Exhibit E – Operations (350 points total)

Mandatory Scored (Unless otherwise specified)

1. Health Plan Experience **(32 maximum points)**

Please limit response to one (1) page.

1.1 Complete Table 1, below, by providing information regarding the employer accounts the Bidder is contracted with to provide the fully insured MA-PD product types listed. **Bidders submitting a Proposal for a National PPO Plan must complete the National PPO row of the table, and Bidders submitting a Proposal for a Regional PPO Plan must complete the Regional PPO row of the table. Bidders submitting Proposals for both a National PPO Plan and a Regional PPO Plan must complete the entire table.**

Product Type	Number of subscribers[2] in the Bidder's Largest Account	Number of members[3] in the Bidder's Largest Account	Years of Experience with the Bidder's Largest Account	Number of Accounts with >5,000 members	Total Years of Experience Offering this Product Type	Total Number of Covered Lives Under All Accounts
National PPO						
Regional PPO[1]						

1. As defined by CMS
2. Main account holders
3. Subscribers and their dependents

1.2 Provide the Bidder's client retention rate for the past 3 years for all MA-PD employer accounts across its Book-of-Business.

2. Claims Services **(35 maximum points)**

Please limit response to four (4) pages, excluding any requested flow charts, examples, etc. Describe the Bidder's:

2.1. Claims processing office, including:

2.1.1. Location;

2.1.2. Hours of operation (converted to Pacific Time);

2.1.3. Number of employees working there;

2.1.4. How long the office has been in service; and

2.1.5. Any back-up Claims center(s) and its location(s).

2.2. Actions taken to deliver a consistently high degree (95-98%) of Claims payment accuracy and timeliness. As part of the response, Bidders must complete the table below to include performance standards the Bidder currently measures. HCA has indicated the first two measures, and Bidder may add additional performance measures as needed.

	2015		2016		2017		2018	
Measure	**Target**	**Result**	**Target**	**Result**	**Target**	**Result**	**Target**	**Result**
Payment accuracy								
Clean Claims payment timeliness	(e.g.) 95% of Clean Claims paid in 30 Business Days							

2.2.1. Is Bidder willing to provide this Claims performance data to HCA on at least a quarterly basis or another timeline requested by HCA?

2.3. Claims processing system, including:

2.3.1. Can the Bidder's Claims processing system auto adjudicate Claims? If yes, what percent of Claims are auto adjudicated?

2.3.2. What is the average time to process in-network Clean Claims from time of receipt to the time of payment?

2.3.3. What is the average time to process out-of-network Clean Claims from time of receipt to time of payment?

2.3.4. Are Members responsible for submitting Claims forms for out-of-network care and or other types of services received? If yes, please describe when a Member must submit Claims forms and what assistance the Bidder provides, including Member education, customer service, and

desktop or mobile-based platforms for Claims submission and tracking.

2.3.5. What is the average time to issue a Member's Explanation of Benefits after payment is made?

2.3.6. Are there any plans to change the Claims processing system in the next five (5) years?

2.4. Internal Claims audit procedures, including whether audits are performed on all Claims or a subset (sample) of Claims.

2.5. Process to make revisions to benefits or benefit design prior to the new Plan Year starting. What is the minimum amount of time needed to make such revisions and receive CMS approval?

2.6. Processes to prevent, detect, and amend internal and external fraud, waste, and abuse.

2.7. Tools and procedures to prevent and detect identity theft on behalf of Members.

2.8. Ability to accept the customized 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, 2020? If not, provide an estimated date by when the Bidder will be able to accept the HIPAA 834 file.

2.8.1. Can the Bidder accept the file daily?

2.8.2. Can the Bidder accept the file weekly?

2.9. Ability to perform a monthly eligibility file audit, which may include a reconciliation process.

2.10. Balance billing policies and procedures for Supplemental Benefits, out-of-network providers, and/or Medicare participating providers who do not accept the Bidder's Health Plan, and how these are communicated to Members.

2.11. Has the Bidder, for any Medicare Advantage plans in its Book-of-Business, ever been fined or had enforcement actions taken against it by CMS for Claims violations (e.g., overcharging beneficiaries, denying or delaying coverage for prescription drugs, and/or failing to respond to patients' complaints)? If yes, describe the violation(s) and what actions were taken by the Bidder to ensure the same issues did not happen in the future.

3. Customer Services **(59 maximum points)**

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

3.1. Customer service center and staff including:

3.1.1. Proposed MA-PD Health Plan customer service center location;

3.1.2. Days and hours of operation (converted to Pacific Time);

3.1.3. Size of MA-PD Health Plan support staff (including ratio of staff to Members) and annual staff turnover rate;

3.1.4. Whether customer service staff would perform other roles, such as processing Claims;

3.1.5. Number of covered lives the Bidder's customer service center currently supports;

3.1.6. How long the customer service center has been in service; and

3.1.7. If there is a back-up customer service center and its location.

3.2. Separate customer service staff for specific programs or benefits (i.e. clinical care management programs, pharmacy coverage, wellness programs, etc.), as applicable.

3.3. Commitment to provide support and resources for the PEBB Annual Open Enrollment. Support may include, but is not limited to: trained staff to attend benefit fairs, written (paper, online) communications to explain the Bidder's MA-PD Health Plan offering(s), and webinar and video support as requested. Topics may include: benefits and Member cost-sharing, network providers, Claims processes, Member services, and informational tools and resources.

3.4. Customer service phone system, including:

3.4.1. Toll-free Customer Service number, including where the number is posted (e.g., online, enrollment welcome packet, ID cards, EOB, benefit summary comparison documents and other coverage documents, Claims denial letters, disenrollment letter, Appeal denial letters, etc.).

3.4.2. Call triage process (e.g., a phone tree). Provide a description or diagram.

3.4.3. Call queuing (in the order received). Is there a time limit for how long Members may be placed on hold?

3.4.4. Transfers. Is there a limit on the number of transfers for a single call? Do customer service representatives provide warm transfers (i.e., stay on the line to describe the issue/provide background to the new customer service representative)?

3.4.5. Call-back feature (so Members don't have to wait on hold). If Members use this feature, how quickly is their call returned?

3.4.6. Customer service operating hours and after-hours access (based on Pacific Time).

3.4.7. Message system, and whether Members can leave a message with a call back within the next Business Day.

3.4.8. Use of recorded messages (when, for what purpose). When and how can Members override recorded messages to speak to a customer service

representative?

3.4.9. Interactive Voice Response System (IVR).

3.4.10. Procedure for dropped or abandoned calls.

3.4.11. Other telephone customer service tools or supports offered to Members (specify).

3.5. Process to ensure consistent information is provided to Members who communicate with customer service staff through different communication channels (e.g. telephone, e-mail, digital messaging), or who speak with multiple customer service staff regarding the same issue.

3.6. Escalation process for customer service issues. Include in the description a diagram or flow chart.

3.7. Support for linguistically and culturally diverse populations through telephone, written, and digital (desktop, mobile) communications. Describe the primary language(s) served and the availability of translation services for other languages.

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

3.9. Current methods of communicating with Members electronically, including but not limited to email, online messaging, mobile applications, and other methods. Include in the response:

3.9.1. Types of transactional activities Members can conduct via these methods; and

3.9.2. Average response time for each.

3.10. Business policies and procedures used to ensure safeguards are in place for PHI when communicating with Members and HCA staff by email or online messaging. Include in the answer whether emails and messaging are secure.

3.11. Customer service training program, including specific training targeted to customer service for Medicare beneficiaries. Describe the customer service representative account onboarding process. Include additional proposed annual customer service training for Annual Open Enrollment.

3.12. Customer service Quality Control monitoring and auditing processes.

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

3.14. Customer service Performance Standard measures by completing Table 2:

Table 2 – Customer Service Performance Standards

Measure	Plan Standard	2017 Actual	2018 Actual
Percentage of calls answered within 30 seconds or less (measured from the time the call begins to ring in the Bidder's customer service center)			
Average call abandonment rate			
Average time for Member issue resolution from initial notification (for all channels of Member notification)			
First-call resolution percentage (Member's issue is resolved to their satisfaction during first call)			
Customer Service Satisfaction Annual Survey			
Average call-in wait time (hold time)			
Average message return time			

3.15. Process for conducting a Member satisfaction survey. Who conducts the survey? What is the frequency? How are the results used to make improvements?

3.16. Process or procedures for communicating with family or friends who are assisting Members with their health insurance benefits. Include in the

response how the Bidder handles communications with family or friends who do not have Power of Attorney on behalf of the Member, and those who do or do not have a written consent from the Member to communicate on their behalf.

4. Communications **(56 maximum points)**

Please limit response to three (3) pages, excluding any requested flow charts, examples, etc. Describe the Bidder's:

4.1. Ability and resources to write, design, print and distribute the following customized materials for each of the Bidder's potential contracted PEBB MA-PD Health Plan(s) and provide an example of each:

- 4.1.1. Enrollment welcome packet
- 4.1.2. ID cards (must display an HCA-approved logo, the Bidder's logo, and any other information needed by providers and Members to access benefits)
- 4.1.3. Explanation of Benefits (EOB)
- 4.1.4. Benefit summary comparison documents and other coverage documents
- 4.1.5. Claims denial letters
- 4.1.6. Disenrollment letter
- 4.1.7. Appeal denial letters (for benefits)

4.2. Resources to provide internet-ready and ADA-compliant electronic forms for each of the Bidder's potential contracted PEBB MA-PD Health Plan(s).

4.3. Ability to mail the enrollment welcome packet a) no later than December 20 (pending HCA's delivery of the eligibility file by December 10) for all enrollments completed during the Annual Open Enrollment; and b) within thirty (30) Business Days of enrolling for Subscribers who enroll in the Bidder's MA-PD Health Plan(s) outside of Annual Open Enrollment. These materials may include:

- 4.3.1. Cover letter
- 4.3.2. Notice of Privacy Practices (print and distribute only)
- 4.3.3. Web services promotional piece
- 4.3.4. Postcard to request a hard copy of the COC
- 4.3.5. Other materials, including other vendor materials, as requested by HCA

4.4. Resources to write the Certificate(s) of Coverage (COCs) for the Bidder's potential contracted PEBB MA-PD Health Plan(s) annually, in collaboration with HCA, so they are compatible with the Bidder's administration of the Health Plan and HCA's responsibility for defining eligibility and enrollment terms.

4.5. Process for distributing hard copies of the annual COC(s), summary benefits and coverage document, or other materials to Members, HCA staff, and Enrollees upon request.

4.6. Bidder must agree to comply with WAC 182-08-220 (1) which states: all materials describing PEBB benefits must be prepared by or approved by HCA before use, distribution or mailing of all benefit descriptions must be performed by or under the direction of HCA, and media announcements or advertising materials which includes any mention of PEBB, HCA, state employees, Retirees, or any group of enrollees covered by PEBB benefits must receive the advance written approval of HCA. Does Bidder agree to comply?

4.7. Whether the Bidder imposes a charge on Members or HCA for reissued or replacement ID cards for any reason. If yes, describe the reason(s).

4.8. Willingness to dual brand communications with HCA and the appropriate Health Plan or network logo and name, unless HCA requests single branding.

4.9. Communication with Members over a calendar year to educate them about the Bidder's PEBB MA-PD benefits and services. Provide two (2) examples.

4.10. Process to ensure all communications sent to Subscribers, Members, or Enrollees will relate directly to the Bidder's contracted PEBB MA-PD Health Plan(s). 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 PEBB MA-PD Health Plan(s), unless authorized in writing in advance by HCA.

5. Online Services **(53 maximum points)**

Please limit response to three (3) pages. Describe the following:

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

5.2. HCA wants a Contractor who can provide a microsite for the PEBB MA-PD Health Plan(s). Please indicate whether the Bidder can provide a dedicated microsite for its PEBB MA-PD Health Plan(s), or if Members can only access Health Plan information through the Bidder's Book-of-Business online services page.

5.3. Whether Enrollees can access public information regarding the Bidder's contracted PEBB MA-PD Health Plan(s) online. If yes, describe the kinds of

information that would be publicly available.

5.4. Describe the Bidder's Member-oriented websites (this may include the PEBB microsite), including desktop and mobile optimization.

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

5.4.2. How often are maintenance updates conducted?

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

5.5. Describe Member-oriented website features, capabilities, and information that 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 and Complaints
- ☐ Benefits and Coverage
- ☐ Bidder's Contact Information
- ☐ Claims Look-up
- ☐ Costs for Services Owed by Subscriber
- ☐ Cost Transparency Tool (e.g., cost estimates, cost by provider, etc.)
  Provide Link (if available):
- ☐ Customer Service Messaging (e.g., instant messaging)
- ☐ Discount or affinity programs available to all Members
- ☐ Explanation of Benefits (EOB) Look-up/Print
- ☐ FAQ
- ☐ Member Accumulators (For example, to track Member out-of-pocket spending toward the MA-PD Health Plan's deductible and any annual out-of-pocket maximum [for medical, pharmacy, or both], remaining allowance for covered services or number of visits for a particular service, etc.). Describe which Member Accumulators are available, and how they work for family accounts (i.e., accounts that include a spouse [or state-registered domestic partner] and/or child[ren]).
- ☐ Member forms and documents: Describe which forms and documents are available for Members to view and/or download
- ☐ Member Notices (check box if "yes"):
  - ☐ Members review Appeal/Grievance Status
  - ☐ Prior Authorization Request Status
  - ☐ Message from Bidder

- ☐ Claim(s) Processed
- ☐ Patient Rights
- ☐ Payments to Providers

☐ Print or Order New Cards

☐ Provider Messaging and/or Text Messaging (Member to Provider)

☐ Provider Directory Search – Current. Check all information available to Members through the Provider Directory Search, if applicable:

- ☐ Accepting New Patients
- ☐ Language(s) Provider Speaks
- ☐ Provider Contact Information (physical address, phone number)
- ☐ Provider Name
- ☐ Provider Network Status
- ☐ (National PPO Proposal Only) For Out-of-Network Providers, whether the Provider accepts the Bidder's PEBB MA-PD Health Plan on a passive basis (accepts the Bidder's Health Plan and has not opted out of Medicare)
- ☐ Provider Ratings (e.g., quality, review, etc.)

☐ Other features, capabilities, and information. Describe Each:

5.6. Describe the Bidder's maintenance of provider directories. The Bidder must include the following in their response:

5.6.1. How often are directories updated?

5.6.2. How will the Bidder ensure accuracy of the provider directory prior to PEBB's Annual Open Enrollment and with each directory update?

5.7. Describe online tools and applications that make it easier for Members to conduct PEBB MA-PD Health Plan-related transactions, and how the Bidder increases Member awareness of these tools. Tools should include the ability to:

5.7.1. Schedule appointments online.

5.7.2. Communicate with a provider online.

5.8. Describe the process to fill/refill prescriptions online.

5.8.1. Are there specific website(s) the Members can fill/refill prescriptions through? If yes, how do Members access them and how do they know if the pharmacy provider is considered in-network, or accepts the PEBB MA-PD Health Plan on a passive basis?

5.8.2. Are the website(s) for prescription fill/refill secure? Describe their security.

5.8.3. Can the Member upload their prescription via their computer, smart phone, or tablet?

5.8.4. Is there free shipping when filling prescriptions online? Please elaborate on whether free/discounted shipping is contingent on the length of the prescription (e.g. 90 days vs. shorter)?

6. Appeals and Complaints **(25 maximum points)**

Please limit response to three (3) pages, excluding any requested flow charts, examples, etc.

6.1. Provide an overview of the Bidder's Appeals process. Please include the following in the response:

6.1.1. How Appeals are received

6.1.2. How the Bidder categorizes communication from a Member as an Appeal (as differentiated from an inquiry, coverage request, or Complaint).

6.1.3. How decisions are made

6.1.4. Who is involved in the decision making process (include the title, credentials, and qualifications for each person involved)

6.1.5. Completion timelines

6.1.6. Under which circumstances Members are notified of Appeals being processed by the Bidder, such as in the event of an Appeal that is being escalated.

6.2. Describe the Bidder's department responsible for processing Appeals and its location (e.g., locally or nationally centralized).

6.3. Provide an overview of the Bidder's Complaint process. Please include the following in the response:

6.3.1. How a Complaint may be filed with the Bidder.

6.3.2. How the Bidder categorizes communication from a Member as a Complaint (as differentiated from an inquiry, coverage request, or Appeal).

6.3.3. How the Bidder's customer service staff are trained to distinguish between coverage requests, Appeals, and Complaints.

6.3.4. The Bidder's process for assigning a Complaint as standard or expedited. Provide an example of each.

6.3.5. The Bidder's procedure for processing two or more issues (Complaints, Appeals, inquiries, or coverage requests) at the same time.

6.3.6. How Complaints are logged, tracked and stored/maintained. Describe the centralized location where Complaints are captured.

6.3.7. Individuals involved in the decision making process (include the titles and qualifications of each person).

6.3.8. Complaint resolution timelines.

6.3.9. How and when Members are notified that their Complaint(s) have been received and their results, and in which circumstances HCA would be notified.

6.4. Describe and provide two (2) examples of how Complaint and Appeal results and information are used to improve the Bidder's Claims processing, Member services, and business processes, such as staff training and Member experience when the ratio of overturned Appeals is high in a particular area or for a specific service or benefit.

6.5. Describe how the Bidder uses Complaints and Appeals data to improve performance of network-provider coordination.

7. Account Management **(31 maximum points)**

HCA is looking for ASB(s) with employees who are knowledgeable, attentive, and responsive to HCA's administrative needs, which may be urgent or need a 24-hour turnaround time. The ASB(s) should provide dedicated staff to HCA in the following areas: medical director, account management, clinical management, data analytics, communications, implementation, Information Technology (IT), and customer service.

Please limit response to three (3) pages, excluding any requested flow charts, examples, etc. Describe:

7.1. The Bidder's office locations for employees dedicated to this account. Preference may be given to Bidders with regional office(s).

7.2. The number of full time employees the Bidder intends to dedicate to the HCA account.

7.3. How the Bidder's account management staff will manage all contracted functions for the HCA account, including:

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

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

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

7.3.4. Report semi-annual performance on utilization and costs for PEBB MA-PD Health Plan(s), or as requested. Present analyses and recommendations in response to reported performance outcomes.

7.3.5. Inform the HCA account manager(s) of federal law changes within thirty (30) Days of notification, which the Bidder will be obligated to do.

7.3.6. Attend meetings of the PEB Board either in person or by phone.

7.4. The Bidder's capacities for and approaches to customer relations, provider relations, and public relations when administering public sector employer group MA-PD 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 plan policy and operations, oppositional lobbying efforts or special interest groups, provider associations, etc. How has (or would) the Bidder handle direct reporting of Complaints and Grievances to the Governor, Governor's senior staff, or cabinet-level agency heads regarding your entity's performance?

7.5. The Bidder's ability to respond to legislative requests for written information, budget analysis, and data for HCA within a 24-hour timeframe.

8. Emergency Response Management **(28 maximum points)**

Please limit response to three (3) pages, excluding any diagrams or flow charts.

8.1. Describe the Bidder's emergency response plan to maintain uninterrupted core business and operations during natural disasters or other system outages, and include in the response detailed descriptions of:

8.1.1. How the Bidder defines core business and operations; and

8.1.2. Where core business and operations would be conducted and by whom.

8.2. Describe the circumstances under which the Bidder's emergency response plan applies.

8.3. Describe the Bidder's emergency records management/back-up.

9. Implementation Plan **(10 maximum points)**

Please limit response to three (3) pages, excluding any requested flow charts, examples, etc.

Bidder(s) must provide a comprehensive implementation plan for the time-period from January 1, 2020 through December 31, 2020 that addresses all key operational areas necessary to implement PEBB Program MA-PD Health Plan(s) including, but not limited to:

9.1. Timeframe to build the eligibility structure and complete eligibility file testing.

9.2. Timeframe for CMS approval of all MA-PD Health Plan(s) and components (i.e. provider network, benefits, etc.).

9.3. Plans for an implementation audit ensuring all components for go-live are ready and 100% operational.

10. Annual Renewal Process **(21 maximum points)**

The Request for Renewal (RFR) process will be on an annual basis to adjust PEBB Program Medicare Retiree benefits in response to (a) new requirements under the ACA or other federal, and state requirements; (b) changes requested by the PEB Board or HCA, changes to Washington Administrative Code promulgated by HCA, or other internal policy drivers; (c) benefit design strategies promulgated by HCA; and/or (d) state 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.

Please limit response to one (1) page.

Describe the Bidder's Resources for responding to and implementing annual proposals through the RFR process.