sixteen (16) pages. Describe the Bidder's:

a. Organizational approach, philosophy, and processes for complex Case Management.

b. Subcontractors used for complex Case Management, if applicable.

c. Experience (in number of years) the Bidder has in complex Case Management.

d. Number of employees and qualifications of clinical case managers and non-clinical staff members.

e. Specific location (city and state) of complex Case Management operations, including the identification of U.S. based and off shore operations, if any.

f. Number of employees and qualifications of clinical specialists for clinical consultations, including physicians and Behavioral Health practitioners.

g. Complex Case Management service delivery model.

h. Common health care conditions targeted for complex Case Management. What role does Social Determinants of Health have in the Case Management assessment or in interventions provided by the case manager?

i. Volume of cases actively enrolled in complex Case Management over the last five (5) years.

j. Communications channels available for interaction between patients/families and providers, including telephone, email, chat, text messaging, etc.

k. Process for integrating the Bidder's systems and/or reporting with other health management programs.

l. Complex Case Management protocols, assessment tools, and other resources used in the Case Management process.

m. Outcomes achieved for the Bidder's Book-of-Business.

## 6. Chronic Condition Management

Please limit response to sixteen (16) pages. Describe the Bidder's:

a. Organizational approach and philosophy for Chronic Condition Management.

b. Training process for the clinical team. How are they specifically trained to address the chronic conditions they manage, including the role and function of the clinical chronic condition manager, and the role and function of clinical specialists (including physicians and Behavioral Health specialists)?

c. Clinical team. Provide the number of staff, staff per 1,000 members, and qualifications of licensed chronic condition managers and non-clinical staff members.

d. Non-clinical support team members. What is their role and function in the Chronic Condition Management process?

e. Provider groups and delivery systems that are delegated for the provision of Chronic Condition Management.

f. Chronic conditions that are included in this program.

g. On-site (i.e., non-telephonic) Chronic Condition Management service delivery model.

h. Chronic Condition Management service delivery model that is telephonic and integrated with the patient's primary care provider or team.

i. Communication channels available for interaction between patients/families and providers, including telephone, email, chat, text messaging, etc.

j. Integration of the Chronic Condition Management systems and/or reporting with other health management programs.

k. Process for assigning patients to chronic condition managers.

l. Process and timeframe from initial patient contact to obtaining consent to assessment to Chronic Condition Management care plan finalization.

m. Process and timeframe for distributing the Chronic Condition Management care plan to the patient/family, providers, and any others.

n. Tools and resources used for patient education and Shared Decision Making.

o. Efforts to assist practices in identifying and connecting patients to community resources that support patients to better manage chronic illnesses?

    a. What efforts are taking to help these individuals pursue their health goals, such as active living, healthy diet, etc.?

    b. Does the Bidder have a means to support tracking and communication across health care and community?

## 7. Other Clinical Management Services

Please limit response to seven (7) pages. Describe the following:

a. Bidder's structure for other Clinical Management Services, including the qualifications and number of staff and other resources, for each.

b. Other Clinical Management Services that might be offered to Members. Please provide a list and description of each clinical program offered to Bidder's fully insured Book of Business.

c. The appropriate sub-population for each of the other Clinical Management Services offered by the Bidder.

d. Bidder's information technology infrastructure/platform for the other Clinical Management Services (e.g., systems used and how they integrate with each other, Claims vs. clinical).

e. How these other Clinical Management programs have impacted costs, quality, and patient and provider satisfaction.

f. How these other Clinical Management Services interact, coordinate, and integrate with Utilization Management, complex Case Management, and Chronic Condition Management.

g. How these other Clinical Management Services optimize the use of technology (e.g., email, chat).

h. How the other Clinical Management Services will coordinate and communicate with provider delivery system, provider group, etc.

## 8. Innovations in Clinical Management

Please limit response to five (5) pages. Describe the Bidder's:

a. Philosophy and guiding principles for health innovation.

b. Experience in identifying and implementing innovations in Clinical Management. The Bidder should describe experiences from previous innovation projects, including successes and lessons learned.

c. Established health innovation structure, including staff and other resources, created and dedicated to health innovation.

d. Process for on-going health innovation, particularly Clinical Management innovation.

e. Applicable experience with health innovation in Washington State, particularly with Clinical Management programs.

f. Approach to involving providers, plan sponsors, patients, and other stakeholders in health innovation initiatives.

Washington State Health Care Authority

**Exhibit H – Operations**

## 1. General Operational Services

Please limit response to six (6) pages, excluding any requested flow charts, examples, etc. Describe the Bidder's:

a. Claims processing office. Including:
   i. Where is it located?
   ii. What are the hours of operation and time zone?
   iii. How many employees work there?
   iv. How long has the office been in service?
   v. Is there a back-up Claims center?
   vi. What measures are taken to deliver a consistently high degree of Claims payment accuracy and timeliness?
   vii. What is the turnaround time for Claims processing, and what is your measure standard?

b. Willingness to propose dedicated Claims processing staff to serve the SEBB account.

c. Claims processing system. How long has the Bidder used the current Claims system? Are there any plans to switch systems in the next five (5) years?

d. Claims adjudication process through a flow chart. Include details from receipt of Claim to issuance of payment and EOB for a typical Clean Claim. If any Claims are adjudicated by Subcontractors, include separate flow charts for those entities.

e. Use of any Subcontractors to adjudicate and process Claims; specify which Claims processing services the Subcontractor provides. If Subcontractors are used for any of this work, where is the Subcontractor located? (10 extra points if no Subcontractors are used for this work.)

f. Processing of Claims that arise outside the Bidder's Washington service area, but still through the Bidder's Book-of-Business contracts. Does the Bidder have Book-of-Business contracts with providers outside of Washington State that SEBB Program Members could see if needed in non-emergent situations?

g. Preferred Coordination of Benefits payment method (i.e., full COB, non-duplication of benefits, etc.).

h. Ability to revise benefits or benefit design prior to the new plan year starting. What is the average amount of time needed to make such revisions?

i. Disaster recovery plan in detail.
   i. Provide a copy of a plan for a current client in Washington with at least 5,000 Covered Lives; include details for health care services, customer service, and Claims adjudication.
   ii. Provide a detailed disaster recovery plan for the SEBB Program account for health care services, customer service, and Claims adjudication. Include where back up office locations, account management, Claims adjudication, and customer services would be provided from, and the number of back-up personnel available in emergency situations, and their location.

j. Fraud, waste, and abuse process. Provide a copy of each.

k. Subrogation process.

l. Ability to accept the customized HIPAA 834 compliant eligibility file found in Appendix 4 – *HIPAA 834 Compliant Eligibility File.* Appendix 4 – HIPAA 834 Compliant Eligibility File If the Bidder is unable to accept this format currently, will the Bidder be able to accept it by February 28, 2019? If not, provide an estimated date by when the Bidder will be able to accept the HIPAA 834 file.

m. Delivery date for member identification (ID) cards after the SEBB Annual Open Enrollment ends (number of calendar days).

n. Turnaround time for member identification (ID) cards by completing the following Table 3:

*Table 1*

| | Plan Standard | 2017 Actual |
|---|---|---|
| New Member (newly eligible School Employee during the plan year) | | |
| Replacement card | | |

If ID cards are out-sourced, please identify the vendor: _____

## 2. Member and Customer Services

Please limit response to eight (8) pages. Describe the Bidder's:

a. Customer service center and staff. Bidder must include the following in their response:
   i. Proposed SEBB Program customer service center location;
   ii. Hours of operation (specify time zone);
   iii. Size of SEBB Program support staff and to what extent the Bidder will commit dedicated customer service representatives to the SEBB account;
   iv. Whether customer service staff would perform other roles, such as processing Claims; and
   v. The number of member lives the Bidder's customer service center currently supports.

b. Current customer service staffing ratio (staff to customers/members) and its annual customer service staff turnover rate.

c. Ability to participate in-person in the SEBB Program's Annual Open Enrollment benefit fairs, covering topics such as benefits and cost-sharing, network providers, Claim procedures, member services, and informational tools and resources.

d. Customer service phone system. Identify all features currently offered by Bidder's customer service phone system, using the following list:

☐ Toll-free Customer Service number

☐ Call triage process (i.e., a phone tree)

☐ Members' calls are queued in the order received

☐ Call-back feature (so members don't have to wait on hold)

☐ Access to Customer Service after hours

☐ Message system; member can leave a message with a call back the next Business Day

☐ Health plan recorded message (i.e. hours of operation, in case of emergency instructions)

☐ Interactive Voice Response System (IVR)

☐ Other (specify): _____

e. Process to implement and prioritize client IT projects.

f. Available language translation services.

g. Accommodations for members who are sight, hearing, and/or speech impaired, in accordance with the ADA.

h. Process for how it would provide seamless customer service coordination with SEBB Program benefits services and other HCA vendors.

i. Process for members to provide feedback or file Grievances of plan operations and how Grievances are resolved. Please include the escalations process the Bidder uses when a member requests to speak with customer service management.

j. Customer service training program, Quality Control monitoring, and auditing processes. Describe the customer service representative account onboarding process. Include additional proposed annual customer service training on Open Enrollment.

k. Process to provide feedback from Members to HCA. What cadence does the Bidder propose? What if feedback was urgent (needs reviewed within 24 hours) and needed escalation to HCA?

l. Performance measures that staff, supervisors, managers, and directors are expected to adhere to and how they have been met them over the last two (2) years.

m. Customer service performance standard measures. Bidder must respond by completing the following Table 4:

*Table 2*

| Measure | Plan Standard | 2016 Actual | 2017 Actual |
|---|---|---|---|
| Average speed to answer (measured from the time the call begins to ring in the Contractor's customer service center) | | | |
| Average call abandonment rate | | | |
| Average time for member issue resolution from initial notification | | | |
| First-call resolution percentage (member's issue is resolved to their satisfaction during first call) | | | |
| Customer Service Satisfaction Annual Survey | | | |

n. Methods offered to members to communicate with the Bidder for general and billing questions, communication with a provider, etc. and how the Bidder responds. The response should include the types of transactional activities members can conduct via the Bidder's website. If members are able to submit questions to the Bidder's customer service office via email, what is the normal response time?

o. Business processes, policies, and procedures used to ensure safeguards are in place for PHI when communicating with subscribers by email. Are emails secure?

p. Method used to assist patients in managing billing and insurance issues with providers.

## 3. Communications

Please limit response to six (6) pages, excluding any requested flow charts, examples, etc. Describe the Bidder's:

a. Ability and resources to write, design, print and distribute the following materials for each of the Bidder's potential contracted SEBB Health Plans and provide an example of each:
    i. Summaries of Benefits and Coverage documents that are readable and comprehensible, to include, but may not be limited to: Statements of Benefits and Coverage (SBCs) and COCs.
    ii. Benefit summary comparison documents and other coverage documents.
    iii. Print copies of provider directories.
    iv. Informational materials, including summaries of what is changing in each plan for each new plan year.
    v. Web services promotional page.
    vi. Postcard for members to submit to request a print copy of the COC.
    vii. Disclosure items required by the applicable part of the Washington State Health Care Patient Bill of Rights described in RCW 41.05.017.
    viii. ID cards
    ix. Enrollment welcome packet
    x. EOB
    xi. Appeal pending, approval, and denial letters
    xii. Claims denial letters
    xiii. Disenrollment letter
    xiv. Wellness Program, including any health risk/wellbeing assessment
    xv. HSA collaterals
    xvi. Case Management Programs.
    xvii. Other communications as directed and approved by HCA (i.e., mid-year benefit changes that HCA is legally required to make).
b. Ability to write the COCs for the Bidder's potential contracted SEBB Health Plans annually, with approval from HCA, so they are compatible with the Bidder's administration of the plan and HCA's responsibility for defining eligibility and enrollment terms.
c. Process for distributing hard copies of the annual COC or other materials to Members, HCA staff, and Enrollees upon request.
d. Ability and resources to write, design, print, and provide an internet-ready and ADA-compliant electronic documents for each of the Bidder's potential contracted SEBB Health Plans.
e. Ability to distribute HCA-requested materials at Open Enrollment benefit fairs. The materials may include, but not be limited to:
    i. HCA materials.
    ii. Other HCA vendor materials.
    iii. SEBB Health Plan Wellness Program materials.

f. Ability and resources to write, design, print, and distribute a hard copy welcome packet for new Members (within thirty (30) Business Days of enrolling) and in future years, reenrolling Members (no later than December 20 of each year). These materials may include:

   i. Cover letter.

   ii. Wellness promotional piece (one page).

   iii. Notice of Privacy Practices (print and distribute only).

   iv. Web services promotional piece.

   v. Postcard to request a hard copy of the COC.

   vi. Other materials, including other vendor materials, as requested by the HCA.

   vii. SEBB Health Plan Wellness Program materials.

g. Ability and resources to design, print and distribute identification cards or replacement cards at no charge to all Members. Identification cards shall display the ASB's logo, and any other information needed by providers and Members to access benefits.

h. Ability and resources to provide both printable and online EOBs in one online portal for each of the Bidder's plans.

i. Ability to reissue identification cards to all Members at no charge to Members or the state, when significant information changes are needed.

j. Ability and resources to update and provide an internet-ready and ADA-compliant PDF and distribute the federal Summary of Benefits and Coverage to all Members in all the ASB's contracted SEBB Health Plans. Show how the Bidder will follow federal formatting standards and guidelines, and provide all documents in alternate formats and required languages.

k. Willingness to dual brand all communications with the HCA and the appropriate plan or network logo and name, unless the HCA requests single branding.

l. Other clients or customers that have discontinued or significantly decreased the amount of printing and mailing of materials to their members. Include how this was achieved, and the associated cost savings to the client or customer.

m. Current methods of communicating with members electronically, including but not limited to email, mobile applications, and other methods.

n. Information shared with Members upon enrollment and annually. Include examples of the unique information the Bidder shares to encourage preventive and appropriate use of care.

o. Communication with Members over a calendar year to educate them about health care services and promote wellness behavior. Provide two (2) examples of how the Bidder shares this information.

p. Intent to obtain advanced written approval from the HCA Account Manager or the HCA Communications staff for any and all ADA-compliant communication sent to Members and Enrollees.

q. Ability to ensure all communications sent will relate directly to the Bidder's contracted SEBB Health Plans. The Bidder may not send, help or allow any other person or entity to send any communications to Subscribers, Members, or Enrollees except those relating directly to the Bidder's contracted SEBB Health Plans, unless authorized in writing in advance by the HCA.

r. Acceptance of HCA approval for any and all Contractor developed communications related to SEBB Health Plans.

## 4. Online Services

Please limit response to six (6) pages. Describe the following:

a. How the Bidder complies with ADA requirements for online services.

b. Whether the Bidder will have a dedicated microsite for its SEBB Health Plans, or if Members will access plan information through the Bidder's Book-of-Business online services page.

c. Whether Enrollees can access public information regarding the ASB's contracted SEBB Health Plans online. If yes, describe the kinds of information that would be publically available.

d. Bidder's capability to provide Members with secure access to account information online. This would require secure sign-in, and a portal that includes PHI, such as services a Member has received. Describe the Bidder's capability to meet the following:

   i. Sign-in security approach that achieves the OCIO security standards (see, Appendix 2 – *OCIO Standard 141.10 – Securing IT Assets* ) and in coordination with other vendors that provide Member online services to ensure a single sign-on across sites.

   ii. Ability for Members to login from the Bidder's SEBB Program-specific microsite.

   iii. Personal and family Claims history that complies with HIPAA privacy requirements (e.g., some family members may need to be masked on diagnosis or age-related Claims), accumulator status, deductible status, and out-of-pocket maximum status.

   iv. Secure email to and from customer services.

   v. Ability to administer incentives via online accounts.

e. How the Bidder ensures dependents age 13 and older have their diagnoses and health care services kept private from the subscriber?

## 5. Member Engagement and Experience

Please limit response to seven (7) pages. Describe the Bidder's:

a. Member-oriented websites, including desktop and mobile optimization.

   i. Is the website built and maintained by the Bidder or by an external vendor?

   ii. How often are maintenance updates conducted?

   iii. Do maintenance updates disrupt member access? If yes, what does the Bidder do to try to limit disruption?

b. Member-oriented website features, capabilities, and information members can access through the website. Provide **the link** to where members can access their information, along with a **dummy login** and **password** credential so HCA evaluators can test the features and capabilities of the resource. Check all of the features, capabilities, and information below that apply to the Bidder's website:

   ☐ Appeals

   ☐ Benefits and coverage

   ☐ Bidder's contact information

   ☐ Case Management

   ☐ Chronic Condition Management

   ☐ Claims look-up

   ☐ Clinical policies

   ☐ Costs for services owed by subscriber

- ☐ Cost transparency tool (cost estimates; cost by provider, etc.); provide the link if available to the public:
- ☐ Customer service messaging, such as instant messaging or texting with the Bidder
- ☐ Discount programs
- ☐ Explanation of Benefits look-up/print
- ☐ FAQ
- ☐ Health coaching
- ☐ Maternity programs and/or information
- ☐ Member accumulators; describe which are available for the member to access through the Bidder's website (i.e. deductibles, out-of-pocket maximum, etc.)
- ☐ Member forms and documents; describe which forms and documents are available for members to view and or download:
- ☐ Member notices:
  - ☐ Members review prior authorization request status (Check the box if "yes.")
  - ☐ Members review Appeal/Grievance status (Check the box if "yes.")
- ☐ Nurse line
- ☐ Patient rights
- ☐ Payments to providers
- ☐ Pharmacy benefits
- ☐ Print or order new cards
- ☐ Provider messaging and/or text messaging
- ☐ Set-up personalized accounts
- ☐ Shared Decision Making tools that include cost and outcome comparisons of alternative treatments
- ☐ Telehealth information (phone number, email address, links, etc.); describe which modalities are accessible through the website:
- ☐ Tools to help a Member select a primary care provider
- ☐ Up-to-date provider directory search. If applicable, check all of the information available to Members:
  - ☐ Accepting new patients
  - ☐ Language(s) provider speaks
  - ☐ Provider contact information (physical address, phone number)
  - ☐ Provider name
  - ☐ Provider network status
  - ☐ Provider ratings (quality, review, etc.)
- ☐ Wellness tools/program

☐ Others; describe each:

c. Current tools and resources available to the Bidder's members for self-management. Can they be integrated with an outside wellness program? If yes, explain how.

d. Promotion of tools and applications that make it easier for patients to conduct health care related transactions, including the ability to:

   i. Schedule appointments online.

   ii. Request prescription refills online.

   iii. Communicate with a provider online.

   iv. Conduct physician appointments over the phone or online (telehealth services).

   v. Any expert medical opinion (EMO) services available for patients.

e. Tools available for use by employers through the Bidder's website.

f. Experience with and approach to supporting and encouraging the use of Shared Decision Making tools in provider agreements, patient communications and patient resources. If Bidder does not use Shared Decision Making tools, describe how these will be incorporated into future plans.

g. Compliance with ADA requirements in all communication methods and how the website supports a culturally and linguistically diverse patient population.

h. Process to educate members on low value care so that they avoid treatments that are medically unnecessary and potentially harmful.

i. Helps members develop and maintain a relationship with a primary care provider.

## 6. Health Savings Account (HSA) Administration

Please limit response to one (1) page.

a. If offering a high-deductible health plan with an HSA, who will administer the Bidder's HSA for eligible Members?

b. Describe the Bidder's capability and capacity to send HSA representatives to all SEBB Program Annual Open Enrollment benefit fairs throughout the State of Washington beginning in the fall of 2019 and continuing through the full term of the Contract(s). Please note, it is not yet known what the Annual Open Enrollment benefits fair schedule will be or where they will be held. These representatives should be trained in the details of HSA accounts.

c. The ASB will be required to provide all services and fulfill all duties necessary to comply with the administration of the HSA accounts. Describe how the Bidder will ensure its HSA Trustee will comply with all federal and state laws.

d. Describe any challenges the Bidder would face if HCA required Bidder to use a specific HSA vendor.

## 7. Appeals and Complaints

Please limit response to six (6) pages, excluding any requested flow charts, examples, etc.

a. Provide an overview of the entire Appeals process. Please include the following in your response:

   i. How Appeals are received;

   ii. How decisions are made;

iii. Who is involved in the decision making process (include the title and qualifications for each person);

iv. Completion timelines;

v. How and when members are notified that their Appeals have been received and of their results; and

vi. In which circumstances clients are notified of Appeals being processed by the Bidder, such as in the event of an Appeal that is being escalated.

b. Does the Bidder's Appeals process meet or exceed the OIC's timeline standards from processing Appeals?

c. Describe the Bidder's responsible department for processing Appeals and its location (e.g., locally or nationally). If Appeals will not be handled locally, describe how processes will be coordinated to assure compliance with applicable timelines defined by the Washington Patient Bill of Rights and potentially other requirements, such as contractual requirements?

d. Describe the roles, responsibilities, titles, credentials (including types of licenses and certifications held by clinicians), and processes associated with medical necessity Appeals.

e. Provide the most recent quarterly report of first- and second-level Appeal results that show the number and percentage of Appeals overturned at each level. Provide a similar report of IRO results.

f. Describe how Appeal results are used to improve Claims processing, Member service and prior authorization processes when the ratio of overturned Appeals is high in a particular area or for a specific benefit.

g. Describe and provide two (2) examples of how Grievance and Appeal information is used to inform the Bidder's business processes, such as staff training, Utilization Management decision-making, and Member experience (data collection or improvement activities). Describe how data is used to improve performance of network-provider feedback and training.

h. Provide an overview of the Complaint process. Include how a Complaint is received, how Complaints are differentiated from Appeals, how decisions are made, which people (state their titles and qualifications) are involved, completion timelines, how and when members are notified that their Complaints have been received and their results, and in which circumstances the HCA would be notified.

i. Describe the methods for communicating Member rights and responsibilities information to Members and providers.

## 8. Overall Account Administration

Please limit response to five (5) pages, excluding any requested flow charts, examples, etc.
Describe the Bidder's:

a. Provision of sufficient, experienced subject matter experts to manage all contracted functions for the size and complexity of this account including:

i. Participation in quarterly account management meetings with HCA staff to be held at the HCA headquarters in Olympia, WA.

ii. Participation in activities to analyze plan performance, identify improvement opportunities, design interventions, and coordinate implementation with the HCA.

iii. Participation in Healthier Washington, community-based health improvement activities and interagency coordination efforts of the five (5) Washington State health care purchasing agencies plus Washington State Board of Health, and the OIC, to:

- Develop common policies, support, and implement the work the Bree Collaborative as requested by the HCA.
- Design and implement health care reform across the Washington State health care purchasing system.

iv. Ensure the account management team is responsive to the HCA's inquiries, contacts and requests, and keeps the HCA informed of new and outstanding issues.

v. Report monthly and quarterly performance including key features of plan operations (including administrative and Clinical Management Services) covered and presentation of analyses and recommendations in response to reported performance outcomes.

vi. Inform the HCA Account Manager(s) of state and federal law changes within fifteen (15) Days of notification.

vii. Attend all public meetings of the SEB Board in person or by phone.

b. Capacities and approaches to customer relations, provider relations, and public relations when administering public sector health plans in a highly transparent and politically active environment. Specifically address Bidder's past experience and successes in managing situations involving negative media exposure about health plan policy and operations, oppositional lobbying efforts or special interest groups, provider associations, etc. and direct reporting of Complaints and Grievances to the Governor, Governor's senior staff, or cabinet-level agency heads regarding your entity's performance.

c. Ability to respond to legislative requests for written information, budget analysis, and data for HCA within a 24-hour timeframe.

## 9. Account Resourcing

HCA is looking for ASBs that can provide employees who will be knowledgeable, attentive, and responsive to HCA's administrative needs, which may be urgent or need a 24-hour turnaround time. The ASB should provide employee resources in the following areas: medical director, account management, clinical management, data analytics, communications, implementation, Information Technology (IT), and customer service. Depending on the number of SEBB Program Members a Contractor has enrolled on their SEBB Health Plan(s), HCA may ask for a dedicated account manager.

Please limit response to two (2) pages, excluding any requested flow charts, examples, etc.

a. Describe all the full time employees who will be dedicated to this account, and provide:

i. Name, title, phone number, and email address;

ii. Full professional biographies for each employee, to include any licenses held, credentials, educational levels, years of experience, the capacity in which the employee has worked for the Bidder, etc.;

iii. The location of each employee.

## 10. Emergency Response Account Management

Please limit response to three (3) pages.

a. Describe the Bidder's emergency response approach to maintain uninterrupted core business and clinical operations during natural disasters or other system outages.

b. Describe the kinds of abnormal events to which the Bidder's emergency response applies.

c. Define what the Bidder classifies as core business and clinical operations and give specific information that clearly relates the emergency response approach to the Bidder's Book-of-Business operations.

d. Describe the Bidder's backup locations and methods to ensure customer and claims data is maintained during and after emergency response.

## 11. Implementation Plan

ASB(s) must provide a comprehensive implementation plan for the time period from December 3, 2018 through December 31, 2019. Below is a description of the work that must be included in the Bidder's implementation plan as well as expected milestone deadlines for completion of the different phases. Please provide a detailed implementation plan that addresses all key operational areas.

Please limit response to ten (10) pages, excluding the implementation plan.

a. Describe the structure of Bidder's implementation team:
    i. Names, roles, responsibilities, and experience level of team members. Identify which team members will be dedicated to the implementation of the SEBB account.
    ii. Staffing plan for implementation team and key account team members listed in section 8, *Account Resourcing* of this exhibit. All must be active on the account during the RFP evaluation phase, including oral presentations.

b. Provide a detailed project management implementation plan, including assigned staff and other resources, project management support, work breakdown structures, contingencies, strategies, and tactics.

c. Provide an implementation plan that addresses the following key areas and meets the key milestone due dates listed below.
    i. On December 3, 2018, start OCIO design review process for the Bidder's technical implementation (For more information, see Appendix 2 – *OCIO Standard 141.10 – Securing IT Assets* and Appendix 3 – *WATech OCS Design Review Checklist* ).
    ii. By April 1, 2019, ensure that the following will be fully tested, accepted, and operational:
        - Transition of care processes for Members receiving treatment for life-threatening or certain other conditions, such as pregnancy.
    iii. By July 15, 2019 finalize:
        - All elements necessary to integrate the SEB Board approved wellness plan are operational.
        - Completed HCA clinical audit. Clinical Management programs are essential to ensure that the HCA is receiving the expected value and outcomes from the ASB. A Clinical Management audit may be completed by HCA or an appointed third party.
    iv. By August 1, 2019, submit:
        - Identification of key knowledgeable staff to support and attend benefit fairs.
        - Detailed project disaster plans for customer service and Claims adjudication.
        - A change management plan that addresses the impact of network changes on both the provider and Member community.
        - A completed Claims Payment Audit that adheres to the following:
            - A professional audit of sample Claims after the ASB completes its system programming for 2020 benefits and Claim processing, and before live Claim processing commences January 1, 2020.
            - The ASB will perform a series of sample Claim adjudications of various types of Claims (hospital, professional, ancillary, Medicare and non-Medicare COB, etc.)

so auditors may confirm the ASB's Claim system is ready to accurately process SEBB Health Plan Claims, all necessary plan features are correctly programmed, and accumulators are working.

- Cooperation with auditors and expedition of the audit as needed. This audit will be performed by independent, professional auditors contracted at the expense of the ASB and completed (including corrective actions) by this date.
- Additional processes, such as Appeals and Complaints, may be added to this implementation audit at HCA's sole discretion.

v. By August 1, 2019, ensure that the following will be fully tested, accepted, and operational:

- Eligibility systems, including the ability to accurately accept and load the HCA's eligibility file.
- All required data transfers and/or integrations with other HCA vendors, such as a wellness program vendor.

vi. By September 2, 2019, finalize:

- A fully operational customer service center and system that meets the required customer service standards available for Members, or for Enrollees that have questions regarding the ASB's contracted SEBB Health Plans, or who may be considering joining the ASB's contracted SEBB Health Plans.
- Final programming of any benefits specific to the Contractor's SEBB Health Plan(s) and plan provisions.
- Programming of SEBB Program benefits and plan provisions.
- Open Enrollment items including communication materials.

vii. By September 30, 2019, ensure that:

- No more than 0.5% of the eligibility files fail to reconcile.
- Customized Member websites for the ASB's contracted SEBB Health Plans are fully developed, tested, and launched.
- All Claims and provider networks are included in one resource for Members to receive EOBs and Claims information (electronically and paper based) and search for providers.
- Customized Member websites for the ASB's contracted SEBB Health Plans.
- The Claims adjudication (benefits and plan provisions) system is fully operational.
- All SEBB Health Plans are operational.

## 12. Disabled Dependent Certifications

Please limit response to five (5) pages, excluding any requested flow charts, examples, etc.
The responsibility for disabled Dependent certifications will be the Contractor(s). Describe the Bidder's disabled Dependent certification process:

a. How are new certifications processed? Include timelines.

b. How are re-certifications processed? Include timelines, to include how many Days in advance of the member losing coverage does the Bidder reach out to them to begin the re-certification process.

c. What does the Bidder do if they need more information?

d. Provide examples of any letters sent to the Member (approvals, denials, requests for additional information, etc.).

e. What percent of certifications needed an extension for completion in 2016 and 2017?

## 13. Annual Renewal for Renewal (RFR) Process

Please limit response to ten (10) pages. Describe the Bidder's:

a. Experience partnering with other large employers on annual strategic initiatives.

b. Resources for responding to and implementing annual proposals through HCA's RFR process (the RFR process is discussed in section 1.6, *Statement of Work*, subsection F, item 19).

c. Process for absorbing any costs of these implementations each year within the premium.