



STATE OF WASHINGTON  
HEALTH CARE AUTHORITY

**REQUEST FOR PROPOSALS (RFP)**

**RFP NO. 2716**

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

**PROJECT TITLE: SEBB Program Fully Insured Medical Plans**

**PROPOSAL DUE DATE:** August 2, 2018 by 4:00 p.m. *Pacific Time*

Only hard copy/physical Proposals and e-mailed Proposals will be accepted. Faxed Proposals will not.

**ESTIMATED TIME PERIOD FOR CONTRACT:** The Washington State Health Care Authority (HCA) estimates the Contract(s) will be signed in November 2018. Benefit plans and Member services will not begin until January 1, 2020, but an extended period of Implementation is expected. Implementation will begin immediately following Contract execution. The initial term of the Contract(s) will extend through December 31, 2023. Thereafter, Contract(s) may be extended for up to an additional eight (8) years in increments of not less than one (1) year, at the sole discretion of the HCA.

**BIDDER ELIGIBILITY:** This procurement is only open to those Bidders that: (1) responded to all mandatory elements of the HCA's Request for Information (RFI) 2646; and (2) satisfy the minimum qualifications stated herein. Failure to meet either of these requirements will result in the rejection of such bid prior to evaluation and scoring.

<b>1. INTRODUCTION.....</b>	<b>5</b>
<b>1.1. Purpose.....</b>	<b>5</b>
<b>1.2. RFP Approach.....</b>	<b>6</b>
<b>1.3. Background .....</b>	<b>6</b>
A. Eligibility Administration of Plan.....	7
B. SEBB Program Population.....	7
C. PEBB Program Population.....	8
D. SEB Board Regulatory Environment.....	8
E. Wellness Program .....	8
F. Marketing Benefit Participation .....	9
G. Other Contractors and Partners .....	9
<b>1.4. HCA's Strategic Vision.....</b>	<b>10</b>
A. Paying for Value – The HCA's Purchasing Strategy .....	11
B. Health Transformation Vision: HCA Value-based Roadmap .....	11
C. Innovative Leadership and Administrative Support .....	12
D. Support of Value Based and Alternative Payment Models.....	12
E. Member Engagement and Experience .....	13
F. Data Reporting and Analytics .....	13
<b>1.5. Objectives .....</b>	<b>13</b>
<b>1.6. Statement of Work .....</b>	<b>13</b>
A. Health Plan, Network, and Service Areas .....	13
B. Participate in Health Transformation .....	14
C. Innovative Leadership and Administrative Support .....	14
D. Member Engagement and Experience .....	15
E. Data Reporting and Analytics .....	16
F. Plan Administration .....	17
G. Clinical Services.....	18
H. Account Management .....	18
I. Eligibility and Systems.....	18
J. Implementation .....	18
<b>1.7. Minimum Qualifications .....</b>	<b>18</b>
<b>1.8. Funding .....</b>	<b>19</b>
<b>1.9. Period of Performance.....</b>	<b>19</b>
<b>1.10. Contracting with Current or Former State Employees .....</b>	<b>20</b>
<b>1.11. Abbreviations and Definitions.....</b>	<b>20</b>
<b>1.12. ADA .....</b>	<b>26</b>
<b>2. GENERAL INFORMATION FOR BIDDERS .....</b>	<b>26</b>
<b>2.1. RFP Coordinator .....</b>	<b>26</b>
<b>2.2. Procurement Schedule.....</b>	<b>26</b>
<b>2.3. Pre-Proposal Conference .....</b>	<b>27</b>
<b>2.4. Bidder Questions Periods.....</b>	<b>27</b>

2.5.	Posting on WEBS .....	27
2.6.	Bidder Responsibilities.....	27
2.7.	Multiple or Alternative Proposals.....	28
2.8.	Approach to Subcontracted Services .....	28
2.9.	Proprietary Information / Public Disclosure.....	28
2.10.	Revisions to the RFP .....	29
2.11.	Diverse Business Inclusion Plan.....	29
2.12.	Acceptance Period .....	29
2.13.	Complaint Process .....	29
2.14.	Responsiveness .....	30
2.15.	Most Favorable Terms .....	30
2.16.	Contract Term .....	30
2.17.	Mandatory Contractual Terms .....	30
2.18.	Contract Delay Contingency .....	31
2.19.	Implementation / Timeframe.....	31
2.20.	Request for Completion Process (RFC Process) .....	31
2.21.	Costs to Propose.....	32
2.22.	Receipt of Insufficient Number of Proposals .....	32
2.23.	Cancellations, Acceptance, Administrative Irregularities, and Discussions .....	32
2.24.	Commitment of Funds .....	33
2.25.	Electronic Payment.....	33
2.26.	Insurance Coverage .....	33
3.	<b>PROPOSAL CONTENTS AND REQUIREMENTS.....</b>	<b>35</b>
3.1.	Proposal Contents Overview .....	35
3.2.	Proposal Format and Length .....	35
3.3.	Proposal Submission.....	36
3.4.	Master Letter of Submittal (Mandatory).....	37
3.5.	Plan Design(s) and Service Area(s) (Mandatory).....	38
3.6.	Evaluation Elements (Mandatory and Scored) .....	38
4.	<b>EVALUATION AND CONTRACT AWARD .....</b>	<b>39</b>
4.1.	Evaluation Procedure.....	39
4.2.	Evaluation Weighting and Scoring .....	40

4.3.	Notification to Bidders.....	42
4.4.	Debriefing of Unsuccessful Bidders .....	42
4.5.	Protest Procedure.....	43
5.	<b>EXHIBITS.....</b>	<b>45</b>
	Exhibit A – Certifications and Assurances.....	46
	Exhibit B – Diverse Business Inclusion Plan .....	47
	Exhibit C – Reference Form .....	48
	Exhibit D – Plan Design(s) and Service Area(s).....	49
	Exhibit E - Organizational Structure and Health Plan Experience.....	50
	Exhibit F – HCA Health Transformation Vision.....	51
	Exhibit G – Clinical Management .....	54
	Exhibit H – Operations .....	61
	Exhibit I – Provider Network .....	73
	Exhibit J – Technical Data Requirements.....	75
	Exhibit K – Draft Contract.....	78
6.	<b>APPENDICES.....</b>	<b>79</b>
	Appendix 1 – CMS Framework for Value-Based Payments or Alternative Payment Models (CMS LAN APM) 80	
	Appendix 2 – OCIO Standard 141.10 – Securing IT Assets .....	81
	Appendix 3 – WATech OCS Design Review Checklist .....	82
	Appendix 4 – HIPAA 834 Compliant Eligibility File .....	83
	Appendix 5 – Non-Disclosure Agreement.....	84
	Appendix 6 – Proposed Service Area(s).....	91
	Appendix 7 – Common Measure Set.....	92
	Appendix 8 – 2017 Paying for Value Survey .....	93
	Appendix 9 – Results HCA Fundamentals Map .....	94
	Appendix 10 – 2018 UMP Classic Plan Design .....	95
	Appendix 11 – Proposed Plan Design(s) .....	100

# 1. INTRODUCTION

## 1.1. Purpose

The Washington State Health Care Authority (HCA) is initiating this Request for Proposals (RFP) to solicit proposals from licensed Carriers interested in providing and administering fully insured Health Plans to Subscribers and their enrolled Dependents of the new School Employees Benefits Board (SEBB) Program. The state is looking to contract with at least one experienced, fully insured health plan Carrier to provide a number of plan options that will be included in the menu of plan choices from which Subscribers can choose. The state is particularly interested in contracting with qualified Carriers who are also interested in accelerating health transformation, as further discussed in sections 1.4, *HCA's Strategic Vision*, 1.6.B, *Participate in Health Transformation*, and 1.6.C, *Innovative Leadership and Administrative Support*.

HCA intends to award one or more Contracts to provide the services described in this RFP in order to provide an adequate portfolio and coverage of health care services for School Employees. This population includes School Employees who work in Washington, but may live in Washington, Oregon, or Idaho. At this time, Bidders are required to propose plans for service areas by county. The maximum number of Carriers and SEBB Plans offered in individual counties has not been determined. It is in the Bidder's best interest to propose any service area(s) in which the Bidder is interested in providing SEBB Health Plans. Ultimately, the final decision for the number of Carriers and SEBB Health Plans offered in a county may be limited by either HCA or the SEB Board.

Funding for the benefits offered under the SEBB Program is dependent on the legislative appropriations finalized during the 2019 legislative session and SEB Board actions.

The HCA will select one or more Apparently Successful Bidders (ASBs) that demonstrate:

1. Commitment to the promotion of person-centered care and advanced Member engagement;
2. Capacity and flexibility to implement HCA-directed initiatives specific to the plans offered under the SEBB Program;
3. Strong alignment with the HCA's purchasing and health transformation vision, including the HCA's Value-based Roadmap<sup>1</sup>, and a demonstrated commitment and capability to implement other Value Based Payment (VBP) methodologies; and
4. Commitment to active partnering and engagement with the HCA and other key health partners to drive innovation in health care purchasing and delivery system reform in Washington State.

Prior to launching new SEBB Health Plans on January 1, 2020, an ASB will be expected to perform the following services:

1. Begin a structured Contract implementation plan as early as November 2018.
2. Support the SEBB Program Annual Open Enrollment activities in fall 2019 for the 2020 plan year as specified and approved by the HCA.
3. Provide all contracted insurance and administrative services beginning January 1, 2020.

Bidders must demonstrate the ability to provide all staffing, systems, and procedures required to perform the services described in this RFP. They must have the ability to meet the needs of the SEBB Program and demonstrate a culture of flexibility, innovation, and adaptability in order to develop and administer creative health care solutions and strategies that align with broader, evolving health care delivery.

---

<sup>1</sup> [https://www.hca.wa.gov/assets/program/vbp\\_roadmap.pdf](https://www.hca.wa.gov/assets/program/vbp_roadmap.pdf)

## 1.2. RFP Approach

Funding rates for the SEBB Program will not be finalized until the summer of 2019. This poses a challenge because the HCA estimates that implementation work must begin in November of 2018 to allow for sufficient preparation for the SEBB Program's Annual Open Enrollment in the fall of 2019, and a Benefits Start Date of January 1, 2020.

As a result of these challenges, HCA must take a particular approach to this RFP. This RFP focuses only on non-cost areas, such as a Bidder's proposed plan offerings, geographic coverage, provider network adequacy, Clinical Management, administrative services, data and reporting, etc. HCA will evaluate Proposals received and select ASB(s) based solely on the non-cost elements outlined in the RFP and plans to execute Contract(s) in early November 2018 so implementation can begin. The ASB(s) resulting from this RFP are expected to sign a contract substantially similar to Exhibit K – *Draft Contract*, to ensure meeting the tight timelines for implementation. See section 2.17, *Mandatory Contractual Terms*, for more information regarding Exhibit K – *Draft Contract*.

**Bidders must not provide any cost information for the proposed plans in response to this RFP.** Cost is not being evaluated as part of this RFP. Instead, this information will be required and evaluated after Contract execution by way of the Request for Completion Process (RFC Process). In December 2018, HCA will initiate the RFC Process to obtain binding rates and final plan design options from Contractor(s). Negotiations to secure not-to-exceed (NTE) rates will take place during January and February 2019. If HCA and a Contractor are unable to agree on NTE rates, HCA has sole discretion to terminate the Contract resulting from this RFP. See section 2.20, *Request for Completion Process (RFC Process)* for more information.

Contractors must be willing to begin a structured Contract implementation plan as early as November 2018, understanding there may be some financial risk in the event HCA and Contractor are unable to agree on NTE rates during the RFC Process. Final funding is up to the Washington legislature.

## 1.3. Background

HCA is a cabinet-level agency within the Washington State executive branch and governed by chapter 41.05 of the Revised Code of Washington (RCW). HCA is the largest purchaser of health care services in Washington State through its management of the Public Employees Benefits Board (PEBB) and Apple Health (Medicaid) Programs. This purchasing influence will expand with the implementation of the SEBB Program. The Employees and Retirees Benefits (ERB) division of HCA will administer benefits designed for both the SEBB and PEBB Programs. Today, the PEBB Program covers all eligible Washington State employees and their Dependents from 522 participating state agencies, higher educations (universities, colleges, etc.), counties, municipalities, political subdivisions, tribal governments, and even some school districts and Educational Service Districts (ESDs) that contract with HCA for PEBB Program benefits.

The SEBB Program was created within HCA pursuant to the passage of Engrossed House Bill (EHB) 2242 (Laws of 2017, 3rd sp.s., Ch. 13, Part XIII<sup>2</sup>) in July 2017. EHB 2242 directs the SEB Board and HCA to develop and administer a suite of benefits for eligible School Employees and their Dependents. During the 2018 Legislative session, SEBB Program statutes were amended by Engrossed Substitute Senate Bill 6241 (Laws of 2018, Ch. 260)<sup>3</sup>. There are currently no plans offered under the SEBB Program.

Starting January 1, 2020, all Washington State school districts, ESDs, and Charter Schools (approximately 314 separate entities) will be required to participate in the SEBB Program. This

<sup>2</sup> [http://lawfilesexternal.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/House/2242.SL.pdf?cite=2017 3rd sp.s. c 13 § 801](http://lawfilesexternal.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/House/2242.SL.pdf?cite=2017%203rd%20sp.s.%20c%2013%20s%20801).

<sup>3</sup> <http://lawfilesexternal.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/Senate/6241-S.SL.pdf>

includes any school districts, ESDs, or Charter Schools currently accessing benefits through the PEBB Program. The SEB Board will design and approve insurance benefit plans and establish eligibility criteria for participation in these plans. The benefit plans resulting from this RFP are subject to SEB Board approval. Under the new law, benefit plans and rules must be in place and fully effective on January 1, 2020.

On March 15, 2018, the SEB Board adopted a resolution that, among other things, directs HCA to “perform a fully insured medical plan procurement for multiple [C]arriers with widespread coverage offerings.”

#### A. Eligibility Administration of Plan

Determination of eligibility for coverage for all SEBB Health Plans is the statutory responsibility of the SEB Board and HCA, and is not open for suggestion under this RFP. However, benefits officers employed by individual school districts, ESDs, or Charter Schools will initially determine and periodically review eligibility for their employees.

HCA retains administrative responsibility for individual eligibility determinations for SEBB Program benefits, and handles individual benefits eligibility Appeals. In addition, the HCA reserves the right to authorize audits by third parties.

The HCA expects to replace and modernize its eligibility and system of record information system in the coming years. The details of the new system are not available at this time. Bidders should expect that some aspects of the electronic data interface will change as a result. For example, the interface may be with an application service provider instead of HCA, and the new system may add unique identifiers instead of requiring ASB(s) to generate them (in this scenario, ASB(s) would be required to use the HCA-generated unique identifier). ASB(s) must agree to make any necessary changes in their systems and all reconciliation processes to accept HCA's eligibility file in the layout and format given by HCA. This may change annually and with HCA system changes.

#### B. SEBB Program Population

As of January 1, 2020, the SEBB Program will offer benefits to School Employees and Dependents who meet the eligibility criteria defined by the SEB Board and codified in the Washington Administrative Code (WAC). These benefits are currently in the process of being developed. The primary SEB Board benefits eligibility criterion is set forth in RCW 41.05.740(6)(d) as any employee anticipated to work at least six hundred and thirty (630) hours during the school year. Currently, when a School Employee retires and meets eligibility requirements, they become eligible for benefits under the PEBB Program. Consequently, the SEBB Program population does not include Retirees. However, RCW 41.05.022(4) requires HCA, in consultation with the PEB and SEB Boards, to complete an analysis by December 15, 2018 to determine the most appropriate risk pool for the retired and disabled School Employees. The analysis, at a minimum, will include:

1. The size of the non-Medicare and Medicare Retiree enrollment pools;
2. The impacts on cost for state and school district Retirees of moving Retirees from one pool to another;
3. The need for and the amount of an ongoing Retiree subsidy allocation from the active School Employees; and
4. The timing and suggested approach for a transition from one risk pool to another.

If the legislature makes changes to the SEBB Program risk pool as a result of this analysis, the Contracts resulting from the RFP may need to be amended to include a Retiree risk pool and population.

Based on data received from the Office of Financial Management (OFM) for the 2015-16 school year, there were approximately 134,000 School Employees statewide who worked at least 630 hours, and approximately 10,500 additional School Employees who worked less than 630 hours. While the exact number of Members will not be known until the end of the Annual Open Enrollment in late fall of 2019 (because it is unknown how many Dependents will be enrolled), it is known that the Subscriber

population is largely female (roughly 75%), and the median age is approximately thirty-seven (37) years. The number of Dependents that will eventually be enrolled in the SEBB Program will likely increase from current levels as the employee premium contribution methodology has changed under the SEBB Program to be relatively more favorable to School Employees with Dependents. The required School Employee share of the cost for family coverage premiums may not exceed three (3) times the premiums for a School Employee purchasing single coverage for the same coverage plan (Laws of 2018, Ch. 260, § 1<sup>4</sup>). HCA estimates that total SEBB Program enrollment (eligible Subscribers and Dependents) will be between 200,000 and 300,000 persons.

While all school districts, ESDs, and Charter Schools may currently contract with HCA for PEBB Program benefits, only seventy-two (72) school districts and five (5) ESDs participate in these benefits. This is approximately three to five percent (3-5%) of all School Employees. Currently most School Employees have benefits arranged by their individual employing districts, local collective bargaining units, or the Washington Education Association. The new state law requires state consolidation of benefits purchasing, benefits administration, and collective bargaining.

### C. PEBB Program Population

The PEBB Program currently offers benefits to all state agency and higher education employees and Retirees in Washington. Political subdivisions, tribal governments, and certain other government entities that meet specific criteria are authorized to contract with HCA to purchase PEBB Program benefits for their governmental employees and certain Retirees under RCW 41.04.205 and chapter 41.05 RCW. As previously mentioned, School Employee Retirees are included in the PEBB Program population. As of March 2018, there were over 379,000 members enrolled in PEBB Program medical plans. In accordance with the legislative intent in RCW 41.05.740(6)(b)(v), which requires PEBB and SEBB to leverage efficient purchasing, the PEB Board may decide to contract for a similar benefit plan for the PEBB Program with any entity that enters into a Contract with HCA for the SEBB Program pursuant to this RFP without conducting another procurement. In other words, any carrier that may be interested in providing a fully insured offering to the PEBB Program may lose that opportunity if it fails to obtain a contract to provide benefits for the SEBB Program. Therefore, Bidders interested in potentially offering a fully insured offering to the PEBB Program are strongly encouraged to respond to this RFP.

### D. SEB Board Regulatory Environment

The SEB Board operates in a unique regulatory environment. Bidders should be familiar with all statutory requirements pertaining to the SEB Board, including but not limited to the provisions of RCW 41.05 (State Health Care Authority). Plans offered as a result of this RFP will not be subject to all provisions of ERISA. Instead, they will be subject to the plans the Bidder is allowed to sell under the Insurance Code, the Public Health Services Act (42 U.S.C. Chapter 6A), the Washington Patient Bill of Rights, and Chapter 70.14 RCW, which sets requirements for health care services purchased by state agencies.

In addition, any High Deductible Health Plan must comply with IRS requirements and the U.S. Department of Health and Human Services regulations.

At this time, the HCA does not expect PEBB Program members, which currently includes Retirees, will be offered any of the health plans made available to the SEBB Program population as a result of this RFP. However, as discussed above, the HCA reserves the right to negotiate any resulting Contracts to add additional populations, to include Retirees and/or PEBB Program members during the life of such Contract without conducting another procurement.

### E. Wellness Program

HCA's wellness program portal (SmartHealth) is a voluntary and confidential wellness program currently offered by the PEB Board. This program offers a financial incentive to subscribers enrolled

---

<sup>4</sup> <http://lawfilesexternal.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/Senate/6241-S.sl.pdf>



in a medical plan offered by the PEBB Program who register and participate in certain activities. As of the release of this RFP, a wellness program has not been proposed for the SEBB Program population. In the event that a wellness program is incorporated into SEBB Program benefits, the ASB(s) must be willing to implement the rules and requirements of the program for the Subscribers to be able to participate and receive the financial incentive (if any).

#### **F. Marketing Benefit Participation**

HCA will market, advertise, and provide education on the SEBB Program to all school districts, ESDs, Charter Schools, and Members. Each year, prior to the SEBB Program's Annual Open Enrollment, HCA will publish and distribute a description of the SEBB Health Plans available (and the Subscriber's share of the premium cost for each plan), as well as plan or benefit changes for the following year.

ASB(s) will be responsible for marketing, advertising, educating, or soliciting participation in their SEBB Health Plans, with final approval of such efforts and materials from, and at the discretion of, HCA.

If an ASB has other lines of business beyond the fully insured plans they provide under the SEBB Program that relate to other benefits offered by the SEB Board, the ASB is prohibited from using any information obtained as a result of the Contract to solicit SEBB Program Enrollees or Members to purchase the ASB's other products or services. For example, an ASB may not solicit SEBB Program Enrollees or Members to enroll in their non-SEBB Program medical plans, including Medicare Advantage, Medicare Supplement, Medicaid and/or Health Insurance Exchange plans using information gained from its participation in the SEBB Program.

#### **G. Other Contractors and Partners**

The ASB(s) may be required to work with a number of other contractors providing services to HCA. This work may involve sharing eligibility, or clinical and service data, or other activities as directed by HCA. HCA has contracts with vendors who provide the following services (this list is a sample and is not meant to be all-inclusive):

- Tobacco cessation
- Actuarial and consulting services
- Health care consulting services
- Online Member Claim and eligibility portal for providers (aka OneHealthPort)
- Wellness program
- Member experience surveys
- Flexible Spending Account administrator
- e-Value8™ and Community Checkup (Washington Health Alliance)
- All Payer's Claims Database (Office of Financial Management)
- Project Management Consulting Services
- Work Site Blood Testing
- Diabetes Prevention and Control
- Disability Insurance
- Life Insurance
- Dental Insurance

This list is provided for illustrative purposes only as the ASB may not have to engage with all of these contracted services. Additionally, vendors for these services are subject to change at any time.

Services in the list provided above and currently performed by other contractors should not be included in the Bidder's Proposal unless specifically requested in this RFP. In the event HCA makes a decision to discontinue any service performed by a contractor other than the ASB, it is likely that the services would be transitioned to another vendor. However, HCA and ASB may negotiate in good faith to incorporate such services into the Contract as permitted under Washington State law.

HCA may require the ASB(s) to subcontract for specific services with other vendors, such as services for a Diabetes Prevention Program (including virtual access) and for a specific Health Savings Account Trustee.

#### 1.4. HCA's Strategic Vision

Healthier Washington, an initiative launched in January 2013, is Washington State's vision for health transformation: better health, better care, and lower health care costs (Triple Aim). Under the Healthier Washington initiative, Washington state agencies, led by HCA, are working with public and private partners (clients of the Bidder that purchase medical insurance for their employees that are either governmental ("public") or non-governmental ("private")) to leverage their regulatory, policy and purchasing powers in three strategic focus areas:

1. Move state-financed health care purchasing to include outcome-based payment models. Work in tandem with other major purchasers and payers to move commercial market purchasing to include outcome-based payment models;
2. Build healthier communities through a regional approach that fosters links between communities and clinical care; and
3. Integrate physical and behavioral health services so that health care focuses on the whole person.



The Healthier Washington initiative has invested heavily statewide in foundational infrastructure and resources to directly support and accelerate the three focus areas and enhance overall system performance in the following ways:

1. Fostering a culture of quality and price transparency to enable providers and communities to benchmark performance against their peers and measure overall health system performance.
2. Engaging individuals and families in their health and health care by providing tools, resources and training.
3. Building Accountable Communities of Health (ACHs) to facilitate local linkages between communities and clinical care to address Social Determinants of Health.

4. Supporting transformation efforts by assisting providers with their transition to VBP.
5. Enabling regional health data capabilities, including analytic tools, interoperable systems and standardized measurement strategies to improve population health.
6. Supporting workforce capacity and flexibility by encouraging team-based approaches and supporting strategies that allow practitioners to work at the top of their license, effectively and efficiently.

#### A. Paying for Value – The HCA's Purchasing Strategy

HCA is the largest health care purchaser in Washington State, providing care for over 2.2 million Washingtonians through Apple Health and PEBB Program. Annually, the HCA spends \$10 billion dollars between the two programs.

Under RCW 41.05.021, HCA is required “to increase the use of value-based contracting, alternative quality contracting, and other payment incentives that promote quality, efficiency, cost savings, and health improvement, for Medicaid and public employee purchasing”.

HCA has pledged that 90% of HCA provider payments under state-financed health care programs, and 50% of provider payments in commercial health care arrangements will be linked to quality and value by 2021, as defined by Categories 2c through 4b in Appendix 1 – *CMS Framework for Value-Based Payments or Alternative Payment Models (CMS LAN APM)*.

In order to send a consistent signal to the marketplace and providers across Washington state, HCA expects that the majority of payment strategies, whether implemented by HCA directly through its own purchasing or through HCA health program partners (providers and Health Plans), will support these payment goals. ASB(s) must agree to participate in designated quality improvement efforts and initiatives linked to measurement of VBP attainment, as required in Exhibit K – *Draft Contract*.

#### B. Health Transformation Vision: HCA Value-based Roadmap

By changing how health care is purchased, HCA will support new models of care that drive toward population-based care while fundamentally changing how health care is provided. HCA produced the HCA Value-based Roadmap in June 2016 to articulate its purchasing vision. This document brings together major components of the Healthier Washington initiative and other health transformation projects into one approach.

HCA's Value-based Roadmap is built on the following principles:

1. Reward the delivery of patient-centered, high value care and increased Quality Improvement.
2. Reward performance on cost, quality, and patient experience of the HCA's Medicaid, PEBB, and SEBB Program Health Plans and their contracted health systems.
3. Align payment and delivery reform approaches with the federal Center for Medicare and Medicaid Services (CMS) for greatest impact and to simplify implementation for providers.
4. Improve quality outcomes and patient experience.
5. Drive standardization based on evidence, including best-practice recommendations from the Bree Collaborative.
6. Increase long-term financial sustainability of state health programs.
7. Continually strive for the Triple Aim.
8. HCA Value-based Roadmap also articulates the following elements of HCA's vision to align the delivery of health care throughout HCA programs by the end of 2021:
  - a. HCA programs implement value-based payment arrangements according to a unified purchasing philosophy;
  - b. HCA's purchasing business is entrusted to accountable delivery networks and plan partners; and
  - c. HCA exercises significant oversight and quality assurance over its contracting partners and implements corrective action as necessary.
9. HCA cannot achieve health transformation alone. HCA desires ASB(s) who can assist in reaching HCA's goals and offer fully insured products aligning with HCA's health transformation vision.

### C. Innovative Leadership and Administrative Support

The health care industry is changing rapidly. If current delivery and payment reforms are successful, Washington State's health care delivery and reimbursement systems will have evolved to reflect the needs of our reformed health care system when ASB(s) begin to administer fully insured plans to the SEBB Program in 2020.

HCA seeks ASB(s) that share its health transformation vision and goals that are strongly positioned to move the Washington health care market toward the Triple Aim. ASB(s) must be able to operate in two disparate systems at the same time: one where volume of services is incentivized, and the other a Value Based Payment system where value is rewarded and whole-person care optimized.

The ASB's executive leadership and management team, including but not limited to its Chief Medical Officer (CMO), must have the intellectual capital and expertise to be a committed partner with the HCA, ready to help HCA realize its health transformation vision and purchasing goals while offering creative ideas and strategies.

### D. Support of Value Based and Alternative Payment Models

HCA seeks an ASB that can develop, implement and administer a broad range of value-based payment and alternative payment models, and work with other payers. HCA has developed and is in the process of implementing, several strategic value-based payment initiatives in the Medicaid and PEBB Programs.

One of HCA's value-based purchasing initiatives is the Center of Excellence (COE) program. Since January 1, 2017, HCA has a bundled payment program through a COE for total hip and knee replacement (TJR) available to Uniform Medical Plan (UMP) Classic and Uniform Medical Plan (UMP) Consumer-Directed Health Plan (CDHP) members. The COE program is a comprehensive program that covers services related to a defined episode of care, including but not limited to pre-surgical consultations, surgery, hospitalization, and post-surgical services (prior to discharge from the hospital). Members work with the third party administrator's team of professionals and the designated COE(s), to ensure that all aspects of treatment are consistent with the program's clinical guidelines.

HCA is actively working to expand the COE program to cover additional health care services, for example: spine fusions, low back pain, maternity and cardiac care, in accordance with Bree Collaborative Alternative Payment Model recommendations, Health Care Payment Learning and Action Network (LAN) recommendations, and other best practice recommendations. HCA is interested in partnering with ASB(s) that deliver a similar COE program and payment model as the one UMP has implemented, and as outlined below.

In the UMP COE model:

1. The COE bears the cost of complications from sub-optimal clinical outcomes, and ensures all aspects of treatment are consistent with Bree Collaborative recommendations and other contracted guidelines.
2. The COE assumes financial risk for preventable surgical complications and infections.
3. The COE's clinical team—including physicians, hospitals and others involved in the clinical episode of care—coordinates patient care and encourages Shared Decision Making with each patient.
4. The HCA pays a single amount prospectively agreed to by the provider and the HCA for each clinical episode of care, called a "bundled payment."
5. Services covered under the COE model may be covered in full for qualifying members enrolled in UMP Classic or UMP CDHP (CDHP members must meet their deductible first).

Throughout the length of this contract, HCA will continue to design and implement VBP strategies through its own purchasing and through multi-payer efforts consistent with CMS LAN alternative payment models (APM) Categories 2c through 4b (see Chart in Appendix 1 – *CMS Framework for Value-Based Payments or Alternative Payment Models (CMS LAN APM)*). Some payment strategies may include pilot projects or additional plan offerings within the ERB Division, and may not require competitive procurement.

## E. Member Engagement and Experience

HCA believes that people who are informed and engaged in their own health are more likely to make appropriate decisions regarding the use of health care resources. Therefore, Member engagement is at the heart of HCA health transformation strategies. HCA's vision of Member engagement involves several strategies, including but not limited to the following:

1. Offering innovative Patient Decision Aids that are culturally and linguistically appropriate so Members can make meaningful care choices.
2. Providing Patient Decision Aids that allow Members to learn about treatment options when engaged in Shared Decision Making on which treatment to seek.
3. Participation in creating and updating care plans that are shared with Members and their family.
4. Providing cost and quality transparency tools that empower Members to make cost-effective selections for health care services.
5. Educating members on low value care so that they avoid treatments that are medically unnecessary and potentially harmful.

## F. Data Reporting and Analytics

Data is key to achieving and supporting value-based care and payment. HCA's vision for health systems transformation depends upon timely reports on the fully insured products and provider performance to actively inform and adjust purchasing strategies. Providers need access to timely, accurate and actionable data at the group/provider/patient level (quality, patient experience, utilization and cost data from HCA vendors) to facilitate effective patient care and conduct population health analytics; and Health Plans need data to inform business decisions and provide feedback to providers. Functional, comprehensive reporting systems are necessary to support and integrate data and provide meaningful reports.

### **1.5. Objectives**

HCA's objectives for this RFP are as follows:

1. Execute Contract(s) with qualified Carriers for fully insured group medical plans for the SEBB Program that have a Benefits Start Date of January 1, 2020.
2. Partner with ASB(s) who: (a) are flexible and understanding of the challenges involved in implementing a new program with specific time constraints; (b) are willing to use the two-phased approach discussed in section 2.19, *Implementation / Timeframe*; and (c) who have experience effectively managing an onboarding of this magnitude.
3. Offer fully insured group medical plans for SEBB Program enrollment in every county within Washington State.
4. Achieve cost efficiency by creating partnerships with the awarded ASB(s) to provide care through strategies like VBP, but also through effective provider contracting and productive Utilization Management.
5. Leverage efficient purchasing by potentially utilizing the resulting Contract(s) to expand fully insured options to the PEBB Program population in the future.

### **1.6. Statement of Work**

HCA is looking to contract with one or more fully insured group medical Carriers. ASB(s) will need to provide the network, services, and staff to perform the tasks or provide the services listed in this section. A final Statement of Work will be negotiated with ASB(s) prior to Contract signature.

#### A. Health Plan, Network, and Service Areas

1. Compliance with Engrossed Substitute House Bill (ESHB) 2408 (Laws of 2018, Ch. 219) for plan years beginning January 1, 2020, and the associated performance requirements in Exhibit K – *Draft Contract*.

2. Have a live or work provision that allows School Employees to enroll in the Contractor's SEBB Health Plans. Thereby, ensuring coverage for school districts that cross county and service area lines.
3. An adequate provider network that is cost effective and delivers high quality services to Members. The network must have sufficient breadth and capacity to provide access to the types and numbers of in-network providers necessary to deliver care for all covered benefits. At a minimum, ASB(s) must comply with the Office of the Insurance Commissioner's (OIC's) access and adequacy requirements for all provider categories covered under the Contract within Washington State. For Service Areas covered under this Contract in Oregon and Idaho counties, the Contractor will comply with access and adequacy requirements for that state.
4. A network contracting and credentialing program consistent with National Committee for Quality Assurance (NCQA) or URAC accreditation standards.

#### B. Participate in Health Transformation

1. Leadership, health transformation expertise, and administrative capabilities to continuously innovate fully insured products to directionally align to health transformation strategies.
2. A willingness to design, implement and administer VBP models to support new models of care delivery and Health Equity.
3. Ability to offer novel Member education and engagement tools and strategies to support appropriate self-management and support Shared Decision Making.
4. Sophisticated data, reporting and analytic expertise, services and capabilities to produce ad-hoc analyses for the HCA, providers, and other stakeholders.
5. Participation in multi-stakeholder Quality Improvement and transparency initiatives.
6. Consent to post a redacted version of the final Contract on the HCA website as a tool for other purchasers to reference who are considering implementing VBP strategies.

#### C. Innovative Leadership and Administrative Support

1. A visionary executive leadership and management team with the attributes as described in Section 1.4(C).
2. Experience with executing value based payment arrangements within fully insured plan offerings.
3. A commitment to demonstrate the implementation of strategic initiatives that offer similar or better results than those stated within Appendix 1 – *CMS Framework for Value-Based Payments or Alternative Payment Models (CMS LAN APM)* and the offering of said initiatives within the ASB's SEBB Health Plan(s); and/or
4. Support and implement HCA strategic initiatives and demonstration projects for example: Accountable Care Networks (ACNs), Center of Excellence (COE) contracting, Healthier Washington initiatives, bundled payments, tiered hospital networks, value based payment contracts, episode of care reimbursements and other VBP initiatives sanctioned by the HCA for Members and across the ASB's Book-of-Business.
5. An organizational commitment to actively support and participate in statewide health transformation efforts.
6. A commitment to and experience supporting linkages between communities and clinical care to address Social Determinants of Health and to promote Health Equity.
7. A commitment to spread and scale the HCA's clinical policies, care transformation vision, and VBP.
8. A commitment to provide and coordinate customized reporting of fully insured plan offerings to HCA leadership at quarterly meetings on care transformation activities, VBP updates, and other reporting, as requested by HCA.
9. Experience designing and implementing innovative payment models in their Book of Business.
10. A commitment to and experience in deploying strategies that improve patient education and self-management.
11. Executive endorsement of community-wide transparency efforts on quality, utilization, pricing, and sharing medical Claims data, including metrics related to price and quality.
12. Flexible Claims and payment systems that can support and adapt to innovative strategies and new financial reimbursement models.

13. Benefit design expertise that accelerates new models of care.
14. A commitment to facilitate conversations between the HCA and providers if needed.

#### D. Member Engagement and Experience

1. Shared Decision Making: Support and encouragement of Shared Decision Making through provider agreements, Member communications, and Member resources. Washington leads the nation in promoting Shared Decision Making and creating a certification process for Patient Decision Aids. Washington state law recognizes that certification plays a significant role in assuring the quality of Patient Decision Aids used by consumers, providers and payers. The HCA began accepting Patient Decision Aids for certification in April 2016. A list of certified Patient Decision Aids is available at <http://www.hca.wa.gov/about-hca/healthier-washington/patient-decision-aids-pdas>.
2. Member website: A robust and secure Member website that is optimized for mobile/tablet access as well as desktop use. This must include, but not be limited to, the following interactive tools and information:
  - a. Cost calculator to help Members understand out of pocket costs before care is received including:
    - Cost information that considers Member benefit designs relative to copays and cost sharing, coverage exceptions and service limits, pharmacy benefits, accumulated deductibles and out-of-pocket maximums.
    - Medical costs searchable by procedure, drug and episode of care that include both professional and facility fees.
    - Cost and outcome comparisons of alternative treatments linked to Shared Decision-Making tools.
    - Cost, quality and outcome comparisons for physicians, hospitals, ambulatory surgery centers and diagnostic centers linked to quality data as much as possible.
  - b. Up-to-date list of providers and their locations.
  - c. Important insurance documents such as Explanation of Benefits (EOBs), Certificates of Coverage (COCs), and Summaries of Benefits and Coverage that clearly differentiates between the SEBB Health Plans. The website must include a process for paper copies of these documents to be requested and provided.
  - d. Information to help Members understand low-value care to help reduce potential harm from unnecessary care.
  - e. Tools to help Members develop and maintain a relationship with a primary care provider.
3. Multichannel Communications: Ability for Members to communicate electronically via email and/or text reminders. In addition, Members must be able to conduct transactional activities such as managing their insurance accumulators via the website or applications.
4. Communication Tools and Resources:
  - a. Multiple channels for Member communication, including but not limited to telephone, in-person and online communication as well as chat, instant messaging, and texting.
  - b. Medical records that patients and other authorized individuals are allowed to read are an important aspect of patient-centered care. When used properly, they let patients see themselves through the eyes of their caregivers and give them insight into diagnoses and treatment options. The ASB must promote the use of electronic health records (EHR) among providers and enable Members to access their own records (clinician chart notes, visit summaries, lab results, etc.) to help them take an active role in their own care.
  - c. Member access to medical records and the ability to conduct insurance and health care related transactions using innovative technology. To that end, an ASB must enable Members to communicate with their Health Plans through electronic means, schedule appointments with providers, request prescription refills, and communicate with providers online or through telehealth services.
  - d. Capability to offer Members an online expert medical option (EMO) or second opinion option.



- e. Member assistance for managing billing and insurance systems to ensure that bills are accurate and appropriate payments are made.
- 5. Tools and Resources for Self-Management:
  - a. Capability to offer, or work with the HCA's wellness vendor so it can offer Members the ability to monitor and track their own participation in activities related to wellness, including diet and nutrition, exercise and weight loss, and tobacco cessation activities.
  - b. Tools that offer Members the ability to manage chronic diseases in an evidence-based way that is convenient and customizable to their needs.
  - c. Support for a culturally and linguistically diverse membership as well as reasonable accommodations for communications that are consistent with ADA requirements for all Member-oriented tools.

#### E. Data Reporting and Analytics

1. Ability to provide both standard and ad hoc customized reports to HCA on SEBB Health Plan quality, cost and utilization performance, Member reported outcomes, provider performance, and population health measures (including disaggregation by race/ethnicity and primary language to identify health disparities).
2. A detailed reporting system (standards and staffing structure) and processes in place, including an approach to developing, testing, modifying and finalizing reports.
3. A current Claims data system that can process and support current and new VBP arrangements.
4. Robust technology and core systems in place to accept, store, process and validate data from various sources (e.g., Claims, clinical data from EHRs, and other HCA vendors).
5. Capacity to create ~~customized-the same~~ reports ~~that are similar to those as HCA~~ receives ~~by HCA's for its~~ self-insured plans so that HCA can obtain a comprehensive overview of clinical factors and cost drivers to inform HCA's internal operations and external stakeholders. A template is currently being built and will be provided to ASB(s) at a later time.
6. Coordination with other HCA vendors regarding Member level Claims data, Member communication, behavioral outreach, wellness programs and benefits, and other programs. HCA data vendors may include but are not limited to the outsourced wellness programs.
7. Detailed reporting capabilities to report measures from the Common Measure Set and HEDIS measures for provider groups, including quality, Claims, Member reported outcomes, and hybrid measures. Additionally, the capability to conduct analyses of sub-populations and to identify health disparities so that providers have actionable data to care effectively for all Members. The measures will be based on standards created at the state and national level, and the data will be configured in accordance with the applicable specifications.
8. Experience, knowledge and expertise providing appropriate data and routine, standardized reporting on provider performance regarding various clinical and quality metrics, including Patient Reported Outcomes, patient experience, and population health. This reporting must be understandable and accessible to providers and provider groups.
9. Provision of SEBB Health Plan-specific HEDIS data to the HCA and/or its business associates.
10. Provide data to HCA to assist HCA reporting on core processes and key outcomes, called "Results HCA," (see Appendix 9 – *Results HCA Fundamentals Map*).
11. Submission of data using the NCQA or URAC Interactive Data Submission System (IDSS) or other NCQA-approved methods.
12. Submission of a summary of primary care expenditures for the SEB Board's fully insured plans using a template approved by HCA's Chief Medical Officer.
13. Submission of data on low-value care services from SEB Board's fully insured plans based upon a list of procedures selected by HCA's Chief Medical Officer from the Choosing Wisely Initiative.
14. Encouragement of provider participation in Washington State's Clinical Data Repository and Health Information Exchange.
15. Submission of data to OFM's All Payer Claims Databased (APCD).
16. Use of innovative, state-of-the-art risk adjustment approaches in data work.



17. Certification that all information sharing is in full compliance with HIPAA and other applicable regulations, with information and reporting structured to meet the needs of Members, providers, the HCA, the community, and other identified stakeholders.
18. Provision of data regarding Appeals and Complaints for an annual legislative report that meets HCA specifications by July 31 of each year.

#### F. Plan Administration

1. A fully operational customer services center with customer service staff that are knowledgeable, responsive, and deliver high quality service to all Members and Enrollees.
2. Online services and web team for Members and Enrollees to access a robust, accurate, and up-to-date array of web-based tools and information. An ASB's online services must at all times meet or exceed the Washington State Office of the Chief Information Officer (OCIO) Technology Standards, or their replacements or successors, found in Appendix 2 – *OCIO Standard 141.10 – Securing IT Assets* and Exhibit K – *Draft Contract*.
3. An effective communications team (including writers, web team, and graphic designers) that can work directly with the HCA communications staff. ASB(s) must be able to provide communications to Members and potential Members to enable them to make informed decisions in selecting a Health Plan, appropriately utilize available benefits, and actively engage in managing their health.
4. A network contracting and credentialing program consistent with NCQA or URAC accreditation standards that applies to all providers in all networks available to SEBB Program Members.
5. A fully operational Claims payment service on January 1, 2020 that includes the ability to pay Claims electronically.
6. Performance of other Claims-related functions necessary to provide a complete administration of Claims services.
7. Payment of the ASB's contracted network of hospitals, professional providers, and other non-hospital providers.
8. Processing and payment of out-of-network Claims, when applicable;
9. Payment of all emergency care, regardless of network restrictions;
10. Processing of Appeals and Complaints per OIC standards.
11. Processing of disabled Dependent new certifications and re-certifications on time so the Dependent does not lose coverage.
12. Generation of a unique, permanently assigned, HIPAA compliant, non-social security number (SSN) based ID number for each Subscriber.
13. Completion of a quarterly full eligibility file match with HCA (and HCA's business partners, if applicable) and prompt reconciliation of any differences and reporting of any reconciled differences and any other discrepancies to the HCA.
14. Acceptance and processing of SEBB Health Plan eligibility files daily in the format outlined in the SEBB Health Plan Eligibility File Format found in Appendix 4 – *HIPAA 834 Compliant Eligibility File* ASB must agree to accept all changes in systems and files as directed by HCA.
15. Acceptance of premium payments from HCA.
16. Ability to apply standard Coordination of Benefits rules for all Medicare-primary Members' Claims (ESRD, etc.), consistent with Washington insurance regulations in chapter 284-51 WAC. Coordination of Benefits with Medicare using all Medicare crossover Claims, including those paid in full by Medicare, and Claims from Members or their providers for services not covered by Medicare that may be covered by the HCA.
17. Medical policies and procedures that are provided to the HCA in order to make them publicly available online on the HCA website by no later than January 1, 2020; including, but not limited to, RCW 41.05.074 related to release of coverage criteria.
18. Provision and/or administration of a Health Savings Account. An ASB must have an HSA Trustee; however, HCA reserves the right to require use of a specific vendor.
19. Participation in an annual Request for Renewal (RFR) process. The annual RFR process will enable the SEB Board, on an annual basis to adjust employee benefits in response to (a) new requirements under the ACA; (b) changes requested by the SEB Board, HCA's Chief Medical Officer, or other internal policy drivers; (c) benefit design strategies promulgated by HCA; and/or (d) legislative mandates and other changes. The purpose of the RFR is not to extend or re-negotiate the Contract, but for both parties to determine resources necessary to

implement possible benefit changes and other potential changes to any of the plans. These changes may result from a mandate from either within or outside HCA.

#### G. Clinical Services

1. Compliance with all the OIC's regulations for Utilization Management (UM), including transitions of care between exiting and receiving Carriers (WAC 284-43-2050).
2. Utilization Management according to OIC regulations and NCQA standards, complex Case Management, Chronic Condition Management, and Quality Management.

#### H. Account Management

1. An experienced and knowledgeable account management team who are flexible, timely, and responsive to HCA. HCA will have the option to be a part of the interview process for team members, as referenced in the Performance Guarantees located in Exhibit K – *Draft Contract*.
2. Account management and executive level staff, including a CMO, in attendance at regular and as needed meetings with HCA.
3. Representatives in attendance at the SEBB Program Annual Open Enrollment benefit fairs that will occur throughout the state in the fall of each contracted year. The representatives must be able to cover topics such as benefits and cost-sharing, network providers, Claim procedures, Member services, and information tools and resources.

#### I. Eligibility and Systems

1. Generation of unique Subscriber/Member identification numbers for eligible Subscribers/Members. The working assumption is HCA will send the first full eligibility file (except for test files) after the SEBB Program Annual Open Enrollment ends in the fall of 2019. Any subsequent changes to the file will be sent over on a daily basis to the Contractor(s).
2. Maintenance of accurate information, and sharing of such information with other contractors working with the HCA (i.e., HCA's actuary, wellness program vendor, etc.). This process may involve transmission of a daily and weekly eligibility files within HCA required timelines.
3. Integration of information from other contractors (who are to be determined) to achieve effective and efficient coordination of services. Additionally, Contractor(s) may be required to transfer Member social security numbers to other HCA vendors via secure files.
4. Completion of quarterly reconciliation file audits with other vendors (if data is passed between the Contractor(s) and other vendors) and the HCA.

#### J. Implementation

1. An implementation plan that incorporates the dates found Exhibit H – *Operations*. An ASB(s) must be willing to take on the full financial risk of beginning implementation on a signed Contract that does not include contracted rates, with the understanding that future proposed rates will not be approved until the summer of 2019. A successful implementation requires a comprehensive and detailed implementation plan that addresses each contract area and all related issues to ensure the ASB is fully operational prior to January 1, 2020. Implementation will conclude by September 1, 2019.
2. A plan for facilitating transitions for new Members that have complex health care needs, have a current and active treatment plan (e.g., pregnancy), or are hospitalized between January 1 and March 31, 2020.
3. Completion of a readiness assessment of ASB's operations conducted by HCA. The timeframe to be agreed upon between HCA and the ASB.

### **1.7. Minimum Qualifications**

Within the *Master Letter of Submittal*, section 3.4, Bidders must explain and demonstrate compliance with the following minimum qualifications to participate as a Bidder in response to this RFP. Bidder must meet these minimum requirements at the time its Proposal is submitted to HCA.

1. Must have responded to all mandatory elements of the HCA's Request for Information 2646, dated April 2, 2018. (Bidder to attest yes or no and HCA will verify.)
2. Must have a health care services plan licensed by the Washington State OIC operating within Washington State.
3. Must have been issued a UBI number to operate as a licensed business in Washington State.
4. Must ~~have proof of~~ possess NCQA or URAC full health plan accreditation (a) in Washington State or, (b) in another state with an intent and plan to receive accreditation in Washington State no later than 12/31/2019. ~~(Bidder to provide evidence of accreditation, which will include current accreditation status, effective date, and when they need to renew their accreditation.)~~
5. Must have a Washington State provider network that meets the OIC's network requirements in WAC 284-170.
6. Must comply with all OIC regulations about Complaints and Appeals processes.
7. Must comply with all state and federal privacy and security laws, statutes, and regulations for protecting Enrollee data, including HIPAA.
8. Must meet an A.M. Best financial rating of A- at the time of Proposal submittal, or comparable rating from one of the independent agencies who rate the financial strength of insurance companies (e.g., Standard & Poor's, Moody's, Fitch, etc.). ~~(Bidder to provide a copy of their most recent A.M. Best rating report with this rating.)~~
9. Must comply with Washington State OCIO security standards and agree to undergo a security design review conducted by Washington Technology Solutions. (See Appendix 2 – OCIO Standard 141.10 – Securing IT Assets and Appendix 3 – WATech OCS Design Review Checklist)
10. Must provide coverage of and access to all benefits required of large group market plans included in Title 48 RCW, other state laws, and federal laws.
11. ~~Must comply with the Affordable Care Act's (ACA's) Administrative Simplification provisions. (Bidder must submit to HCA the documentation certifying compliance with the adopted standards and operating rules.)~~

## 1.8. Funding

As stated above, HCA will select ASBs based solely on non-cost elements of their services. Afterwards, HCA and ASBs who sign a Contract will then engage in the RFC process to determine a final benefit design and agreed upon rates. The continuation of any Contract beyond the RFC process is contingent upon the agreement to rates such that the HCA can manage the overall SEBB expenditures to remain within the budget approved in the final omnibus appropriations act.

## 1.9. Period of Performance

The initial period of performance of any contract resulting from this RFP is tentatively scheduled to begin in early November 2018, and to end on December 31, 2023. Benefit coverage and operational services will not begin until January 1, 2020, at which time, monthly premium payments will begin. HCA may not be obligated to make any payment to Contractor(s) prior to January 1, 2020.

HCA reserves the right to extend any such contract for up to eight (8) additional years in increments of not less than one (1) year. Amendments extending the period of performance, if any, will be at the sole discretion of HCA.

#### 1.10. 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. Bidders should familiarize themselves with the requirements prior to submitting a proposal that includes current or former state employees.

#### 1.11. Abbreviations and Definitions

For the purposes of this RFP, the following abbreviations and terms have the meanings indicated below:

**Accountable Communities of Health or ACH** – Is a regionally governed, public-private collaborative tailored by the region to align actions and initiatives of diverse coalition of players in order to achieve healthy communities. Nine ACHs serve the entirety of Washington State, the boundaries of which align with Medicaid Regional Service Areas.

**All Payer Claims Database or APCD** – Washington's statewide all-payer health care claims database to support transparent public reporting of health care information as described in RCW 43.371.020.

**Annual Open Enrollment** – An annual event set aside for a period of time when Subscribers may make changes to their Health Plan enrollment and salary reduction elections for the following Plan Year. During the Annual Open Enrollment, Subscribers may transfer from one Health Plan to another, enroll or remove Dependents from coverage, or enroll or waive enrollment in SEBB Program medical. School Employees eligible to participate in the salary reduction plan may enroll in or change their election under the dependent care assistance program (DCAP), the medical flexible spending arrangement (FSA), or the premium payment plan.

**Apparently Successful Bidder or ASB** – Any Bidder selected as an entity to perform the anticipated services under this RFP, subject to completion of contract negotiations and execution of a written contract.

**Appeal** – A written or oral request for reconsideration of a decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services, including the admission to, or continued stay in, a health care facility.

**Benefits Start Date** – The day the ASB will begin providing benefit coverage and services under the Contract. This date is currently scheduled for January 1, 2020.

**Bidder** – An entity interested in the RFP that submits a Proposal in order to attain a contract with the Health Care Authority.

**Book-of-Business** – All commercial business of the Bidder, including any and all fully insured and self-insured products within the Bidder's accounts.

**Bree Collaborative** – The statewide public-private consortium established in 2011 by the Washington State Legislature "to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State." Annually, the Bree Collaborative identifies up to three areas where there is substantial variation in practice patterns and/or high utilization trends that do not produce better care outcomes. Recommendations from the Bree are sent to the HCA to guide state purchasing for programs such as Medicaid and Public Employees Benefits Board.

**Business Day** – Monday through Friday, 8:00 a.m. to 5:00 p.m., Pacific Time, except for holidays observed by the State of Washington, unless otherwise specified within the RFP.

**Care Coordination** - The coordination of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

**Carrier** – An insurance company.

**Case Management** - A collaborative process of assessment, planning, facilitation, Care Coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

**Certificate of Coverage or COC** – A summary of the essential features of the group coverage contract produced and made available to each covered person. The COC is in effect during a given benefit year in which the date of service(s) received by the Member, falls.

**Charter School** – Per Chapter 241, Laws of 2016 (E2SSB 6194), a "Charter School" is a public school that is established in accordance with this chapter, governed by a charter school board, and operated according to the terms of a charter school contract executed under this chapter.

**Choosing Wisely** – A campaign by the American Board of Internal Medicine Foundation (ABIM) to promote conversations between patients and providers in an effort to reduce unnecessary and/or low-value care.

**Chronic Condition Management** – The oversight and education activities conducted by health care professionals to help members with chronic diseases and health conditions such as diabetes, high blood pressure, congestive heart failure, and chronic obstructive pulmonary disease learn to understand their condition and live successfully with it. The work involves motivating members to persist in necessary therapies and interventions and helping them to achieve an ongoing, reasonable quality of life.

**Claim** – The written notice on a form acceptable by the Carrier for reimbursement for any health care service or supply pursuant to the terms of the applicable Certificate of Coverage.

**Clinical Management** – means the programs that apply systems, science, incentives, and information to improve medical practice and assist both consumers and their support system to become engaged in a collaborative process designed to manage medical/social/Behavioral Health conditions more effectively. The goal of Clinical Management is to achieve an optimal level of wellness and improve Care Coordination while providing cost effective, non-duplicative services.

**Clinical Management Services** – The use of best practice recommendations (such as the Bree Collaborative recommendations) in the provision of Clinical Management to support optimal health outcomes, in collaboration with the HCA's clinical team; proactive identification and management of members who are at risk for health service utilization; provision of Patient Decision Aids to support appropriate patient self-management; collaboration and integration with providers and delivery systems; reduction of unnecessary variation in clinical practice; and lower healthcare costs.

**CMS** – Centers for Medicare and Medicaid Services.

**Center of Excellence or COE** – A "Center of Excellence" a health care provider or facility that is identified by the Bidder and/or HCA as a high quality, cost efficient provider that produces the best outcomes for a specific service.

**Common Measure Set** – A set of statewide measures for Washington State that provide the foundation for health care accountability and measuring performance. The Performance Measures Coordinating Committee, which was created by legislation (RCW 41.05.690), approved a “starter set” of measures in December 2014 that are intended to evolve over time as the science of measurement and state priorities evolve.

**Complaint (Grievances)** – An oral or written expression of dissatisfaction submitted by or on behalf of a Member regarding: (i) the denial of health care services or payment for health care services; (ii) issues other than denial of or payment for health care services, including dissatisfaction with health care services, delays in obtaining health care services, conflicts with Carrier staff or providers; or (iii) dissatisfaction with UMP plan practices or action unrelated to health care services.

**Continuation Coverage** – The temporary continuation of SEBB Health Plan coverage available to Enrollees after a qualifying event occurs as administered under Title XXII of the Public Health Service (PHS) Act, 42 U.S.C. Secs. 300bb-1 through 300bb-8.

**Contract** – A written agreement, resulting from this procurement, between an ASB and the HCA, including all exhibits, schedules, attachments, and other terms or documents referred to, incorporated by reference, or attached hereto. The HCA's Draft Contract is included as Exhibit K.

**Contractor** – What an ASB becomes after a Contract has been executed. This includes its employees and agents, and any firm, provider, organization, individual or other entity performing services under the Contract. It also includes any Subcontractor retained by Contractor as permitted under the terms of the Contract.

**Coordination of Benefits or COB** – Defined in WAC 284.51.195(7).

**Covered Lives** - The number of people enrolled in a particular health insurance plan.

**Day** – Any calendar day, including weekends and holidays. All statements referring to a number of Days mean calendar days, regardless of the number of Days, unless something different is explicitly specified. If the time when something must be performed falls on a weekend, a day observed as a holiday by the State of Washington as an employer, or a day when HCA is officially closed for other reasons, then that action is due on the next Business Day. Day one is the Day after receipt, unless something different is explicitly specified.

**Dependent** – An eligible spouse, Washington State state-registered domestic partner, and/or child, who meets SEBB Program eligibility requirements as described in the SEB Board policy resolutions SEBB 2018-01, SEBB 2018-02, and SEBB 2018-03.

**Educational Service District (ESD)** – A regional education unit Washington State. There are nine (9) ESDs; each ESD serves multiple school districts. ESD are established under RCW 28A.310.020 to provide cooperative and information services to local school districts; assist superintendents in the performance of their duties, and provide services to the school districts and the Washington State center for childhood deafness and hearing loss and the school for the blind to assure equal education opportunities.

**Enrollee** – A person who meets all the eligibility requirements defined in RCW 41.05.470, and (i) is enrolled in SEBB Program benefits for whom all applicable premium payments and any applicable premium surcharges have been paid, or (ii) waived SEBB Program available medical coverage.

**e-Value8** – A program of the National Business Group on Health that measures and evaluates health plan performance. The Washington Health Alliance deploys e-Value8 in Washington State every other year.

**Explanation of Benefits or EOB** – A statement sent to covered individuals explaining what medical treatments and/or services were paid on their behalf

**HCA Account Manager** – An employee of the HCA designated to represent HCA in matters relating to the Contract.

**Health Care Quality** – The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

**Health Equity** – Health equity exists when all people have the opportunity to attain their full health potential and no one is disadvantaged. HCA proactively pursues the elimination of health inequities and preventable differences in health among groups based on socioeconomic status, source of income, gender identity, sexual orientation, race and ethnicity, tribal membership, language, immigration status, age, religion, the job they have, education, disability, housing status, the neighborhood they live in or any other socially determined circumstances.

**Health Plan** – One of the fully insured or self insured medical plans offered by the HCA. Each “Health Plan” includes a Certificate of Coverage for services relating to medical, behavioral health, and pharmacy Claims.

**Health Savings Account or HSA** – Health Savings Account. A tax-advantaged medical savings account linked to a High Deductible Health Plan (HDHP) in which Members, the employer, and others may deposit funds.

**Healthier Washington** – The state initiative aimed at health transformation so Washington State residents experience better health and receive better, more affordable care.

**High Deductible Health Plan or HDHP** – An IRS-qualified high-deductible health plan that allows for tax-deferred contributions to a Health Savings Account (HSA).

**HIPAA** – The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended from time to time, and its corresponding federal regulations.

**HSA Trustee** – The subcontracted IRS-qualified trustee responsible for managing a HSA accounts.

**Independent Review Organization or IRO** – Shall have the meaning set forth in WAC 246-305-010(14).

**Insurance Code** – As comprised in Chapter 48 RCW and Chapter 284 WAC.

**LAN** – The Health Care Payment Learning and Action Network, a collaborative effort between Department of Health and Human Services, acting through CMS, and its private, public, and non-profit partners to transform the nation’s health system to emphasize value over volume.

**Medication-Assisted Treatment or MAT** – The combination of using US Food and Drug Administration (FDA) approved drugs with counseling and behavioral therapies to treat substance use disorders.

**Member** – Subscribers and their Dependents who are enrolled in a SEBB Program contracted fully insured medical plan with a Carrier that results from this RFP, and for whom applicable premium contributions and any applicable premium surcharges have been made.

**NCQA or National Committee for Quality Assurance** – A private 501(c)(3) not-for-profit organization dedicated to improving Health Care Quality. NCQA is the accrediting body for health plans in the United States. NCQA uses the Healthcare Effectiveness Data and Information Set (HEDIS) tool to measure health plan performance on important dimensions of care and service.

**Patient Decision Aid** – A tool that can help people engage in shared health decisions with their health care provider. Research shows that use of Patient Decision Aids leads to increased knowledge, more accurate risk perception, and fewer patients remaining passive or undecided about

their care. A list of certified Patient Decision Aids can be found here: <https://www.hca.wa.gov/about-hca/healthier-washington/certified-aids>.

**Patient Reported Outcomes** – Outcomes from medical care that are important to patients and their support groups.

**PEB Board** – The Public Employees Benefits Board, which is authorized to design benefits and determine the terms and conditions for participation in health insurance benefits for eligible public employees and Retirees under chapter 41.05 RCW.

**PEBB Program** – The program administered by HCA that purchases and coordinates benefits for eligible public employees and Retirees.

**Performance Credit** – The financial consequence associated with failure to meet the applicable performance standards or guarantees.

**Performance Guarantee** – A list of expectations that the HCA views as critical to the success of the plans resulting from this RFP. Failure to achieve a Performance Guarantee will result in the issuance of Performance Credits.

**PHI** – Protected Health Information, as defined in 45 C.F.R. §160.103.

**Proposal** – A formal offer submitted in response to this RFP.

**Quality Improvement** – A systematic and continuous set of actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

**Quality Management** – A planned systemic, organization-wide approach to the monitoring, analysis, and improvement of organizational performance, thereby continually improving the quality of patient care and services provided and the likelihood of desired patient outcomes.

**RCW** – Revised Code of Washington. Any references to specific titles, chapters, or sections of the RCW include any substitute, successor, or replacement title, chapter, or section.

**Request for Completion** or **RFC** – A letter HCA will draft to request information from a Contractor to finalize the details of the Contract (specifically rates and final plan design).

**Request for Completion Process** or **RFC Process** – A process HCA will initiate after Contract execution in order to finalize rates and plan designs with a Contractor.

**Request for Completion Response** or **RFC Response** – A Contractor's response to HCA's RFC that will include the HCA requested information and have a specific due date.

**Retiree(s)** – A Member who has retired from service that is eligible for PEBB Program benefits, and includes all retired School Employees and is either a) not yet Medicare eligible, therefore, the Retiree's PEBB Program coverage is the primary payor of the Retiree's medical services; or b) Medicare eligible and their Medicare Parts A and B are the primary payor for the Retiree's medical services.

**School Employee** – An employee of a Washington State school district, Educational Service District, or Charter School. This includes both certificated and non-certificated (otherwise known as "classified") employees.

**School Employees Benefits Board or SEB Board** – A board made up of members appointed by the Governor that is authorized to design and approve insurance benefit plans for School Employees and to establish eligibility criteria for participation in benefit plans under RCW 41.05.740.

**SEBB Health Plan** - A health plan approved by the SEB Board that is offered under the SEBB Program.



**SEBB Program** – The program administered by HCA that purchases and coordinates benefits for eligible School Employees.

**Shared Decision Making** – The process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences.

**SmartHealth** – The PEBB Program's wellness incentive program initiated by the Governor's Executive Order 13-06.

**Social Determinants of Health** – Describes a set of factors surrounding Health Equity that contribute to a person's current state of health. These factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature.

**Subcontractor** – A person, partnership, or entity not in the employ of or owned by the Bidder, who is performing all or part of those services under a separate contract with or on behalf of the Bidder. The terms "Subcontractor" mean Subcontractors in any tier.

**Subscriber** – The School Employee, Continuation Coverage enrollee, or survivor who has been determined eligible by the SEBB Program, school district, ESD, or Charter School and is the individual to whom the SEBB Program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of Members.

**Summary of Benefits and Coverage** – A document, required by law under the Affordable Care Act, that insurance companies and group health plans provide to consumers comparing benefits and coverage for different plans. The information provided must be concise, and in plain language and must be consistent with the health plans benefits and coverage information for consumers to easily compare different coverage options in order to select their health plan.

**Triple Aim** – A framework for optimizing health system performance to improve the health of populations, improve customer experience of care (quality and patient experience), and reduce cost.

**Uniform Medical Plan or UMP** – The self insured, preferred provider health plan administered by the UMP third party administrator, Regence. The plans offered by HCA under UMP to PEBB Program Members includes UMP Classic, UMP CDHP, and UMP Plus.

**Uniform Medical Plan Classic or UMP Classic** – The self insured, preferred provider health plan administered by the UMP third party administrator, Regence, and offered by HCA to PEBB Program Members.

**Uniform Medical Plan Consumer Directed Health Plan or UMP CDHP** – The self insured, preferred provider high deductible health plan administered by the UMP third party administrator, Regence, and offered by HCA to PEBB Program Members.

**Utilization Management or UM** – The evaluation of medical necessity appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan. Utilization Management is sometimes called utilization review.

**Value Based Payment or VBP** – A form of reimbursement that ties payments for care delivery to the quality of care provided and rewards providers for both efficiency and effectiveness. The HCA defines Value Based Payments as payment arrangements in the CMS Health Care Learning & Action Network Categories 2c – 4b (See Appendix 1 – *CMS Framework for Value-Based Payments or Alternative Payment Models (CMS LAN APM)*).

**WAC** – The Washington Administrative Code. Any references to specific titles, chapters, or sections of the WAC includes any substitute, successor, or replacement title, chapter, or section.

**Washington Health Alliance** – A nonprofit, nonpartisan organization that reports data on Health Care Quality and value through the collection and analysis of Claims and clinical data from providers, health plans, health trusts, and employers. They focus on evidence-based practices and providing information to providers, patients, employers, and union trusts in order to help them make better decisions about how to reduce waste and cost while focusing on quality.

## 1.12. ADA

HCA complies with the Americans with Disabilities Act (ADA). Bidders may contact the RFP Coordinator to receive this RFP in Braille or on tape.

## 2. GENERAL INFORMATION FOR BIDDERS

### 2.1. RFP Coordinator

The RFP Coordinator is the sole point of contact in HCA for this procurement. All communication between the Bidder and HCA upon release of this RFP must be with the RFP Coordinator, as follows:

Primary RFP Coordinator	Lesley Houghton
Alternate RFP Coordinator	Andria Howerton
E-Mail Address	<a href="mailto:contracts@hca.wa.gov">contracts@hca.wa.gov</a>
Mailing Address	PO Box 42702 Olympia, WA 98501
Physical Address for Delivery	626 8 <sup>th</sup> Ave SE Olympia, WA 98501

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

### 2.2. Procurement Schedule

Issue Request for Proposals	June 8, 2018
Round 1 Bidder Questions Due	June 18, 2018 – 2:00 pm (PT)
Pre-Proposal Conference Call	June 20, 2018 – 11:00 am – 12:00 pm (PT)
Round 1 HCA Answers Posted	June 28, 2018
Round 2 Bidder Questions Due	July 9, 2018 – 2:00 pm (PT)
Round 2 HCA Answers Posted	July 19, 2018
Proposals Due	August 2, 2018 – 4:00 pm (PT)
Evaluate Proposals	August 7-17, 2018
Announce “Apparently Successful Bidder(s)” and send notification via e-mail to unsuccessful Bidder(s)	August 27, 2018
Debrief Request Period	August 28-30, 2018
Estimated End of Protest Period	September 7, 2018
Contract Negotiations	September 8 – October 31, 2018
Anticipated Award Date	November 9, 2018

HCA reserves the right in its sole discretion to revise the above schedule.

### **2.3. Pre-Proposal Conference**

A pre-proposal conference call is scheduled to be held on June 20, 2018 at 11:00 am, Pacific Time. All prospective Bidders are advised to attend; however, attendance is not mandatory.

HCA will be bound only by written answers to questions provided by the RFP Coordinator. Questions arising at the pre-proposal conference or in subsequent communication with the RFP Coordinator will be documented and answered in written form. A copy of the questions and answers will be sent to each prospective Bidder that has made the RFP Coordinator aware of its interest in this procurement, and will be posted on the Washington Electronic Business Solutions (WEBS) website.

The RFP Coordinator will provide further details on the pre-proposal conference call.

### **2.4. Bidder Questions Periods**

Bidders are provided two (2) scheduled opportunities to ask questions as set forth in section 2.2, *Procurement Schedule*. The due date by which Bidders must submit their questions for each of these periods is listed.

Both rounds are written question periods only. Questions regarding the RFP will only be accepted in writing, sent by email to the RFP Coordinator. The Bidder should include the email subject line as "RFP 2716 Question(s) – [Bidder name]" to ensure timely review of the questions submitted.

The HCA is only obligated to answer questions received in writing by the dates/times stated in the Procurement Schedule. The HCA will post answers to the questions in WEBS as an RFP amendment.

The HCA is under no obligation to respond to any questions received after the final scheduled question opportunity, but may do so at its discretion.

### **2.5. Posting on WEBS**

The HCA will use WEBS as the one official means to communicate with Bidders regarding activities related to this RFP. As required by RCW 39.26.150, the HCA will post this RFP and all amendments to the WEBS website located at <https://fortress.wa.gov/ga/webs/>. To ensure receipt of all RFP documents, the RFP and all attachments and amendments thereto must be downloaded from WEBS. The HCA is only obligated to provide notification of amendments to the RFP by posting to WEBS. A Bidder's failure to download and review all documents posted to WEBS risks submitting a Proposal that is incomplete, inaccurate, or an otherwise inadequate. Bidders accept full responsibility and liability for failing to receive any amendments resulting from their failure to register with WEBS, or from failure to download all RFP documents, and hold the State of Washington harmless from all claims of injury or loss resulting from such failure.

The HCA may also maintain, for convenience purposes only, an unofficial repository for this RFP and all attachments and amendments on its internet site at the following address:  
<http://www.hca.wa.gov/about-hca/bids-and-contracts>.

### **2.6. Bidder Responsibilities**

Bidders are solely responsible for:

1. Properly registering within WEBS at <https://fortress.wa.gov/ga/webs/>; and
2. Maintaining an accurate Bidder profile in WEBS; and

3. Downloading and reviewing the full solicitation consisting of the RFP, with all exhibits, appendices, attachments, and amendments related to the RFP from WEBS.

The Proposal(s) of each ASB will be incorporated as an exhibit to its Contract. Compliance with the terms of its Proposal will therefore be a requirement of the Contract.

## **2.7. Multiple or Alternative Proposals**

Bidder(s) may not submit more than one (1) Proposal; Proposals may be for a number of different plan design options.

Bidders may withdraw a Proposal that has been submitted at any time up to the Proposal due date and time in the Procurement Schedule. A written notice of withdrawal provided by an authorized representative of the Bidder must be submitted to the RFP Coordinator prior to the Proposal due date and time. After withdrawing a previously submitted Proposal, the Bidder may submit another Proposal at any time up to the Proposal due date and time as listed in the Procurement Schedule.

## **2.8. Approach to Subcontracted Services**

It is the HCA's intent to contract with an entity that meets or exceeds the minimum qualifications and mandatory requirements on its own merits. The HCA recognizes that in order to provide comprehensive services, Bidders may propose subcontracting services with other parties.

If Subcontractors are used, HCA must be granted the right to remove a Subcontractor or other third party staff from the performance of services described in this RFP, the Proposal, or the Contract. Further, the Contractor will bear sole responsibility for performance under any resulting Contract. In addition, the Contractor will also be required to incorporate some provisions of the Contract into any agreement with a permitted Subcontractor for these services.

## **2.9. Proprietary Information / Public Disclosure**

Proposals submitted in response to this RFP will become the property of HCA. All Proposals received will remain confidential until the Apparently Successful Bidder(s) are announced; thereafter, the Proposals will be deemed public records as defined in chapter 42.56 of the Revised Code of Washington (RCW).

**After ASB(s) have been announced, HCA intends to post redacted versions of Proposals submitted in response to this RFP to its website (similar to what was done with RFI 2646).**

Bidders are advised to carefully review this section and appropriately mark all proprietary information as directed below.

Any information in the Proposal that the Bidder desires to claim as proprietary and exempt from disclosure under chapter 42.56 RCW, or other state or federal law that provides for the nondisclosure of a document, must be clearly designated. The information must be clearly identified and the particular exemption from disclosure upon which the Bidder is making the claim must be cited. **In addition**, each page containing the information claimed to be exempt from disclosure must be clearly identified as proprietary or confidential by words printed on the page. Marking the entire Proposal exempt from disclosure or as Proprietary Information **will not be honored**.

If a public records request is made for the information that the Bidder has marked as proprietary or confidential, HCA will notify the Bidder of the request and of the date that the records will be released to the requester unless the Bidder obtains a court order enjoining that disclosure. If the Bidder fails to obtain the court order enjoining disclosure, HCA will release the requested information on the date specified. If a Bidder 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 Bidder'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 one (1) Business Days' notice to the RFP Coordinator is required. The HCA asks that all requests for information be directed to the RFP Coordinator.

The submission of any public records request to HCA pertaining in any way to this RFP will not affect the *Procurement Schedule*, as outlined in section 2.2, unless HCA, in its sole discretion, determines that altering the schedule would be in HCA's best interests.

## **2.10. Revisions to the RFP**

HCA reserves the right to amend this RFP at any time prior to contract award. HCA will post any RFP amendments to WEBS. In addition to being posted to WEBS, HCA may also, but will not be obligated to, post amendments to its internet located at <http://www.hca.wa.gov/about-hca/bids-and-contracts>, and/or directly email amendments to Bidders that have expressed an interest in submitting a Proposal.

HCA also reserves the right to request additional information to determine if the Bidder can successfully meet the requirements of the RFP.

If a conflict exists between amendments, between an amendment and the RFP, or between multiple amendments, the document last in time controls. If a conflict exists between any document posted to WEBS and any document posted to HCA's internet site or sent directly to Bidders, the document posted to WEBS shall control. Published Bidders' questions and HCA's official answers will be issued as an amendment to the RFP.

HCA reserves the right, in its sole discretion, to cancel or amend this RFP at any time and for any reason.

## **2.11. Diverse Business Inclusion Plan**

Bidders are required to submit a Diverse Business Inclusion Plan with their Proposal. 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 regulations included or referenced in the contract documents will apply.

## **2.12. Acceptance Period**

Proposals must provide 180 Days for acceptance by HCA from the Proposal due date listed in this RFP.

## **2.13. Complaint Process**

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

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

- 2.13.2. A complaint must be submitted to HCA prior to five Business Days before the bid response deadline. The complaint must:
- a. Be in writing;
  - b. Be sent to the RFP Coordinator in a timely manner;
  - c. Clearly articulate the basis for the complaint; and
  - d. Include a proposed remedy.

The RFP Coordinator will respond to the complaint in writing. The response to the complaint and any changes to the RFP 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. If a Bidder chooses to file a protest at a later date (see section 4.5, *Protest Procedure*), a such Bidder cannot raise any issue that the Bidder previously raised in its complaint. HCA's action or inaction in response to a complaint will be the agency's final decision. There will be no administrative appeal process.

## **2.14. Responsiveness**

The RFP Coordinator will review all Proposals to determine compliance with administrative requirements and instructions specified in this RFP. A Bidder's failure to comply with any part of the RFP may result in rejection of the Proposal as non-responsive.

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

## **2.15. Most Favorable Terms**

HCA reserves the right to make an award without further discussion of the Proposal submitted. Therefore, the Proposal should be submitted initially on the most favorable terms that the Bidder can propose. HCA reserves the right to contact a Bidder for clarification of its Proposal.

The ASB should be prepared to accept this RFP for incorporation into a Contract resulting from this RFP. The Contract resulting from this RFP will incorporate some, or all, of the Bidder's Proposal. The Proposal will become a part of the official procurement file on this matter without obligation to HCA.

## **2.16. Contract Term**

Any Contract(s) resulting from this RFP will be for the provision of specified services. HCA estimates Contract(s) will be signed in November 2018. Any Contract resulting from this RFP may be amended depending on whether or not the SEB Board approves the plans and plan design(s). Contract(s) resulting from the RFP will be signed for the purpose of beginning implementation activities, and to ensure a smooth transition from the plans SEBB Program Members are currently enrolled in. The initial term of any such Contract will expire December 31, 2023. Thereafter Contract(s) may be extended for increments of one (1) year or more for no more than eight (8) additional years. Extension of the Contract beyond the initial term is not guaranteed by the HCA.

HCA's monthly premium payments to the Contractor(s) will begin following January 1, 2020, and may be updated annually through the Request for Renewal (RFR) process. HCA may not be obligated to make any other payment to Contractor(s) prior to January 1, 2020.

HCA reserves the right, in its sole discretion, to not issue any Contract as a result of this RFP.

## **2.17. Mandatory Contractual Terms**

By submitting a Proposal, a Bidder, if selected for award, shall be held to all statements within the Proposal. This RFP and the ASB's Proposal will be made a part of any Contract resulting from this RFP.

A Draft Contract included as Exhibit K, will serve as the base for contract negotiations with an ASB. The Bidder must be prepared to agree to all terms of the attached Draft Contract as presented or the Proposal may be rejected. Bidders must include a copy of the Draft Contract with its Proposal that shows the changes Bidder proposes be made if it is selected as an ASB. **If the Bidder fails to identify an objection to any particular term or condition, the term or condition will be deemed agreed to by the Bidder.** HCA reserves the right to discuss any Bidder proposed change to terms or conditions and to clarify and supplement such proposal.

Bidders are reminded that this is a competitive solicitation for a public contract and that HCA cannot accept a Proposal, or enter into a contract, that substantially changes the material terms and specifications published in this RFP. Proposed changes to any particular term or condition of the Draft Contract will be used to determine the responsiveness of the Proposal. Proposals that are contingent upon HCA making substantial changes to the material terms and specifications published in the RFP may be disqualified.

If, by December 3, 2018, an ASB and HCA cannot reach agreement on acceptable terms for the Contract, HCA may cancel the selection and award the Contract to the next most qualified Bidder.

The services to be performed by an ASB will involve the use of information that is protected by HIPAA. As such, the ASB must agree, as a component of the final Contract, to abide by the Data Share Agreement (DSA) included as part of the Contract.

#### **2.18. Contract Delay Contingency**

In the event the Benefits Start Date under a Contract is delayed until a later year for any reason, HCA reserves the right to terminate the Contract at its sole discretion. It may also choose to make a good faith effort to maintain the contractual relationship and to amend the Contract as necessary to address the delay.

#### **2.19. Implementation / Timeframe**

It is anticipated that contracted services will be implemented in two (2) phases.

*Phase One - Implementation and Planning:* This phase includes coordination with the HCA staff, consultants, and other contractors to build the infrastructure necessary to support the plan(s) and make sure the ASB is prepared to provide services. This will include such items as the eligibility files and group structure for Members. This phase will begin once the Contract is signed (which HCA estimates to be early November 2018), and will continue at least through October 1, 2019. Implementation will begin based on a number of assumptions, which are subject to change.

*Phase Two – Delivery of Health Plan Services:* This phase is the delivery of the plan(s) the ASB is contracted to provide. Specific services described in the Contract will begin on January 1, 2020, or thereafter, as specified in the Contract and continue for the term of the Contract.

HCA will work with the ASB(s) to further define the contents of each phase in the implementation plan and Contract. The HCA reserves the right, in its sole discretion, to alter the timing of the implementation timeframe at any time.

#### **2.20. Request for Completion Process (RFC Process)**

The HCA anticipates completing the process of obtaining and negotiating rates from apparently successful bidders and determining final payment rates to Contractor(s) in four (4) phases.

1. **September – November 2018**

Orientation to rates approach and methodology, including risk adjustment and area adjustment using geographic rating regions similar to OIC's rating regions.

2. **December 2018 – February 2019**

Release of Request for Completion (RFC), submission of initial rates by Contractors, and negotiation of not-to-exceed (NTE) rates. This process will allow Contractors to receive an updated data book that contains summarized School Employee data to assist in the development of proposed rates for the plan designs approved by the SEB Board. HCA anticipates that Contractors will use School Employee enrollment data they have to develop rates and will use the statewide data as a reasonableness check. Prior to receiving this data, Contractors may be required to sign a non-disclosure agreement (NDA) or a data share agreement (DSA). The RFC will request rates and final plan designs, and any other information that may be required to include in a Contract for providing health care services. The RFC will also include instructions regarding how to access the claims data, and a specific due date by which a Contractor must provide their RFC Response. At this time, HCA anticipates that the RFC will go out in early December 2018. If HCA and a Contractor are unable to agree on NTE rates, HCA has sole discretion to terminate the Contract resulting from this RFP.

3. **March - June 2019**

Negotiation of final rates and plan designs as needed to align with 2019-2021 biennial budget development. Final rates and plan designs will be added to the Contract(s) as amendment(s). It is anticipated that any such amendments will be executed by September 2019.

4. **January - June 2020**

Develop and apply risk and area adjustments to produce final payment rates for plan year 2020. Final payment rates will be incorporated into Contract(s) via contract amendment(s).

## **2.21. Costs to Propose**

HCA will not be liable for any costs incurred by the Bidder in preparation of a Proposal, in conducting a presentation, or any other activities related in any way to this RFP.

## **2.22. Receipt of Insufficient Number of Proposals**

If HCA receives only one responsive Proposal as a result of this RFP, HCA reserves the right to either: 1) directly negotiate and contract with the Bidder; or 2) not award any contract at all. HCA may continue to have the Bidder complete the entire RFP process. HCA is under no obligation to tell the Bidder if it is the only Bidder.

## **2.23. Cancellations, Acceptance, Administrative Irregularities, and Discussions**

This RFP does not obligate the State of Washington or the HCA to contract for services specified herein in full or in part. The HCA reserves the right to:

1. Cancel all or part of this RFP at any time for any reason.
2. Accept or reject any and all Proposals, in whole or in part.
3. Reject any part of any or all Proposals and continue to evaluate the modified version of the Proposals.
4. To waive, or permit cure of, administrative irregularities (however, waiver or permitting cure of such an irregularity does not imply the HCA will waive or permit cure of other or subsequent irregularity(-ies)).
5. To modify the RFP at any time.



6. To conduct discussions with all qualified or potentially qualified Bidders in any manner necessary to serve the best interests of the HCA and the people of the State of Washington.

#### **2.24. 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 RFP. No cost chargeable to the proposed Contract may be incurred before receipt of a fully executed Contract.

#### **2.25. Electronic Payment**

The State of Washington prefers to utilize electronic payment in its transactions. The ASB will be provided a form to complete with the Contract to authorize such payment method.

#### **2.26. Insurance Coverage**

As a requirement of the resultant Contract, the ASB 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 ASB must, at its own expense, obtain and keep in force insurance coverage that will be maintained in full force and effect during the term of the Contract. The ASB must furnish evidence in the form of a Certificate of Insurance that insurance will be provided, and a copy must be forwarded to HCA within 15 Business Days of the Contract effective date.

##### **2.26.1. Liability Insurance**

- a. Commercial General Liability Insurance: ASB shall 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 must be at least twice the "each occurrence" limit. CGL insurance must have products-completed operations aggregate limit of at least two times the "each occurrence" limit. CGL insurance must be written on ISO occurrence from CG 00 01 (or a substitute form providing equivalent coverage). All insurance must 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 ASB is responsible for ensuring that any Subcontractors provide adequate insurance coverage for the activities arising out of subcontracts.

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

##### **2.26.2. Employers Liability ("Stop Gap") Insurance**

In addition, the ASB shall 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.

2.26.3. Cyber-Liability Insurance / Privacy Breach Coverage. For the purposes of this section, 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 three (3) years following its termination or expiration, ASB must maintain insurance to cover costs incurred in connection with a security incident, privacy Breach, or potential compromise of Data, including:

- a. Computer forensics assistance to assess the impact of a Data Breach, determine root cause, and help determine whether and the extent to which notification must be provided to comply with Breach notification laws;
- b. Notification and call center services for individuals affected by a security incident, or privacy Breach;
- c. Breach resolution and mitigation services for individuals affected by a security incident or privacy Breach, including fraud prevention, credit monitoring, and identity theft assistance; and
- d. Regulatory defense, fines, and penalties from any claim in the form of a regulatory proceeding resulting from a violation of any applicable privacy or security law(s) or regulation(s).

2.26.4. Additional Provisions

Above insurance policy must include the following provisions:

- a. 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.

- b. 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 Business Days advance notice of cancellation or non-renewal. If cancellation is due to non-payment of premium, the state must be given ten Days advance notice of cancellation. Insurers subject to 48.15 RCW (Surplus lines): The state must be given 20 Business Days advance notice of cancellation. If cancellation is due to non-payment of premium, the state must be given ten Days advance notice of cancellation.
- c. Identification. Policy must reference the state's Contract number and the Health Care Authority.
- d. 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 the Health Care Authority 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.
- e. Excess Coverage. By requiring insurance herein, the state does not represent that coverage and limits will be adequate to protect ASB, and such coverage and limits will not limit ASB's liability under the indemnities and reimbursements granted to the state in this Contract.

#### 2.26.5. Workers' Compensation Coverage

The ASB 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 responsible in any way for claims filed by the ASB or their employees for services performed under the terms of this Contract.

### 3. PROPOSAL CONTENTS AND REQUIREMENTS

#### 3.1. Proposal Contents Overview

In order to have its Proposal evaluated by HCA, Bidder **must provide** the items listed below following the specific instructions outlined in sections 3.2, *Proposal Format and Length* and 3.3, *Proposal Submission*.

- 3.1.1. Master Letter of Submittal (see section 3.4)
- 3.1.2. Proposed Plan Design(s) and Service Area(s) (see section 3.5)
- 3.1.3. Evaluation Elements (see section 3.6)

#### 3.2. Proposal Format and Length

Proposals must comply with the format requirements or restrictions listed below. Failure to do so may result in the disqualification of the Bidder's Proposal:

- 3.2.1. Use standard 8.5" x 11" white paper, with no smaller than 11 point font. All page margins can be no less than 1 inch.

- 3.2.2. State the Bidder's full legal name on the first or cover page of all copies of the Proposal.
- 3.2.3. Proposals must provide information in the same order as presented in this document with the same headings. Title and number each item in the same way it appears in the RFP. Each question must be restated prior to the Bidder's response.
- 3.2.4. Items marked "mandatory" must be included as part of the Proposal for the Proposal to be considered responsive; however, these items are not scored. Items marked "scored" must be included as part of the Proposal for the Proposal to be considered responsive and are awarded points by the evaluation team.
- 3.2.5. Page limits stated in this RFP are determined counting single-sides of the response. HCA has no obligation to read, consider, or score any material exceeding the stated page limits. Also, there will be no grounds for protest if critical information is on the pages exceeding the specified page limit that is not reviewed.
- 3.2.6. Proposals are to be prepared simply and economically, providing a straightforward, concise description of the Bidder's Proposal to meet the requirements of this RFP.
- 3.2.7. Bidders are liable for all errors or omissions contained in their Proposals. Bidders will not be allowed to alter Proposal documents after the deadline for Proposal submission. HCA is not liable for any errors in Proposals. HCA reserves the right to contact a Bidder for clarification of Proposal contents.
- 3.2.8. HCA is under no obligation to consider any supplemental materials submitted that have not been requested.

### **3.3. Proposal Submission**

Bidders are required to submit their Proposal both an electronic copy via email, and a physical copy. Proposals must be organized as outlined in section 3.1, *Proposal Contents Overview*. Each response to a particular section or exhibit must be clearly organized and labeled.

- 3.3.1. *Electronic delivery (email)* - Proposals must be submitted electronically as an attachment to an e-mail to the RFP Coordinator at the e-mail address listed in section 2.1. Attachments to e-mail should be in Microsoft Word format or PDF. Zipped files cannot be received by HCA and cannot be used for submission of Proposals. 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 Bidder to the offer. HCA does not assume responsibility for problems with Bidder's e-mail. If HCA e-mail is not working, appropriate allowances will be made.
- 3.3.2. *Hard copy delivery (mail)* - Bidders are required to provide ~~six~~<sup>sixtytwo</sup> (62) hard copies, each bound in a 3-ring binder(s). Bidders should allow sufficient time for delivery to ensure timely receipt of their Proposals by the RFP Coordinator. Bidders assume the risk for the method of delivery chosen. HCA assumes no responsibility for delays caused by any delivery service.
- 3.3.3. Proposals may not be transmitted using facsimile transmission.
- 3.3.4. Bidders should allow sufficient time to ensure timely receipt of the Proposal by the RFP Coordinator. Late Proposals will not be accepted and may be disqualified from further consideration, unless HCA e-mail is found to be at fault. All Proposals and any accompanying documentation become the property of HCA and will not be returned.
- 3.3.5. If multiple Carriers within the same holding company are responding to this RFP, each must submit their own Proposal instead of submitting a joint Proposal.

### 3.4. Master Letter of Submittal (Mandatory)

This is a cover letter to the Proposal that provides Bidder-specific information, and acknowledges the receipt of all parts of the RFP and any amendments thereto. The Letter of Submittal and the attached Certifications and Assurances form (Exhibit A to this RFP) must be signed and dated by a person authorized to legally bind the Bidder 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 must include the following information in the following order:

#### 3.4.1. The following information about the Bidder and any proposed Subcontractors:

- a. 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.
- b. Name, title, address, and telephone number of each principal officer (President, Vice President, Treasurer, Chairperson of the Board of Directors, etc.).
- c. Legal status (sole proprietorship, partnership, corporation, etc.) and the year the entity was organized to do business as the entity now substantially exists.
- d. 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.
- e. (Bidder only) A description of Bidder's ownership, organizational structure (including executive leadership), and history. Include an organizational chart for the company.
- f. (Bidder only) Intent to make changes to ownership in the near future. Has the Bidder undergone such a change in the last five (5) years? Please provide a detailed answer.
- g. (Bidder only) Count of employees. Has that number undergone significant changes in the last five (5) years and, if so, why? Does the Bidder intend to make significant changes to that number in the next five (5) years?
- h. (Bidder only) What kind of health plan license does the Bidder hold in: (i) Washington, (ii) Oregon, and (iii) Idaho?
- i. (Bidder only) Location of the facility from which the Bidder would operate.
- j. (Bidder only) Identify any state employees, former state employees, or SEB Board members employed or on the firm's governing board as of the date of the Proposal. Include their position and responsibilities within the Bidder's organization. If following a review of this information, it is determined by HCA that a conflict of interest exists, the Bidder may be disqualified from further consideration for the award of a Contract.
- k. (Bidder only) Any information in the Proposal that the Bidder desires to claim as proprietary and exempt from disclosure must be clearly designated as described previously in section 2.9 – *Proprietary Information / Public Disclosure*.

#### 3.4.2. The following additional information about any proposed Subcontractors:

- a. Indicate if any of the Bidder's Washington State provider contracts are held under a Subcontractor or affiliate. If yes, list all counties where the Subcontractor/affiliate holds these contracts.

- b. Indicate if Bidder uses Subcontractors to process Claims. If yes, describe which elements remain in the primary control of the Bidder. These may include elements such as reimbursement arrangements and rates and Appeals.
- 3.4.3. A statement and explanation of how Bidder meets ALL of the minimum requirements specified in section 1.7 of this RFP. Bidder will need to provide legible copies of the appropriate documents that demonstrate how the Bidder complies with the eligibility requirements to participate as a Bidder in response to this RFP.
- 3.4.4. A statement from Bidder confirming acknowledgement of and intent to comply with the requirements of Engrossed Substitute House Bill (ESHB) 2408 (Laws of 2018, Ch. 219).
- 3.4.5. A copy of the *Certification and Assurances* form (Exhibit A) signed by a person authorized to bind the Bidder to a Contractor.
- 3.4.6. A completed *Diverse Business Inclusion Plan* (Exhibit B). This is a requirement as described in section 2.11.
- 3.4.7. Two (2) references from each Product Type listed in Exhibit E, section 2, *Health Plan Experience*, Table 1. Please provide references using Exhibit C – *Reference Form*.
- 3.4.8. A redlined copy of the *Draft Contract* (Exhibit K) identifying issues or proposed alternative text that reflects the actual content of the Bidder's Proposal (see section 2.17).
- 3.4.9. Provide the following information to show what the Bidder is doing to address the gap in coverage that will occur from when the school organization's Plan Year ends and when the SEBB Program benefits begin (i.e. October 31, 2019 – December 31, 2019):
- a. A list of the school organizations (school districts, ESDs, and Charter Schools) for which the Bidder currently provides health benefits.
- b. An explanation of what the Bidder is doing to address the gap in coverage, and the current status of the actions taken between the school organization(s) and the Bidder?

### **3.5. Plan Design(s) and Service Area(s) (Mandatory)**

Bidders must provide their proposed plan design(s) and service area(s) per the instructions in Exhibit D – *Plan Design(s) and Service Area(s)* This information must be included for a Proposal to be responsive, but will not be one of the elements scored by the evaluation team.

### **3.6. Evaluation Elements (Mandatory and Scored)**

Bidders must respond in detail for all items and provide information in the exact order specified in the exhibits below. Bidders should describe plans, approach, and methodology as to how Bidder intends to perform these services.

Bidders must submit this portion of their Proposal in the following six (6) separate exhibits:

- Exhibit E - Organizational Structure and Health Plan Experience
- Exhibit F – HCA Health Transformation Vision
- Exhibit G – Clinical Management
- Exhibit H – Operations
- Exhibit I – Provider Network
- Exhibit J – Technical Data Requirements

Please do not cut and paste responses into these exhibits. Instead, provide a response as a separate document following the instructions outlined in section 3.2, *Proposal Format and Length*.

## 4. EVALUATION AND CONTRACT AWARD

### 4.1. Evaluation Procedure

All Proposals received by the stated deadline in section 2.2, *Procurement Schedule*, will undergo an administrative review to be completed by the RFP Coordinator. Proposals that pass the administrative review are considered responsive and will move on to be evaluated by the evaluation team. A Bidder submitting any Proposal that does not pass administrative review will be notified by the RFP Coordinator, and the Proposal will be rejected as non-responsive.

#### 4.1.1. Administrative Review

- a. The administrative review of responsiveness is made on a pass/fail basis and will be used to initially evaluate a Bidder's compliance with the administrative requirements of this RFP. To meet the administrative requirements, a Proposal must follow the specifications, and include all of the mandatory information outlined in section 3, *Proposal Contents and Requirements*.
- b. The RFP Coordinator may, at his or her sole discretion, contact the Bidder for clarification of any portion of the Bidder's Proposal. Bidders should take every precaution to ensure that all answers are clear, complete, and directly address the specific requirement.
- c. HCA reserves the right, in its sole discretion, to waive administrative irregularities.

#### 4.1.2. Evaluation of Proposals

- a. Responsive Proposals will be evaluated and scored in accordance with the requirements stated in this RFP and any addenda issued. Evaluations will only be based upon information provided in the Bidder's Proposal.
- b. The evaluation of Proposals will be accomplished by an evaluation team, to be designated by HCA. Evaluation team members will review each Proposal before evaluating and scoring each section they have been assigned.
- c. The scores assigned by individual evaluation team members will be used in calculating the total number of points awarded to each Bidder. Included in section 4.2, *Evaluation Weighting and Scoring*, is a listing of all the scored Exhibits broken out by section, and the associated weights and the maximum points possible for each (Evaluation Table). Also included in this section is the scale of scores used by individual team members (0 – 10) and a brief statement about the scoring criteria associated with each of the scores (Scoring Methodology).
- d. Points awarded to a Bidder will first be calculated by section. The scores assigned by individual evaluation team members will be summed and averaged for an average score that will then be multiplied by the weight assigned to the section. Individual section scores will then be combined to result in the Bidder's total weighted score. The maximum number of points a Bidder can earn for all exhibits is 2,000.
- e. For a Bidder to be announced as an ASB and have their plan designs reviewed by the SEB Board for approval they must meet the following:
  - Bidder's total weighted score, as outlined in the Evaluation Table of section 4.2, is no less than 60% of the total maximum points (1200 points); and

- Bidder's average score for the following Key Sections must be no less than a score of five (5), as defined in the Scoring Methodology in section 4.2.

Key Sections	
Exhibit G	Clinical Management
<del>2</del>	<del>Clinical Objectives</del>
<del>23</del>	Clinical Management
<del>34</del>	Utilization Management (UM)
<del>45</del>	Quality Management (QM)
<del>56</del>	Complex Case Management
<del>67</del>	Chronic Condition Management
Exhibit H	Operations
1	General Operational Services
2	Member and Customer Services
3	Communications
4	Online Services
5	Member Engagement and Experience
7	Appeals and Complaints
8	Overall Account Administration
10	Emergency Response Account Management
11	Implementation Plan
Exhibit I	Provider Network
1	Provider Network
Exhibit J	Technical Data Requirements
2	Data File Transfer and Access
3	Eligibility System Requirements

- f. If one or more Bidders' fail to meet one or both scoring requirements in 4.1.2.e., it is at HCA's discretion whether to announce that/those Bidders as an ASB.
- g. HCA reserves the right to award the Contract(s) to the Bidder(s) whose Proposal(s) are deemed to be in the best interest of HCA and the state of Washington.

## 4.2. Evaluation Weighting and Scoring

Each section of the scored exhibits included in section 3.6 has been assigned a weight. Points will be assigned to each section based upon the average of all evaluation team member scores for the



section (0 – 10) multiplied by the weight indicated below. The weight and maximum points for each section are as follows:

<b>Evaluation Table</b>			
<b>Exhibit / Section No.</b>	<b>Title</b>	<b>Weight</b>	<b>Maximum Points</b>
<b>E</b>	<b>Organizational Structure and Health Plan Experience</b>		<b>80</b>
1	Organization	4	40
2	Health Plan Experience	4	40
<b>F</b>	<b>HCA Health Transformation Vision</b>		<b>200</b>
1	Innovative Leadership and Administrative Support	6	60
2	Support of Value Based and Alternative Payment Models	8	80
3	Multi-Stakeholder Quality Improvement and Transparency	6	60
<b>G</b>	<b>Clinical Management</b>		<b>560</b>
1	Clinical Objectives	7.5	75
2	Clinical Management	7.5	75
3	Utilization Management (UM)	7.5	75
4	Quality Management (QM)	7.5	75
5	Complex Case Management	7.5	75
6	Chronic Condition Management	7.5	75
7	Other Clinical Management Services	5.5	55
8	Innovations in Clinical Management	5.5	55
<b>H</b>	<b>Operations</b>		<b>560</b>
1	General Operational Services	4	40
2	Member and Customer Services	10	100
3	Communications	6	60
4	Online Services	6	60
5	Member Engagement and Experience	6	60
<del>6</del> 5	Health Savings Account (HSA) Administration	2	20
<del>6</del> 7	Appeals and Complaints	3	30
<del>7</del> 8	Overall Account Administration	4	40
<del>8</del> 9	Account Resourcing	2	20
<del>9</del> 10	Emergency Response Account Management	3	30
<del>10</del> 11	Implementation Plan	8	80
<del>11</del> 12	Disabled Dependent Certifications	1	10
<del>12</del> 13	Annual Renewal Process	1	10
<b>I</b>	<b>Provider Network</b>		<b>400</b>

1	Provider Network	40	400
<b>J</b>	<b>Technical Data Requirements</b>		<b>200</b>
1	Data, Reporting, and Analytics	8	80
2	Data File Transfer and Access	6	60
3	Eligibility System Requirements	6	60
<b>Total Maximum Points</b>			<b>2000</b>

Evaluation team members will score the sections outlined in the Evaluation Table above using the following (0-10) scale:

<b>Scoring Methodology</b>		
<b>Score</b>	<b>Description</b>	<b>Scoring Criteria</b>
9 - 10	Far Exceeds Requirements	The Bidder has provided an innovative, detailed, efficient approach or established, by presentation of material, far superior capability in this area.
7 - 8	Exceeds Requirements	The Bidder has demonstrated an above-average capability, approach, or solution and has provided a complete description of the capability, approach, or solution.
5 - 6	Meets Requirements	The Bidder has an acceptable capability of solution to meet this criterion and has described its approach in sufficient detail to be considered "as substantially meeting the requirements".
3 - 4	Below Requirements	The Bidder has established some capability to perform the requirement but descriptions regarding their approach are not sufficient to demonstrate the Proposer will be fully able to meet the requirements.
1 - 2	Substantially Below Requirements	The Bidder has not established the capability to perform the requirement, has marginally described its approach, or has simply restated the requirement.
0	No value	The Bidder has omitted any discussion of this requirement or the information provided is of no value.

#### **4.3. Notification to Bidders**

HCA will notify the ASB(s) of their selection in writing upon completion of the evaluation process. Bidders whose Proposals were not selected for further negotiation or award will be notified separately by e-mail.

#### **4.4. Debriefing of Unsuccessful Bidders**

Any Bidder who has submitted a Proposal and was not selected as an ASB may request a debriefing. The request for a debriefing conference must be received by the RFP Coordinator no later than 5:00 p.m., Pacific Time, within three Business Days after receipt of such notice. The debriefing will be held within three Business Days of the request, or as schedules allow.

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

- 4.4.1. Feedback on the evaluation and scoring of the Bidder's Proposal; and
- 4.4.2. Review of the Bidder's final score in comparison with other final scores without identifying the other Bidders.

Topics a Bidder could have raised as part of the complaint process (section 2.13) cannot be discussed as part of the debriefing conference, even if the Bidder did not submit a complaint.

Other than as set forth above, comparisons between Proposals, or discussions concerning the evaluations of the other Proposals, will not be allowed. Debriefing conferences may be conducted in person or on the telephone and will be scheduled for a maximum of thirty (30) minutes.

#### **4.5. Protest Procedure**

A bid protest may be made only by Bidders who submitted a response to this RFP and who have participated in a debriefing conference. Upon completing the debriefing conference, the Bidder is allowed five Business Days to file a protest with the RFP Coordinator. Protests must be received by the RFP Coordinator no later than 4:30 p.m., Pacific Time on the fifth Business Day following the debriefing. Protests may be submitted by e-mail or by mail.

Bidders protesting this RFP must 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 Bidders under this RFP.

All protests must be in writing, addressed to the RFP Coordinator, and signed by the protesting party or an authorized agent. The protest must state (1) the RFP number, (2) the grounds for the protest with citation to specific facts, (3) complete statements of the action(s) being protested, and (4) the relief or corrective action being requested.

- 4.5.1. Only protests alleging an issue of fact concerning the following subjects will be considered:
  - a. A matter of bias, discrimination, or conflict of interest on the part of an evaluator;
  - b. Errors in computing the score; or
  - c. Non-compliance with procedures described in the RFP or HCA requirements.

Protests based on anything other than those items listed above will not be considered. Protests may not be made on grounds that could have been or were raised during the complaint process set forth in section 2.13, *Complaint Process*. Protests will be rejected as without merit to the extent they address issues such as: 1) an evaluator's professional judgment on the quality of a Proposal; or 2) HCA's assessment of its own needs or requirements.

Upon receipt of a protest, HCA will undertake a protest review. The HCA Director, or an HCA employee delegated by the HCA Director who was not involved in the RFP, will consider the record and all available facts. 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. The HCA Director or his or her designee will have the right to seek additional information from sources he or she deems appropriate in order to fully consider the protest.

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

4.5.2. The final determination of the protest will:

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

If the protest is not successful, HCA will enter into a Contract with the ASB(s), assuming the parties reach agreement on the Contract's terms.

## **5. EXHIBITS**

Exhibit A – Certifications and Assurances

Exhibit B – Diverse Business Inclusion Plan

Exhibit C – Reference Form

Exhibit D – Plan Design(s) and Service Area(s)

Exhibit E - Organizational Structure and Health Plan Experience

Exhibit F – HCA Health Transformation Vision

Exhibit G – Clinical Management

Exhibit H – Operations

Exhibit I – Provider Network

Exhibit J – Technical Data Requirements

Exhibit K – Draft Contract

## Exhibit A – Certifications and Assurances

I/we make the following certifications and assurances as a required element of the Proposal to which it is attached, understanding that the truthfulness of the facts affirmed here and the continuing compliance with these requirements are conditions precedent to the award or continuation of the related Contract:

1. I/we declare that all answers and statements made in the Proposal are true and correct.
2. The attached Proposal is a firm offer for a period of 180 Days following receipt, and it may be accepted by HCA without further negotiation (except where obviously required by lack of certainty in key terms) at any time within the 180-Day period.
3. In preparing this Proposal, I/we have not been assisted by any current or former employee of the state of Washington or SEB Board Member whose duties relate (or did relate) to this Proposal or prospective contract, and who was assisting in other than his or her official, public capacity. If there are exceptions to these assurances, I/we have described them in full detail on a separate page attached to this document.
4. I/we understand that HCA will not reimburse me/us for any costs incurred in the preparation of this Proposal. All proposals become the property of HCA, and I/we claim no proprietary right to the ideas, writings, items, or samples, unless so stated in this Proposal.
5. I/we agree that submission of the attached Proposal constitutes acceptance of the solicitation contents and the attached Draft Contract (Exhibit K). If there are any exceptions to these terms, I/we have described those exceptions in detail as required by the RFP.
6. No attempt has been made or will be made by the Bidder to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition.
7. I/we grant HCA the right to contact references and others who may have pertinent information regarding the ability of the Bidder and the lead staff person to perform the services contemplated by this RFP.
8. If any staff member(s) who will perform work on this Contract has retired from the State of Washington under the provisions of the 2008 Early Retirement Factors legislation, his/her name(s) is noted on a separately attached page.

**On behalf of the Bidder submitting this Proposal, my name below attests to the accuracy of the above statement. *If electronic, also include: We are submitting a scanned signature of this form with our Proposal.***

\_\_\_\_\_  
Signature of Bidder

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

## Exhibit B – Diverse Business Inclusion Plan

Do you anticipate using, or is your firm, a State Certified Minority Business? Y/N

Do you anticipate using, or is your firm, a State Certified Women's Business? Y/N

Do you anticipate using, or is your firm, a State Certified Veteran Business? Y/N

Do you anticipate using, or is your firm, a Washington State Small Business? Y/N

If you answered No to all of the questions above, please explain:

---

Please list the approximate percentage of work to be accomplished by each group:

Minority                      \_\_\_%

Women                        \_\_\_%

Veteran                       \_\_\_%

Small Business             \_\_\_%

Please identify the person in your organization to manage your Diverse Inclusion Plan responsibility.

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**Exhibit C – Reference Form**

This reference applies to the \_\_\_\_\_ Product Type from Exhibit E - *Organizational Structure and Health Plan Experience*, section 2, Table 1.

Note: Bidder submission of this form constitutes permission for HCA to contact the reference indicated herein.

Organization Legal Name:

Contact Name of Reference:

Contact's E-mail:

Contact's Phone Number:

Name of the Bidder's employee(s) who are known to this Contact:

Time Frame of Services Provided:

Number of subscribers the organization provides benefits for:

Description of Services Performed:

(This space reserved for HCA use)



## Exhibit D – Plan Design(s) and Service Area(s)

### 1. Plan Design(s)

In order to accurately evaluate plan design options HCA is using the PEBB self-insured 2018 Uniform Medical Plan Classic, “UMP Classic,” benefit design as its benchmark for company proposed variations for covered services and exclusions. For any proposed plan options, the Bidder must indicate how their proposed plan(s) will differ from UMP Classic.

- a. See Appendix 10 – *2018 UMP Classic Plan Design* for the following UMP Classic information:
  - a. Table 1: 2018 UMP Classic Point of Service Cost Sharing;
  - b. Table 2: 2018 UMP Classic Benefit Specific Cost Sharing; and
  - c. The 2018 UMP Classic List of Exclusions.
- b. Further information can be found in the UMP Classic COC at:  
<https://www.hca.wa.gov/assets/ump/ump-classic-coc-2018.pdf>
- c. HCA expects the SEB Board to vote in 2018 on whether they wish to adopt self-insured medical plans substantially similar to those offered under the PEBB Program. It is likely that a plan similar to that listed in Appendix 10 – *2018 UMP Classic Plan Design* will be offered to SEBB Members starting January 1, 2020.
- d. At this time, HCA intends to purchase only medical plans with a Federal Actuarial Value(s) (AV) of 76 percent (76%) or more. If a Carrier provides a plan with a Federal AV below this, it will not be considered for the SEBB portfolio. With the Bidder’s plan design proposal, the Bidder will need to:
  - i. Indicate the Federal AV of each proposed plan option using the 2019 Federal AV Calculator;
  - ii. For any HDHP, note the impact on AV from any assumed HSA contribution; and
  - iii. Provide a screen snapshot of the Federal AV calculator used for each proposed plan.
- e. HCA’s goal is to procure viable, meaningful options for the SEBB Program and offer a diverse benefits portfolio with plans that fit the needs of all SEBB Members. Please consider this when proposing the Bidder’s plan designs.
- f. Plan designs must be submitted on the form provided in Appendix 11 – *Proposed Plan Design(s)*. If a Bidder submits more than one (1) plan design, a new form must be submitted for each plan along with the name of the plan (Plan A, Plan B, etc.).

Note: There is no guarantee that vision benefits will be imbedded in the medical benefits. Therefore, if a Bidder is interested in maximizing the coverage they could potentially offer to School Employees, HCA recommends the Bidder bid on both this RFP and the Fully Insured Group Vision RFP, which will be released at a later time.

### 2. Service Area(s)

Bidder must use Appendix 6 – Proposed Service Area(s) to define the proposed service area for the SEBB Health Plan(s) Bidder is proposing to start on January 1, 2020. Please note the following clarifications:

- a. Service areas must be by county.
- b. Final service area determinations of the Contractor(s) are left to the SEB Board, and therefore, could be limited based on SEB Board decisions. The SEB Board may also limit the number of plans proposed in the final counties.

## Exhibit E - Organizational Structure and Health Plan Experience

### 1. Organization

Please limit response to ten (10) pages, excluding the professional biographies requested. Describe the Bidder's:

- a. Organizational approach and philosophy to delivering health care (for integrated delivery and insurance systems) and/or health care coverage.
- b. Customer support team the Bidder intends to assign to the HCA account if selected as an ASB. Provide detailed professional biographies for assigned employee(s).
- c. Locations for regional offices in Washington, Idaho, and/or Oregon.

### 2. Health Plan Experience

Please limit response to two (2) pages.

- a. Complete Table 1 below by providing information regarding how many large employer accounts (5,000 or more covered lives) the Bidder is contracted with to provide the fully insured medical plan types listed below.

Table 1

Product Type	Number of Large Accounts	Total Number of Subscribers in Large Accounts	Total Number of Members in Large Accounts
Health Maintenance Organization			
Preferred Provider Organization			
High Performance Network			
Point-of-service			
Other network types			
Totals			

- b. What makes the Bidder different from other fully insured group medical plan competitors? Why should HCA choose the Bidder over another fully insured group medical plan?

## Exhibit F – HCA Health Transformation Vision

### 1. Innovative Leadership and Administrative Support

Please limit response to eight (8) pages, excluding any requested flow charts, examples, etc.  
Describe the Bidder's:

- a. Vision for health transformation, progress made to date, and future tasks. Please describe how the Bidder's vision aligns with HCA's purchasing and transformation vision described in section 1.4, *HCA's Strategic Vision*.
- b. Vision for Washington State's health care system in 2025. Include what the organization is currently implementing to achieve that vision.
- c. Past, current and future strategies to evolve the Bidder's business model to prepare for new delivery and payment models. Include specific examples, including how Social Determinants of Health will be addressed.
- d. Experience collaborating with community and social service organizations to help address Social Determinants of Health members may face.
- e. Past and current experience working with other public and private payers to accelerate health care transformation. Public and private payers refers to the Bidder's clients that purchase medical insurance for their employees that are either governmental ("public") or non-governmental ("private").
- f. Current financial risk arrangements using the Alternate Payment Model (APM) framework (see Appendix 1 – *CMS Framework for Value-Based Payments or Alternative Payment Models (CMS LAN APM)*) to indicate by category the proportion of providers in VBP arrangements. Beginning in Plan Year 2020, the Bidder should anticipate responding annually to HCA's VBP Survey (an example of this can be found in Appendix 8 – 2017 Paying for Value Survey). The updated survey is scheduled to be released in the summer of 2018, and the Bidders should not can submit aits response to this survey as part of their Proposal response to this question.
- g. Approach and experience aligning fully insured products with clients' individual organizational strategies, including when providing benefit design advice for large clients (5,000 or more employees).
- h. Plans to incorporate elements similar to the HCA's health transformation vision across its Book-of-Business.
- i. Experience developing and supporting strategies to improve access and quality of care for a culturally and linguistically diverse patient population.
- j. Experience with improving rural area access to subscribers.
- k. Involvement and experience with the following initiatives:
  - i. Washington state legislative efforts on health care.
  - ii. Local, regional, statewide or national health transformation efforts (not including Healthier Washington).
- l. Proposed approach to continuously innovate and improve programs for Members and incorporate HCA-supported clinical strategies. Some examples include:
  - i. Ability to implement the Governor's Executive Order 16-095 addressing the Opioid Use Public Health Crisis, which includes effective screening for opioid use disorder and increased management of medication-assisted and other needed treatments.
  - ii. Ability to implement payment models that integrate physical and behavioral health.
  - iii. Ability to support rural health systems to ensure Members have sustainable access to needed primary and specialty care.

<sup>5</sup> [https://www.governor.wa.gov/sites/default/files/exe\\_order/eo\\_16-09.pdf](https://www.governor.wa.gov/sites/default/files/exe_order/eo_16-09.pdf)

- m. Commitment to participating in rural multi-payer health systems transformation.

## 2. Support of Value Based and Alternative Payment Models

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

- a. Experience in promoting VBP.
  - i. Are there VBP programs the Bidder has implemented?
  - ii. Does the Bidder use COEs?
  - iii. Does the Bidder do bundled payments for defined episodes of care?
  - iv. How does the Bidder use VBP to control pharmacy costs, e.g., through a closed formulary, purchasing strategies for specialty drugs, or other costs trend control strategies.
- b. Ability to support HCA's Center of Excellence (COE) approach, which includes, but may not be limited to:
  - i. Implementing the Bree Recommendations for select procedures within the ASB's network to ensure clinical alignment with HCA's current and future COEs.
  - ii. Demonstrating how the Bidder achieves the same or better results within the Bidder's own bundled payment and/or COE model.
- c. Experience administering or implementing VBP arrangements to providers using arrangements in CMS LAN APM Categories 2c through 4b (see Appendix 1 – CMS Framework for Value-Based Payments or Alternative Payment Models (CMS LAN APM)). Include the process for selecting provider groups or delivery systems for these current VBP arrangements, including the assessment of clinical, operational and financial capabilities.
- d. Lessons learned and best practices used for developing, implementing and monitoring VBP arrangements, and how lessons learned have been applied to new payment initiatives.
- e. Ability to provide, support and/or administer newly emerging forms of Value Based Payment strategies while offering suggestions on other forms of Value Based Payment strategies that have been proven to be successful.
- f. Process for monitoring and implementing emerging forms of VBP.
- g. Approach to aligning benefit design with new models of payment and care such as value-based insurance design that promotes the effective treatment and management of members with chronic conditions.
- h. Experience participating in multi-payer efforts to accelerate VBP efforts.
- i. Commitment to participate in multi-payer initiatives and data sharing.
- j. Experience modifying its current Claims system to support new payment methodologies, including working with and customizing payment programs for large purchasers.
- k. Innovative payment and Quality Improvement strategies for improving maternity care and pregnancy outcomes (e.g. Group Prenatal Care).

## 3. Multi-Stakeholder Quality Improvement and Transparency Initiatives

Please limit response to six (6) pages.

- a. For the Bidder's involvement in Washington Healthcare Alliance (WHA) committees, the Bree Collaborative, and Accountable Communities of Health (ACHs) or other community organizations, please describe the Bidder's:
  - i. Specific roles.
  - ii. Length of participation.

- iii. Staff level (e.g., executive level, staff, etc.).
  - iv. Committee participation, both current and past.
  - v. Approach to encouraging provider and hospital participation.
  - vi. Approach to monitoring provider and hospital participation in community initiatives.
- b. Describe how the Bidder will permit access to and use of enrollment and price data at the HCA's discretion, to be used in multi-stakeholders Quality Improvement and transparency initiatives.
- c. In Table 2 below, provide a "Yes" or "No" response to each question listed, and include the completed table with Bidder's response to this section.

*Table 2*

TOPIC	RESPONSE (Yes/No)
Did the Bidder participate in data submission with Book-of-Business for the WHA Community Checkup project in 2017?	
Has the Bidder submitted data on Book-of-Business to Fred Hutchinson Institute for Cancer Outcomes Research in the past?	
Did the Bidder participate in a National Business Coalition on Health (NBCH) e-Value8™ survey as a <b>PPO</b> in 2017 in Washington or another U.S. market?	
Did the Bidder participate in an NBCH e-Value8™ survey as a <b>HMO</b> in 2017 in Washington or another U.S. market?	
Will the Bidder participate in an NBCH e-Value8™ survey as a <b>PPO</b> in 2020 in Washington or another U.S. market, and will share results with the HCA?	
Will the Bidder participate in an NBCH e-Value8™ survey as a <b>HMO</b> in 2020 in Washington or another U.S. market, and will share results with the HCA?	
Will the Bidder agree to respond affirmatively to all WHA invitations to participate in the e-Value8™ survey as a Washington PPO during the term of the Contract?	
Will the Bidder commit resources toward ACHs and other Healthier Washington programs and initiatives without charging additional fees?	
Will the Bidder submit appropriate data for its entire Book-of-Business to the All Payer Claims Database (APCD)?	
Will the Bidder agree to encourage fully insured purchaser clients to submit their data to the APCD?	
Will the Bidder submit clinical data for its entire Book-of-Business to the Clinical Data Repository (CDR)?	
Will the Bidder assist hospitals and clinics (through financial and/or other support) to submit clinical data from their Electronic Health Records (EHRs) to the CDR?	

## 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.
- b-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.
- c-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?
- d-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?

e-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?

f-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?

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

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

i-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?

j-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.

k-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.

l-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?

m-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?

~~a-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.

~~a-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 patterns 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.

## 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.).
- ~~g.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?
- ~~h.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.
- ~~i.j.~~ Fraud, waste, and abuse process. Provide a copy of each.
- ~~j.k.~~ Subrogation process.
- ~~k.~~ Appeals and Complaints management process. Provide a flow chart.
- 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 3

	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 4*

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. If it is determined an independent, professional auditor is needed for the Claims payment audit, then HCA will work with Contractor to select an auditor at a later date. The auditor will be contracted at the expense of the Contractor and the audit will be completed (including corrective actions) by August 1, 2019, unless otherwise agreed to by HCA.
    - 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.



## Exhibit I – Provider Network

### 1. Provider Network

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

- a. Capabilities and capacity relative to the size and complexity of the SEBB Program population and their status as a public sector fully insured HMO or PPO.
- b. Current actions for controlling facility fees through network contracts, and describe how it will maintain current provider network discounts during the term of the Contract.
- c. Capability to provide a network that contains an adequate number of Behavioral Health providers to diagnose and treat Members for all covered services for conditions used in the current version of the ICD-10-CM and DSM 5 Diagnostic Guides. Bidder must promote the use of evidence-based, research-based or promising Behavioral Health practices recognized by the Washington State Institute for Public Policy (See <http://wsipp.wa.gov/Reports>) or the Substance Abuse and Mental Health Services Administration (SAMSHA).
- d. Capability to contract with providers who are authorized under the Drug Addiction and Treatment Act (DATA) 2000 to prescribe buprenorphine products to patients for the treatment of opioid use disorder to ensure all Members who need this treatment have access (see <https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/increase-patient-limits>).
- e. Capability to provide a network that contains or will contain an adequate number of Applied Behavioral Analysis (ABA) providers within their local network(s).
- f. Abilities and methods of expanding the network as needed if eligible membership increases significantly in future years.
- g. Process to establish who is in the Bidder's network.
- h. Use of a tiered provider network. If the Bidder does have a tiered provider network, describe the different coverage levels.
- i. ~~[Mandatory not Scored] Network adequacy in Washington State, Oregon, and Idaho, by providing the network adequacy filings the Bidder's submits to Washington, Idaho, and/or Oregon, whichever states the Bidder intends to offer a Service Area in for the SEBB Program. For each state, Bidder must attest whether or not they meet the state network adequacy standards. for each state using Appendix 5 – Provider Network Adequacy~~
- j. Out-of-state provider network that is currently in place. Is the out-of-state network owned and managed by the Bidder, subcontracted, or provided under another arrangement? If subcontracted or provided under another arrangement, identify:
  - i. The responsible party and the relationship between the Bidder and responsible party, and
  - ii. How long the contract has been in place
- k. International coverage. If the Bidder has international coverage please describe what types of services are covered (i.e., emergency care only, urgent care, etc.).
- l. Book-of-Business policy on paying for emergency care Claims outside of its Washington/Idaho/Oregon network of emergency care providers; include coverage outside of the United States.
- m. Book-of-Business policy on paying for urgent care Claims outside of its Washington/Idaho/Oregon network of urgent care providers; include coverage outside of the United States.
- n. Out-of-network waivers policy, if applicable. How are they granted and processed?

- o. Transition of care standards between providers, guidelines and processes that are in place and how they will be used for Members.
- p. Maintenance of provider directories. Bidder must answer the following in their response:
  - a. How often are directories updated?
  - b. What is the Bidder's commitment to ensuring accuracy of the provider directory prior to SEBB's Annual Open Enrollment?

## Exhibit J – Technical Data Requirements

### 1. Data, Reporting, & Analytics

Please limit response to sixteen (16) pages, excluding any requested flow charts, examples, etc.

- a. What is the Bidder's current Claims system and does it have the capability and capacity to support VBP and alternative payment methodologies?
- b. How does the Bidder obtain Patient Reported Outcomes from network providers that are not within the direct delivery of care system (i.e., Patient Reported Outcomes with a contracted hospital)?
- c. What is the Bidder's experience and reporting capabilities for HCA selected quality metrics from the Common Measure Set (Appendix 6 – *Proposed Service Area(s)* ) and HEDIS measures (including Claims, Patient Reported Outcomes, and hybrid measures), financial measures, and patient experience? Include in the response the Bidder's experience and capability to provide such reports, including:
  - i. Approach to data flow processes.
  - ii. Approach to receiving and managing data from EHRs.
  - iii. Staffing.
  - iv. Core reporting systems, structures, and standards.
  - v. Approach to testing, modifying, and finalizing reports that ensure timely and accurate reporting.
- d. Describe the Bidder's experience calculating quality measures and providing data and analytic reports to providers. Include examples of reports, frequency of delivery of data and reports, and technical assistance offered to providers to integrate data into workflows.
- e. Provide a list of the quality measures the Bidder currently reports on.
- f. Willingness and capability to disaggregate data (race/ethnicity, primary language, geography) to identify and address health disparities between populations. Some examples include differences in diagnoses rates, the proportion of patients receiving appropriate preventative care, and effective chronic care management.
- g. Describe the Bidder's capabilities to ensure members diagnosed with opioid use disorder initiate Medication-Assisted Treatment (MAT) and ability to report the percentage of members with an opioid use disorder diagnosis who obtained a Buprenorphine prescription
- h. Does the Bidder have any dashboards available for purchaser use?
  - i. If yes, describe the features and capabilities and provide examples of the types of dashboards an employer could create for their account.
  - ii. If no, will the Bidder have dashboards available for HCA use by January 1, 2020?
- i. Describe the Bidder's experience providing customized reports to purchasers (i.e. employers, insured trusts, etc.) on plan portfolio performance. List of the kinds of reports the Bidder can create and provide an example of each.
- j. Describe the Bidder's experience providing reports on medical management, changes in medical policy, performance outcomes, executive level portfolio reports, eligibility and Claims reports, SOC1 Type II Audit results, quarterly, bi-annual, and annual plan performance reports.
- k. Because of the environment HCA operates in, often times a data request or inquiry is submitted to HCA with a short turnaround time; for example, a legislative request during legislative session. Describe the Bidder's ad-hoc reporting capabilities. What is the average number of Days the Bidder needs to produce an ad-hoc report from the time the request is received by the Bidder, to delivery of the final report to the requestor?

- l. Describe the Bidder's experience and process for analyzing and reporting data for legislative requests.
- m. Describe the Bidder's ability to comply with Washington State OCIO standards.
- n. Describe the Bidder's intent to participate in data transfers with HCA data projects.
- o. Provide a copy of Bidder's standard data security policies and standards, as well as a SOC 2 Type II report completed within twelve (12) months prior to the date of Response. If Bidder does not have a SOC 2 Type II report from such time frame, please provide any audit report of data security policies and standards completed within twelve (12) months prior to the date of Bidder's Response. If no such audit report has been completed in that timeframe, indicate this in the Bidder's Response. NOTE: A SOC 2 Type II report is not strictly required, but it does contain much of the information needed to complete a full security design review. A SOC 1 Type II report does contain some security-related information as its focus is on financial controls. However, in the absence of a SOC 2 Type II report, HCA will need to gather required security information from other Bidder-provided source documents. The availability, quantity, and quality of those documents may affect the timing of the required security design review.
- p. Is the Bidder able and willing to deliver PHI, including Claims data, to HCA pursuant to 45 CFR 164.504(f)?
- q. Describe any limitations to the Bidder's ability and/or willingness to deliver Claims data to HCA, including any specific HCA uses or disclosures that Bidder will not agree to.
- r. Does the Bidder currently provide claims data on any of its fully insured medical plans to the employer/purchaser?

## 2. Data File Transfer and Access:

Please limit response to six (6) pages, excluding any requested flow charts, examples, etc. Describe how the Bidder will comply with all of the following Data File Transfer and Access Requirements:

- a. Pick up and process electronic data files from Washington State's secure file transfer service.
- b. Only accept and execute, or transfer electronic data files on behalf of HCA to business associates of HCA when requested.
- c. Execute separate data sharing contracts with other HCA vendors for purposes of sharing HCA data.
- d. Administer Member information in compliance with HIPAA and OCIO standards for privacy, security, and electronic data interchange.
- e. Comply with HCA data requests for any internal or external audits.
- f. Give network and non-network providers access to eligibility and Claims look-up through OneHealthPort.
- g. Create a current version HIPAA 834 standard transaction to send to HCA required business partners, including any optional fields requested by the HCA, at no additional cost.
- h. Transmit and/or retrieve SEBB Health Plan data directly to/from external contracted vendors and other HCA business associates as determined by HCA.
- i. Provide Claims data extracts to ~~HCA and~~ HCA business associates at no additional cost. An example of an HCA business associates include but are not limited to: is an HCA's actuarial consultants and polypharmacy vendor. Data transfers may occur on a weekly or monthly basis, as specified by HCA.
- j. The Bidder's willingness and capability to transmit data to different study partners of HCA? On occasion, HCA participates in health care data research partnering with entities such as the University of Washington, Washington Health Alliance, SCCA, or the diabetes collaborative. When that occurs, the ASB may be expected to assist by transmitting data to any study partner as directed by HCA. The file format, data fields, and transmission will be customized to the data request.

### 3. Eligibility System Requirements

Please limit response to seven (7) pages, excluding any requested flow charts, examples, etc. Provide an overview of the Bidder's capability to comply with all of the following Eligibility System Requirements:

#### *Member ID Numbers*

- a. The Bidder will generate a unique, permanently assigned, HIPAA compliant non-Social Security Number (SSN) based ID number for each Subscriber or Member. If the Bidder uses its own algorithm to assign ID numbers, that algorithm must be approved in advance by the HCA. It must guarantee a random number, from which the SSN and other PHI cannot be determined or approximated; it must be nine (9) or ten (10) characters; it cannot duplicate other IDs used by the ASB.

#### *Eligibility Files*

- a. Create a current version HIPAA 834 standard transaction to send to HCA's business partners, including any optional fields requested by HCA, at no additional cost.
- b. Conduct a ~~quarterly~~ full eligibility file match with HCA not less frequently than monthly and promptly reconcile any differences and report any reconciled differences and any other discrepancies to HCA.
- c. Accept and process SEBB Program eligibility files daily in the format outlined in the SEBB Program Eligibility File Format found in Appendix 4 – *HIPAA 834 Compliant Eligibility File*
- d. Store Member data, including SSNs, along with non-SSN and other non-PHI algorithm-generated Member IDs, in order to communicate with SEBB Program eligibility staff and perform quarterly eligibility audits.
- e. Transfer SSNs of Employees and their Dependents to HCA vendors and Subcontractors, as that is HCA's Member ID within its eligibility system.
- f. Provide Member SSNs for transfer from the ASB to other HCA vendors, as requested by HCA.

#### *Eligibility Files and Matches*

- a. Conduct a reconciliation of the full eligibility file with HCA not less frequently than monthly. See Enrollment Reconciliation in Exhibit K – *Draft Contract*, for details.

#### *Implementation Plan: (Eligibility requirements only)*

- a. By August 1, 2019, ensure that the following will be fully tested, accepted, and operational:
  - i. Eligibility systems, including the ability to accurately accept and load the HCA's eligibility file.
  - ii. All required data transfers and/or integrations with other HCA vendors.
- b. By September 30, 2019, ensure that Claims adjudication (benefits and plan provisions) system is fully operational.

## **Exhibit K – Draft Contract**

The Draft Contract is still under construction. It will be provided as an amendment to the RFP as soon as possible.

## 6. APPENDICES

Appendix 1 – CMS Framework for Value-Based Payments or Alternative Payment Models (CMS LAN APM)

Appendix 2 – OCIO Standard 141.10 – Securing IT Assets

Appendix 3 – WATech OCS Design Review Checklist

Appendix 4 – HIPAA 834 Compliant Eligibility File

Appendix 5 – Non-Disclosure Agreement ~~Appendix 5 – Provider Network Adequacy~~

Appendix 6 – Proposed Service Area(s)

Appendix 7 – Common Measure Set

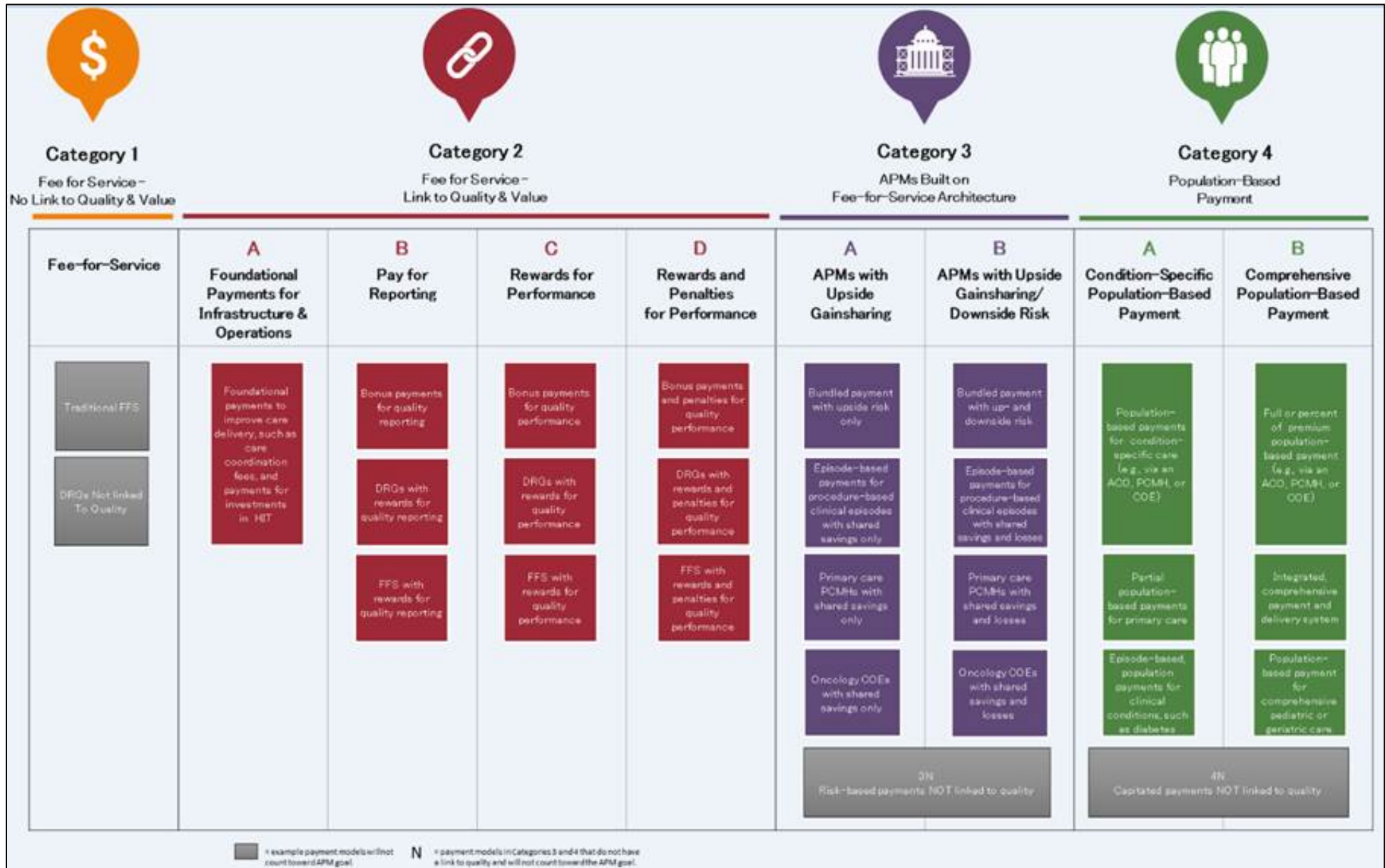
Appendix 8 – 2017 Paying for Value Survey

Appendix 9 – Results HCA Fundamentals Map

Appendix 10 – 2018 UMP Classic Plan Design

Appendix 11 – Proposed Plan Design(s)

## Appendix 1 – CMS Framework for Value-Based Payments or Alternative Payment Models (CMS LAN APM)



For more information, see CMS LAN APM Framework White Paper, go to: <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>



## **Appendix 2 – OCIO Standard 141.10 – Securing IT Assets**

This appendix has been included as a separate attachment.

### **Appendix 3 – WATech OCS Design Review Checklist**

This appendix has been included as a separate attachment.

## **Appendix 4 – HIPAA 834 Compliant Eligibility File**

This appendix has been included as a separate attachment.

APPENDIX 5 - NON-DISCLOSURE AGREEMENT

**Statement of Confidentiality**

Between

**WASHINGTON STATE HEALTH CARE AUTHORITY (HCA)**

And

**[Insert Vendor's Legal Name and remove brackets: EXAMPLE: ABC COMPANY]**

Vendor's Employee Name and/or Subcontractor or Subcontractor's Employee Name:

---

(Please Print)

[Insert Company Legal Name AND remove brackets] will have access to a subset of the SEBB Program data which was either publicly available or received by way of the Washington K-12 Legislated Data request from the Washington State Health Care Authority (HCA), strictly for the purposes of submitting a response to Request for Proposals (RFP) 2716, SEBB Program Fully Insured Medical Plans. This information is confidential and private and Vendor is responsible for maintaining this confidentiality and privacy. Before Vendor is allowed access to this information, Vendor is required to sign this statement.

Please note that this census data is aggregate data provided by two different sources: the Office of the Superintendent of Public Instruction (OSPI) F275 report accessed by HCA in December 2017 and Carrier claims data received on or around April 30, 2018, and does not encompass a complete picture of the populations to be served under this RFP. HCA is not liable in any way to any bidder with respect to the data conveyed by HCA to the bidders under this RFP.

**Confidentiality/Safeguarding Of Information** -- The Vendor shall not use or disclose this information for any purpose not directly connected with the response to RFP 2716, except with prior written consent of HCA, or as may be required by law.

**Privacy** -- This information shall be used solely for the purposes of this RFP. Vendor agrees not to release, divulge, publish, transfer, sell or otherwise make known to unauthorized persons this information without the express written consent of the HCA or as provided by law. Vendor agrees to implement physical, electronic and managerial safeguards to prevent unauthorized access to this information.

The HCA reserves the right to monitor, to audit, or investigate the use of this information. The monitoring, auditing or investigating may include but is not limited to "salting" by the HCA. Salting is the act of placing a record containing unique but false information in a database that can be used later to identify inappropriate disclosure of data contained in the database.

Any breach of this provision may result in actions to be determined by the HCA, and the demand for return of all information. The Vendor agrees to indemnify and hold harmless the HCA for any damages related to the Vendor's unauthorized use of this information.

---

Signature of Employee/Subcontractor

Date

Please complete the table(s) below for Bidder's provider network adequacy. Bidder must provide a completed table for each state in which Bidder is proposing coverage (Table 5.1 for Washington, Table 5.2 for Idaho, and Table 5.3 for Oregon).

**Washington State Network Provider Adequacy**

During the term of any resulting Contract, Contractor must offer and maintain a provider network meeting or exceeding the minimum standards for provider network access as required by the OIC. Please complete Table 5.1 for Bidder's provider network adequacy in Washington.

Table 5.1 – Washington Provider Network Adequacy			
Provider Type	Urban Standard (Miles)	Rural Standard (Miles)	Percent of Members Within Standard
<b>Primary Care</b>			
All Primary Care			
Pediatrics			
Women's Health OB/GYN			
<b>Pediatric Subspecialties</b>			
All Pediatric Subspecialties			
Pediatric Cardiology			
Pediatric Neurology			
Pediatric Psychiatry			
<b>Medical Specialties</b>			
All Medical Specialties			
Allergy/Immunology			
Cardiology			
Dermatology			
Endocrinology			
Gastroenterology			
Hematology/Oncology			
Infectious Disease			
Nephrology			
Neurology			
Pulmonology			
Rheumatology			
<b>Surgical Specialties</b>			
All Surgical Specialties			
General Surgery			
Neurosurgery			
OB/GYN			

<b>Table 5.1 – Washington Provider Network Adequacy</b>			
<b>Provider Type</b>	<b>Urban Standard (Miles)</b>	<b>Rural Standard (Miles)</b>	<b>Percent of Members Within Standard</b>
Ophthalmology			
Orthopedic Surgery			
Urology			
<b>Behavioral Health</b>			
Psychiatry			
Behavioral Health: Non-Physician PhD and Master's-Level Providers			
Behavioral Health: Non-Physician with All Other Credentials			
Applied Behavioral Analysis			
Inpatient and Outpatient Behavioral Health Facility/Treatment Center			
Inpatient and Outpatient Chemical Dependency Facility/Treatment Center			
<b>Facility</b>			
Hospital	(In minutes)	(In minutes)	(All enrollees)
Urgent/Emergent Care	(In minutes)	(In minutes)	(All enrollees)
<b>Ancillary</b>			
Home Health			
Durable Medical Equipment			
Therapies: Chiropractic			
Therapies: OT/PT			
Therapies: Acupuncture			
Therapies: Massage			
Hospice			
<b>Pharmacy Dispensing</b>			
Pharmacy Dispensing			

#### **Idaho State Network Provider Adequacy**

During the term of any resulting Contract, Contractor must offer and maintain a provider network meeting or exceeding the minimum standards for provider network access as required by law in Idaho State. Please complete Table 5.2 for Bidder's provider network adequacy in Idaho.

Table 5.2 – Idaho Provider Network Adequacy			
Provider Type	Urban Standard (Miles)	Rural Standard (Miles)	Percent of Members Within Standard
<b>Primary Care</b>			
All Primary Care			
Pediatrics			
Women's Health OB/GYN			
<b>Pediatric Subspecialties</b>			
All Pediatric Subspecialties			
Pediatric Cardiology			
Pediatric Neurology			
Pediatric Psychiatry			
<b>Medical Specialties</b>			
All Medical Specialties			
Allergy/Immunology			
Cardiology			
Dermatology			
Endocrinology			
Gastroenterology			
Hematology/Oncology			
Infectious Disease			
Nephrology			
Neurology			
Pulmonology			
Rheumatology			
<b>Surgical Specialties</b>			
All Surgical Specialties			
General Surgery			
Neurosurgery			
OB/GYN			
Ophthalmology			
Orthopedic Surgery			
Urology			
<b>Behavioral Health</b>			
Psychiatry			

<b>Table 5.2 – Idaho Provider Network Adequacy</b>			
<b>Provider Type</b>	<b>Urban Standard (Miles)</b>	<b>Rural Standard (Miles)</b>	<b>Percent of Members Within Standard</b>
Behavioral Health: Non-Physician PhD and Master's-Level Providers			
Behavioral Health: Non-Physician with All Other Credentials			
Applied Behavioral Analysis			
Inpatient and Outpatient Behavioral Health Facility/Treatment Center			
Inpatient and Outpatient Chemical Dependency Facility/Treatment Center			
<b>Facility</b>			
Hospital	(In minutes)	(In minutes)	(All enrollees)
Urgent/Emergent Care	(In minutes)	(In minutes)	(All enrollees)
<b>Ancillary</b>			
Home Health			
Durable Medical Equipment			
Therapies: Chiropractic			
Therapies: OT/PT			
Therapies: Acupuncture			
Therapies: Massage			
Hospice			
<b>Pharmacy Dispensing</b>			
Pharmacy Dispensing			

#### **Oregon State Network Provider Adequacy**

During the term of any resulting Contract, Contractor must offer and maintain a provider network meeting or exceeding the minimum standards for provider network access as required by law in Oregon State. Please complete Table 5.3 for Bidder's provider network adequacy in Oregon.

<b>Table 5.3 – Oregon Provider Network Adequacy</b>			
<b>Provider Type</b>	<b>Urban Standard (Miles)</b>	<b>Rural Standard (Miles)</b>	<b>Percent of Members Within Standard</b>
<b>Primary Care</b>			
All Primary Care			
Pediatrics			
Women's Health OB/GYN			



Table 5.3 – Oregon Provider Network Adequacy			
Provider Type	Urban Standard (Miles)	Rural Standard (Miles)	Percent of Members Within Standard
<b>Pediatric Subspecialties</b>			
All Pediatric Subspecialties			
Pediatric Cardiology			
Pediatric Neurology			
Pediatric Psychiatry			
<b>Medical Specialties</b>			
All Medical Specialties			
Allergy/Immunology			
Cardiology			
Dermatology			
Endocrinology			
Gastroenterology			
Hematology/Oncology			
Infectious Disease			
Nephrology			
Neurology			
Pulmonology			
Rheumatology			
<b>Surgical Specialties</b>			
All Surgical Specialties			
General Surgery			
Neurosurgery			
OB/GYN			
Ophthalmology			
Orthopedic Surgery			
Urology			
<b>Behavioral Health</b>			
Psychiatry			
Behavioral Health: Non-Physician PhD and Master's-Level Providers			
Behavioral Health: Non-Physician with All Other Credentials			
Applied Behavioral Analysis			

<b>Table 5.3 – Oregon Provider Network Adequacy</b>			
<b>Provider Type</b>	<b>Urban Standard (Miles)</b>	<b>Rural Standard (Miles)</b>	<b>Percent of Members Within Standard</b>
Inpatient and Outpatient Behavioral Health Facility/Treatment Center			
Inpatient and Outpatient Chemical Dependency Facility/Treatment Center			
<b>Facility</b>			
Hospital	(In minutes)	(In minutes)	(All enrollees)
Urgent/Emergent Care	(In minutes)	(In minutes)	(All enrollees)
<b>Ancillary</b>			
Home Health			
Durable Medical Equipment			
Therapies: Chiropractic			
Therapies: OT/PT			
Therapies: Acupuncture			
Therapies: Massage			
Hospice			
<b>Pharmacy Dispensing</b>			
Pharmacy Dispensing			

## **Appendix 6 – Proposed Service Area(s)**

This appendix has been included as a separate excel attachment. Bidders must complete the spreadsheet indicating which counties Bidder will be covering in its Proposal starting January 1, 2020. Proposed service areas are by county.

## **Appendix 7 – Common Measure Set**

This appendix has been included as a separate attachment.

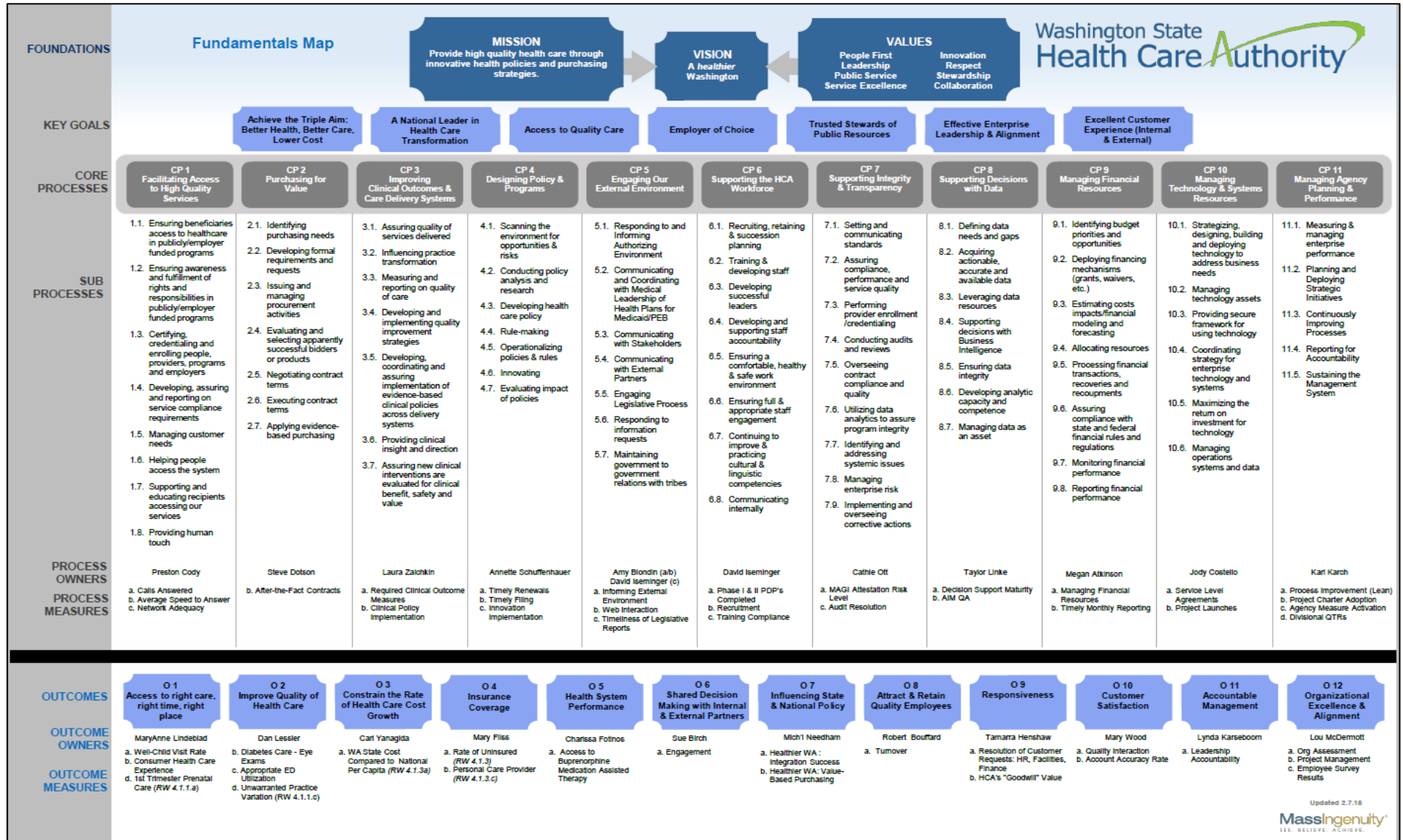
## Appendix 8 – 2017 Paying for Value Survey

Please follow the link below to access the appendix.



Appendix 8 - 2017  
Paying for Value Surv

## Appendix 9 – Results HCA Fundamentals Map



Here is a direct link to "Fundamentals Map" above: <https://www.hca.wa.gov/assets/program/FundamentalsMap.pdf>  
 More about "Results HCA" can be found at: <https://www.hca.wa.gov/about-hca/performance-measures>.

## Appendix 10 – 2018 UMP Classic Plan Design

Table 1

2018 UMP Classic Point of Service Cost Sharing	
Medical	
Deductible (single/family)	\$250/\$750
Coinsurance	15%
Maximum out of Pocket (single/family)	\$2,000/\$4,000
Drug	
Deductible (single/family)	\$100/\$300
Coinsurance	Preventative- 0% Value- 5% Generic- 10% Preferred- 30% Non-preferred- 50%
Maximum out of Pocket (single/family)	\$2,000/no max

Table 2

2018 UMP Classic Benefit Specific Cost Sharing		
Covered Services	Cost Share	Subject to Deductible?
Ambulance (medical emergencies)	Subject to Coins.	Yes
Acupuncture (16 visits)	Subject to Coins.	Yes
Applied Behavior Analysis Therapy (ABA)	Subject to Coins.	Yes
Chemical Dependency:		
Inpatient	Subject to Coins.	Yes
Outpatient	Subject to Coins.	Yes
Contraceptive Services	Preventative: 0% Coins. Standard: Subject to Coins.	Preventative: No Standard: Yes
Dental Services (covered medical services)	Subject to Coins.	Yes
Diabetes Control Program	0% Coins.	No
Diabetes Prevention Program	0% Coins.	No
Diagnostic tests, laboratory, and x-rays	Subject to Coins.	Yes
Durable medical equipment, supplies, and prostheses	Subject to Coins.	Yes
Emergency Room	Subject to Coins.	Yes
End-of-life counseling (hospice)	0% Coins.	Yes
End-of-life counseling (non-hospice, 30 visits)	Subject to Coins.	Yes
Family planning services	Subject to Coins.	Yes
Headaches, chronic migraines (Botox)	Subject to Coins.	Yes
Hearing aids	Any dollar amount over \$800	No
Hearing exams, routine (1 per year)	0% Coins.	No
Home health care	Subject to Coins.	Yes
Hospice (includes respite and prescription drugs, up to 6 months hospice, 14 visits respite)	Medical and prescription drug services paid 100% after deductible	Yes
Hospital Services:		

Inpatient	Copay/Subject to Coins.	Yes
Outpatient	Subject to Coins.	Yes
Immunizations	0% Coins.	No
Joint replacement surgery		
Inpatient	Copay/Subject to Coins.	Yes
Outpatient	15% coinsurance	Yes
<del>Mammograms (diagnostic)</del>	<del>Subject to Coins.</del>	<del>Yes</del>
<del>Mammograms (screening)</del>	<del>0% Coins.</del>	<del>No</del>
<del>Immunizations</del>	<del>0% Coins.</del>	<del>No</del>
Joint replacement surgery: COE Program	0% Coins.	Yes
Mammograms (diagnostic)	Subject to Coins.	Yes
Mammograms (screening)	0% Coins.	No
Massage Therapy (16 visits)	Subject to Coins.	Yes
Mastectomy and breast reconstruction	Subject to Coins.	Yes
Mental health treatment:		
Inpatient	Copay/Subject to Coins.	Yes
Outpatient	Subject to Coins.	Yes
Naturopathic physician services	Subject to Coins.	Yes
Obstetric and newborn care (inpatient)	Subject to Coins.	Yes
Office visits	Subject to Coins.	Yes
Physical, occupational, speech and neurodevelopmental therapy (60 visits)	Subject to Coins.	Yes
Preventative care: vaccines, routine exams, and some screening tests	0% Coins.	No
Skilled nursing facility	Copay/Subject to Coins.	Yes
Spinal and extremity manipulations/chiropractic (10 visits per year)	Subject to Coins.	Yes
Surgery:		
Inpatient	Copay/Subject to Coins.	Yes
Outpatient	Subject to Coins.	Yes
Telemedicine services	Subject to Coins.	Yes
Tobacco cessation	0% Coins.	No
Transgender services	Subject to Coins.	Yes
Urgent care	Subject to Coins.	Yes
Vision care: diseases and disorder of the eye	Subject to Coins.	Yes
Vision exams, routine	0% Coins.	No
Vision hardware, adults (glasses, contact lenses)	Any amount over \$150 every 2 years	No
Vision hardware children (age 18 and under), glasses: plan pays 1 pair per year	\$0	No
Well-child visits	0% Coins.	No

#### 2018 UMP Classic List of Exclusions:

1. Air ambulance, if ground ambulance would serve the same purpose.
2. Autologous blood and platelet-rich plasma injections.
3. Bariatric surgery under the following circumstances: BMI 30 to 34 without Type II Diabetes Mellitus. BMI less than 30. Patients younger than 18 years of age.
4. Bone growth stimulators for: Nonunion of skull, vertebrae or tumor related. Ultrasonic stimulator – delayed fractures and concurrent use with other noninvasive stimulator.



5. Bone morphogenetic protein-7 (rhBMP-7) for use in lumbar fusion.
6. Bronchial thermoplasty for asthma.
7. Cardiac nuclear imaging for: Asymptomatic patients, patients with known coronary artery disease and no changes in symptoms.
8. Carotid artery stenting of intracranial arteries.
9. Carotid intima media thickness testing.
10. Complications arising directly from services that would not be covered by the plan during the current plan year. The plan will cover complications arising directly from services that the plan paid for you in the past.
11. Computed tomographic colonography (CTC), also called a virtual colonoscopy, for routine colorectal cancer screening
12. Corneal refractive therapy (CRT), also called orthokeratology.
13. Coronary or cardiac artery calcium scoring.
14. Coronary artery tomographic angiography for: Patients who are asymptomatic or at high risk of coronary artery disease; CCTA used for coronary artery disease investigation outside of the emergency department or hospital setting; and CT scanners that use lower than 64-slice technology.
15. Cosmetic services or supplies, including drugs and pharmaceuticals. However, the plan does cover: Reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury. Reconstructive surgery of a congenital anomaly, such as cleft lip or palate, to improve or restore function.
16. Court-ordered care, unless determined by the plan to be medically necessary and otherwise covered.
17. Custodial care
18. Deep brain stimulation and transcranial direct current stimulation when used as non-pharmacological treatments for treatment-resistant depression.
19. Dental care for the treatment of problems with teeth or gums, other than the specific covered dental services
20. Dietary or food supplements, including but not limited to; herbal supplements, dietary supplements, medical foods, and homeopathic drugs. Infant or adult dietary formulas. Medical foods. Minerals. Prescription or over-the-counter vitamins.
21. Dietary programs.
22. Discography for patients with chronic low back pain and lumbar degenerative disc disease. This does not apply to patients with the following conditions: Radiculopathy, Functional neurologic deficits (motor weakness or EMG findings of radiculopathy), Spondylolisthesis greater than Grade 1, Isthmic spondylolysis. Primary neurogenic claudication associated with stenosis. Fracture, tumor, infection, inflammatory disease. Degenerative disease associated with significant deformity
23. Drugs or medicines not covered by the plan
24. Drugs or medicines obtained through mail-order pharmacies located outside the U.S.
25. Educational programs, except as part of a diabetes control program, diabetes education, diabetes prevention program, and tobacco cessation services.
26. Electrical Neural Stimulation (ENS), which includes Transcutaneous Electrical Nerve Stimulation (TENS) Units.
27. Email consultations or e-visits.
28. Equipment not primarily intended to improve a medical condition or injury, including but not limited to: Air conditioners or air purifying systems, arch supports, communication aids, elevators, exercise equipment, massage devices, overbed tables, residential accessibility modifications, sanitary supplies, telephone alert systems, vision aids, whirlpools, portable whirlpool pumps, or sauna baths.
29. Erectile or sexual dysfunction treatment with drugs or pharmaceuticals.
30. Experimental or investigational services, supplies, or drugs.
31. Extracorporeal shock wave therapy for musculoskeletal conditions.
32. Eye surgery to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
33. Facet neurotomy for the thoracic spine or headache.
34. Fecal microbiota transplantation for treatment of inflammatory bowel disease.
35. Foot care not related to diabetes: cutting of toenails, treatment for diagnosed corns and calluses, or any other maintenance-related foot care.
36. Functional neuroimaging for primary degenerative dementia or mild cognitive impairment.
37. Treatment of chronic tension-type headache with Botox. Treatment of chronic migraine or chronic tension-type headache with acupuncture, massage, trigger point injections, transcranial magnetic stimulation, or manipulation/manual therapy (example: chiropractic services).
38. Hip resurfacing.
39. Hip surgery for treatment of Femoroacetabular Impingement (FAI) Syndrome.
40. Home health care such as: private duty or continuous care in the member's home, housekeeping or meal services, care in any nursing home or convalescent facility, care provided by or for a member of the patient's family, any other services provided in the home that do not meet the definition of skilled home health care.

41. Hospital inpatient charges for non-essential services or features such as: admissions solely for diagnostic procedures that could be performed on an outpatient basis, reserved beds, services and devices not medically necessary, personal or convenience items.
  42. Hyaluronic acid injections (viscosupplementation) for treatment of pain in any joint other than the knee.
  43. Hyperbaric oxygen therapy treatment for: brain injury including traumatic (TBI) and chronic brain injury, cerebral palsy, multiple sclerosis, migraine or cluster headaches, acute and chronic sensorineural hearing loss, thermal burns, non-healing venous, arterial and pressure ulcers.
  44. Imaging of the sinus for rhinosinusitis using X-ray or ultrasound.
  45. Immunizations for the purpose of travel or employment, even if recommended by the Centers for Disease Control and Prevention.
  46. Implantable drug delivery systems (infusion pumps or IDDS) for chronic non-cancer pain.
  47. In vitro fertilization and all related services and supplies, including all procedures involving selection of embryo for implantation.
  48. Incarceration: Services and supplies provided while confined in a prison or jail.
  49. Infertility or fertility testing or treatment after initial diagnosis, including drugs, pharmaceuticals, artificial insemination, and any other type of testing, treatment, complications resulting from such treatment (e.g., selective fetal reduction), or visits for infertility.
  50. Knee arthroscopy for osteoarthritis of the knee.
  51. Late fees, finance charges, or collections charges.
  52. Learning disabilities treatment after diagnosis, except as covered under the following benefits: ABA therapy, physical, occupational, speech, and neurodevelopment therapy, or when part of treating a mental health disorder.
  53. Lumbar artificial disc replacement.
- Uniform Medical Plan Classic 2018 Certificate of Coverage 106
54. Lumbar fusion for degenerative disc disease.
  55. Magnetic resonance imaging, upright (uMRI).
  56. Maintenance care
  57. Manipulations of the spine or extremities (non-spinal, arms or legs.)
  58. Marriage, family, or other counseling or training services, except as provided to treat an individual member's neuropsychiatric, mental, or personality disorder.
  59. Massage therapy services when the massage therapist is not a preferred provider.
  60. Medicare-covered services or supplies delivered by a provider who does not offer services through Medicare, when Medicare is the patient's primary coverage.
  61. Microprocessor-controlled lower limb prostheses (MCP) for the feet and ankle.
  62. Missed appointment charges.
  63. Noncovered provider types: Services delivered by providers not listed as a covered provider type
  64. Novocure (tumor treating fields).
  65. Orthoptic therapy except for the diagnosis of strabismus, a muscle disorder of the eye.
  66. Orthotics, foot or shoe: Items such as shoe inserts and other shoe modifications
  67. Osteochondral allograft/autograft transplantation for joints other than the knee.
  68. Out-of-network provider charges that are above the allowed amount.
  69. Over-the-counter contraceptive supplies intended for use by males.
  70. Pharmacogenomics testing for depression, mood disorders, psychosis, anxiety, ADHD, and substance use disorder.
  71. Positron Emission Tomography (PET) scans for routine surveillance of lymphoma.
  72. Postage and handling related to medical services and supplies.
  73. Prescription drug charges over the allowed amount, regardless of where purchased.
  74. Prescription drugs that require preauthorization unless the request is supported by medical justification from a clinician other than the patient or member of the patient's family or approved by the plan.
  75. Proton beam therapy for conditions other than: ocular cancers, pediatric cancers central nervous system tumors, other non-metastatic cancers with the following conditions when expected treatment has failed.
  76. Provider administrative fees—any charges for completing forms, copying records, or finance charges, except for records requested by the plan to perform retrospective (post payment) review.
  77. Recreation therapy.
  78. Replacement of lost, stolen, or damaged durable medical equipment.
  79. Replacement of medications that are any of the following: confiscated or seized by Customs or other authorities, contaminated, damaged, expired, lost or stolen, ruined.
  80. Residential treatment programs that are not licensed to provide residential treatment.
  81. Reversal of voluntary sterilization (vasectomy, tubal ligation, or similar procedures).

82. Riot, rebellion, and illegal acts: services and supplies for treatment of an illness, injury, or condition caused by a member's voluntary participation in a riot, armed invasion or aggression, insurrection or rebellion, or sustained by a member arising directly from an act deemed illegal by a court of law.
83. Separate charges for records or reports.
84. Service animals: any expenses related to a service animal.
85. Services covered by other insurance, including but not limited to motor vehicle, homeowner's, renter's, commercial premises, personal injury protection (PIP), medical payments (Med-Pay), automobile no-fault, general no-fault, underinsured or uninsured motorist coverage.
86. Services delivered by providers or facilities delivering services outside the scope of their licenses.
87. Services or supplies that are not medically necessary for the diagnosis and treatment of injury or illness or restoration of physiological functions, and are not covered as preventive care, even if services are prescribed, recommended, or approved by your provider. Services or supplies provided by a family member or any household member, a resident physician or intern acting in that capacity, solely for comfort, or for which you are not obligated to pay.
88. Services performed during a non-covered service.
89. Services performed primarily to ensure the success of a non-covered service, including but not limited to a hiatal hernia repair done to ensure the success of a non-covered laparoscopic adjustable gastric banding surgery.
90. Services supplemental to digital mammography. Non-high-risk patients: magnetic resonance imaging (MRI), Hand held ultrasound (HHUS), automated breast ultrasound (ABUS). High-risk patients: hand held ultrasound (HHUS), automated breast ultrasound (ABUS).
91. Services, supplies, or drugs related to occupational injury or illness
92. Services, supplies, or items that require preauthorization unless the request is supported by medical justification from a clinician other than the patient or member of the patient's family or approved by the plan.
93. Skilled nursing facility services or confinement: when primary use of the facility is as a place of residence, when treatment is primarily custodial.
94. Sleep apnea diagnosis and treatment as indicated in referenced Medicare national and local coverage determinations.
95. Spinal cord stimulation for chronic neuropathic pain.
96. Spinal injections, therapeutic of the following types: medial branch nerve block, intra-discal, facet injections
97. Spinal surgical procedures known as vertebroplasty, kyphoplasty, and sacroplasty.
98. Stereotactic radiation surgery and stereotactic body radiation therapy.
99. Telephone or virtual consultations or appointments, except when considered 'telemedicine' services.
100. Travel, transportation, and lodging expenses, except as specified for ambulance services covered by the plan, or approved travel and lodging costs related to the Center of Excellence (COE) Program for joint replacement.
101. Ultrasounds during pregnancy (non high-risk only): any more than one in week 13 or earlier, any more than one during weeks 16-22.
102. Upright magnetic resonance imaging (uMRI)
103. Vagal nerve stimulation for the treatment of depression.
104. Vitamin D screening and testing is not covered as part of routine screening.
105. Weight control, weight loss, and obesity treatment: programs, drugs, services, or supplies for weight control, weight loss, or obesity treatment. Exercise or diet programs (formal or informal), exercise equipment, or travel expenses associated with non-surgical or surgical services are not covered. Such treatment is not covered even if prescribed by a provider, except as covered under diabetes control program, diabetes prevention program, nutrition counseling and therapy, or preventative care. Any bariatric surgery procedure, any other surgery for obesity or morbid obesity, and any related medical services, drugs, or supplies, except when approved by preauthorization review.
106. Workers' compensation: When a claim for workers' compensation is accepted as being caused by a work-related injury or illness, all services related to that injury or illness are not covered, even if some services are denied by workers' compensation.

## Appendix 11 – Proposed Plan Design(s)

“Plan Name”		
<b>Counties Offered in:</b>		
Point of Service Cost Sharing		
Medical		
Deductible (single/family)		
Coinsurance		
Maximum out of Pocket (single/family)		
Drug		
Deductible (single/family)		
Coinsurance	Preventative- % Value- % Generic- % Preferred- % Non-preferred- %	
Maximum out of Pocket (single/family)		
Benefit Specific Cost Sharing		
Covered Services	Cost Share	Subject to Deductible?
Ambulance (medical emergencies)		
Acupuncture (16 visits)		
Applied Behavior Analysis Therapy (ABA)		
Chemical Dependency:		
Inpatient		
Outpatient		
Contraceptive Services		
Dental Services (covered medical services)		
Diabetes Control Program		
Diabetes Prevention Program		
Diagnostic tests, laboratory, and x-rays		
Durable medical equipment, supplies, and prostheses		
Emergency Room		
End-of-life counseling (hospice)		
End-of-life counseling (non-hospice, 30 visits)		
Family planning services		
Headaches, chronic migraines (Botox)		
Hearing aids		
Hearing exams, routine (1 per year)		
Home health care		
Hospice (includes respite and prescription drugs, up to 6 months hospice, 14 visits respite)		
Hospital Services:		

Inpatient		
Outpatient		
Immunizations		
Joint replacement surgery		
Inpatient		
Outpatient		
<del>Mammograms (diagnostic)</del>		
<del>Mammograms (screening)</del>		
<del>Immunizations</del>		
Joint replacement surgery: COE Program		
Mammograms (diagnostic)		
Mammograms (screening)		
Massage Therapy (16 visits)		
Mastectomy and breast reconstruction		
Mental health treatment:		
Inpatient		
Outpatient		
Naturopathic physician services		
Obstetric and newborn care (inpatient)		
Office visits		
Physical, occupational, speech and neurodevelopmental therapy (60 visits)		
Preventative care: vaccines, routine exams, and some screening tests		
Skilled nursing facility		
Spinal and extremity manipulations/chiropractic (10 visits per year)		
Surgery:		
Inpatient		
Outpatient		
Telemedicine services		
Tobacco cessation		
Transgender services		
Urgent care		
Vision care: diseases and disorder of the eye		
Vision exams, routine		
Vision hardware, adults (glasses, contact lenses)		
Vision hardware children (age 18 and under), glasses: plan pays 1 pair per year		
Well-child visits		

## Exclusions List:

Assuming exclusions are the same for every plan the Bidder submits, only one redline exclusion list is necessary for the plan submittals. If there are changes to the exceptions list based on plan design, note those changes.