STATE OF WASHINGTON
HEALTH CARE AUTHORITY

REQUEST FOR PROPOSALS (RFP)

RFP NO. 3872

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 any RFP amendments or bidder questions/agency answers. HCA is not responsible for any failure of your organization to send the information or for any repercussions that may result to your organization because of any such failure.*

PROJECT TITLE: Public and School Retirees Medicare Advantage plus Prescription Drug (MA-PD)

PROPOSAL DUE DATE: August 23, 2019 by 2:00 p.m. *Pacific Time*, Olympia, Washington, USA.

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

ESTIMATED TIME PERIOD FOR CONTRACT: January 1, 2021 to December 31, 2025

The Health Care Authority reserves the right to extend the Contract for up to five (5) additional 1-year periods at the sole discretion of the Health Care Authority.

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

1. INTRODUCTION

1.1. DEFINITIONS

Definitions for the purposes of this RFP include:

Alternative Payment Model (APM) – Payments made between a payer or insurer and a provider that reward providers for attaining specific value-based targets that may include quality of care, cost, access, patient experience, and other metrics. HCA defines value-based payments as payment arrangements in the CMS Health Care Learning & Action Network Categories 2c – 4b, as described in Appendix 1.

Annual Open Enrollment – An annual event set aside for a period of time when Subscribers may make changes to their plan enrollment and salary reduction elections for the following Plan Year. During the Annual Open Enrollment, Subscribers may transfer from one plan to another, enroll or remove Dependents from coverage, or enroll or defer (Retirees) or waive (employees) enrollment in the PEBB and SEBB Programs medical benefits.

Apparent Successful Bidder (ASB) – The Bidder selected as the 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 resulting Contract(s). The date is currently scheduled for January 1, 2021.

Bidder – Individual or company 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 – A collaborative of appointed health care experts established in 2011 by the Washington State Legislature to "identify health care services for which there are substantial variation in practice patterns or high utilization trends in Washington State, without producing better care outcomes for patients, that are indicators of poor quality and potential waste in the health care system" [70.250.050 RCW]. The collaborative identifies up to three areas of health care services every year and provides evidence-based clinical recommendations for improved care. HCA sponsors the Bree Collaborative and works with purchasers and providers to encourage adoption of the Collaborative's recommendations across communities.

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.

Calendar Day – Any day of the week, month, or year. Includes weekends and holidays. When "days" are not specified, Calendar Days shall prevail.

Care Coordination – The coordination of patient care activities between two (2) or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Coordinating 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 – For the purposes of this RFP, a private entity that provides health insurance coverage under Medicare Part C and may also include coverage for Medicare Part D. Alternatively referred to as a Medicare Advantage Organization.

Certificate of Coverage (COC) – A summary of the essential features of the group coverage contract produced and made available to each covered person, and, as the context requires, the plan year version in effect on the date of service.

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.

Clean Claim – Any Claim that has no material defect, impropriety, lack of any required substantiating documentation, or special circumstances (e.g., suspected fraud, subrogation, or coordination of benefits) that prevents timely adjudication of the Claim.

Clinical Data Repository (CDR) – A real-time database that consolidates clinical data from a variety of sources to present a unified view of a single patient's clinical history. When fully operational, the CDR will allow clinicians to retrieve data for a single patient rather than a population of patients with common characteristics. The CDR will be operated by the State Health Information Exchange (HIE) on behalf of sponsoring organizations. HCA will be the initial sponsoring organization. Currently the CDR only accepts clinical information for Medicaid clients; however, HCA intends to add Fee-for-Service Medicaid, PEBB Program, and SEBB Program clients in the coming years.

Clinical Management – Programs that use science, incentives, and information to improve medical practice and support collaboration between providers, health care consumers, and their support systems 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 HCA's clinical team; proactively identify and manage Members wo are at risk for health service utilization; provide Patient Decision Aids to support appropriate patient self-management; collaborate and integrate with providers and delivery systems; reduce unnecessary variation in clinical practice; and lower healthcare costs.

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 Carrier plan practices or action unrelated to health care services.

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

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.

Creditable Prescription Drug Coverage – Prescription drug benefits that are deemed by CMS to be equivalent to, or more generous than, the Medicare Part D Defined Standard Benefit.

Dependent – A Medicare-eligible spouse, state registered domestic partner, and/or dependent child of a Subscriber, who meets the eligibility requirements of WAC 182-12-260, or a Medicare eligible surviving spouse, state registered domestic partner, and/or dependent child of an emergency service person killed in the line of duty defined in WAC 182-12-250.

Employees and Retirees Benefits (ERB) Division – The division of the HCA that manages the operations that provide insurance coverage for eligible employees, Retirees, and their eligible dependents of Washington State agencies, higher education institutions, public schools, educational service districts (ESDs), charter schools, and certain employer groups. ERB includes both the PEBB and SEBB Programs, and any future replacement or successor benefit program(s) administered by HCA for public and school employees and/or Retirees.

Enrollee – Individuals who are eligible for and enrolled in PEBB Program Retiree insurance coverage.

Employee Retirement Income Security Act of 1974 (ERISA) – A federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans.

Explanation of Benefits (EoB) – A statement sent to Members explaining what medical treatments and/or services were paid by their Health Plan on their behalf.

Health Care Authority (HCA) – The executive agency of the State of Washington that is issuing this RFP. The Washington State Health Care Authority includes any division, section, office, unit or entity of HCA, or any of the officers or other officials lawfully representing HCA.

Health Equity – A state in which every person has the opportunity to achieve full health potential, regardless of personal characteristics or identities.

Health Plan – One of the fully-insured medical plans (including prescription drug coverage) offered by HCA. Health Plan includes a Certificate of Coverage for services relating to medical, behavioral health, and pharmacy Claims.

Medicare Advantage plus Prescription Drug (MA-PD) – A private Medicare insurance plan that provides medical coverage under Medicare Part C and prescription drug coverage under Medicare Part D.

Medicare Coordination of Benefits (COB) – A CMS rule that determines which entity pays first when a Medicare beneficiary has other health insurance. Under Medicare COB, Medicare pays up to the limits of its coverage and the health plan only pays if there are costs that Medicare doesn't cover (up to the plan's particular coverage limits).

Medicare Part D Defined Standard Benefit – The defined standard Medicare prescription drug benefit, which includes parameters for the annual deductible, initial coverage limit, annual out-of-pocket spending threshold, total covered drug spending at the annual out-of-pocket threshold, and minimum cost-sharing above the annual out-of-pocket threshold (copayment for generic/preferred multisource drugs and copayment for other prescription drugs). These parameters are updated annually by CMS at the same rate as the annual change in beneficiaries' average drug expenses (https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/announcements-and-documents.html).

Medication Therapy Management – Programs that optimize medication therapy outcomes and reduce adverse health events through personalized recommendations for improvements in medication use.

Member – Subscribers and their Dependents who are enrolled in a PEBB Program MA-PD Health Plan with a Carrier that results from this RFP, and for whom premium payments have been made.

National Preferred Provider Organization (PPO) – A PPO that offers MA-PD coverage nationwide through a network of providers as well as through all Medicare-participating (certified) providers that accept the plan's payment terms, with all care reimbursed at a single cost-share level (coinsurance, copay, and/or deductible) regardless of whether care is received in-network or out-of-network. Also referred to as a Non-differential or Passive PPO Plan.

OneHealthPort – HCA's contracted online Member Claim and eligibility portal for providers.

Patient Decision Aids (PDAs) – Tools that provide patients with information they need to make an informed decision. Providers can use PDAs as part of shared decision making with their patients. Through Shared Decision Making, a patient has the information and support needed to make the best choice, based on their personal values and preferences.

Patient Reported Outcome (PRO) - Any report of the status of a patient's health condition that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else.

PEBB Program Retiree Insurance Coverage – Any Health Plan, dental insurance, life insurance, long-term care insurance, or property and casualty insurance administered as a PEBB Program benefit to Retirees.

Performance Credit – The financial consequence associated with failure to meet the applicable Performance Guarantees. To be negotiated within any resulting contract(s).

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

Plan Year – Time period for Health Plan coverage as established by HCA. Typically this is January 1 through December 31.

Protected Health Information (PHI) – As defined in 45 C.F.R. §160.103.

Public Employees Benefits Board (PEB Board) – A board made up of members appointed by the Governor that is authorized to design benefits and determine the terms and conditions for participation in health insurance benefits for eligible public employees and Retirees under RCW 41.05.

Public Employees Benefits Board (PEBB) Program – The program within HCA that administers insurance and other benefits for eligible employees, Retirees, eligible dependents, eligible survivors, and other eligible individuals as defined in RCW 41.05.011.

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

Quadruple Aim – Better health, better care, lower health care costs, and improved patient and provider experience.

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 the desired patient outcomes.

Regional Preferred Provider Organization (PPO) – A PPO that offers in-network coverage within every county in Washington State. For the purposes of this RFP, a Regional PPO refers to a plan that covers at least all counties in Washington State but may extend regional coverage to additional states.

Request for Proposals (RFP) – Formal procurement document in which a service or need is identified but no specific method to achieve it has been chosen. The purpose of an RFP is to permit the bidder community to suggest various approaches to meet the need at a given price.

Response – A bid or Proposal that meets all material terms of the solicitation document.

Retiree(s) – A retired employee who is eligible for PEBB Program Retiree Insurance Coverage as described in WAC 182-12-171, 182-12-180, 182-12-211, and 182-12-265

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

Shared Decision Making – A process in which clinicians and patients work together to make decisions and select tests, treatments, and care plans based on clinical evidence that balances risks and expected outcomes with patient preferences and values.

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

School Employees Benefits Board (SEBB) Program – The program within HCA that administers insurance and other benefits for eligible school district, charter school, and represented ESD employees, and their eligible dependents.

Social Determinants of Health (SDOH) – Social structures and economic systems—including the social environment, physical environment, and health services—that are responsible for most health inequities.[1]

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 term “Subcontractor” means Subcontractors of any tier.

Subscriber – The Retiree who is also Medicare-eligible, has signed up to participate in a PEBB Program MA-PD Health Plan, is the main account holder (i.e., not a Dependent) and the individual who will receive all notices, information, and requests on behalf of enrollees

Supplemental Benefits – Services that Medicare does not cover, but that a private Medicare health plan may choose to offer. These services may be offered individually or as a group of services, and they may be different for each private Medicare health plan.

Uniform Medical Plan (UMP) – A self-funded health plan offered through HCA in the PEBB and SEBB Programs. UMP is administered by Regence BlueShield and Washington State Rx Services.

Utilization Management (UM) – Techniques used by or on behalf of health care purchasers to manage health care costs by evaluating the medical necessity, appropriateness, and efficiency of the

[1] Commission on Social Determinants of Health (CSDH), Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. 2008, World Health Organization: Geneva.

use of health benefits by a patient or a group of patients according to evidence-based criteria or clinical guidelines.[2]

Value – The combination of quality—as measured based on defined outcome or performance metrics—and cost efficiency in health care delivery or purchasing, consistent with the Quadruple Aim.

Value-based Insurance Design (VBID) – Designing health plan benefits to encourage use of high-value services, or those that provide a high clinical benefit to cost ratio, and discourage use of low-value services.

Value-based Purchasing (VBP) – Contractual arrangements made between a purchaser (e.g. HCA) and its Contractors and partners (e.g. Health Plans) that incentivize them to meet specified value-based targets that may include quality, cost, access, patient and provider experience, and other value-based metrics.

Washington Administrative Code (WAC) – Regulations of executive branch agencies issued by authority of statutes. These regulations are a source of primary law in Washington State. Any references to specific titles, chapters, or sections of the WAC includes any substitute, successor, or replacement title, chapter, or section.

1.2. PROCUREMENT SCHEDULE

Issue Request for Proposals	July 16, 2019
Letters of Intent to Propose & Non-Disclosure Agreement Due	July 24, 2019 at 2:00pm (PT)
Bidder Questions Due	July 31, 2019 at 2:00pm (PT)
HCA Responses to Questions Posted	August 7, 2019
Proposals Due	August 23, 2019 at 2:00pm (PT)
Evaluate Proposals	August 23, 2019 – September 10, 2019
Remaining Timeline if Oral Interviews are NOT Conducted	
Announce "Apparent Successful Bidder" and send notification via e-mail to unsuccessful Bidders	September 17, 2019
Debrief Request Deadline (if requested)	September 20, 2019
Contract Negotiations	October 2019 – December 15, 2019
Administrative Contract Start Date	January 1, 2020
Benefit Coverage Start Date	January 1, 2021
Remaining Timeline if Oral Interviews are Conducted	
Conduct Oral Interviews with Finalists	September 17-19, 2019
Announce "Apparent Successful Bidder(s)" and send notification via e-mail to unsuccessful Bidders	September 24, 2019
Debrief Request Deadline (if requested)	September 27, 2019

[2] Institute of Medicine Committee on Utilization Management, 1989; URAC

Contract Negotiations	October 2019 – December 15, 2019
Administrative Contract Start Date	January 1, 2020
Benefit Coverage Start Date	January 1, 2021

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

1.3. PURPOSE & OBJECTIVES

The Washington State Health Care Authority (HCA) is initiating this Request for Proposals (RFP) to solicit proposals from Carriers interested in providing and administering fully-insured group Medicare Advantage plus Prescription Drug (MA-PD) Health Plans. The resulting MA-PD Health Plan(s) may be made available to Retirees who are eligible to enroll in Medicare Retiree Health Plans that are administered by HCA, as well as to Retirees' Medicare-eligible Dependents. Additional information about the employee benefit programs currently being administered by HCA can be found in Section 1.4, *Background*.

It is possible that during the term of any Contract(s) resulting from this RFP that HCA may be required or provided the opportunity to administer other employee benefit programs (Future Programs). If that occurs, then it is possible that (i) one (1) or more of the existing programs will be replaced with a Future Program, and/or (ii) that some or Medicare-eligible Retirees, and their Medicare-eligible dependents, are required to transition from an existing program to a Future Program. Regardless, it is the intent of HCA that the MA-PD Health Plan(s) described in this RFP and in any resulting Contract(s) be made available to any eligible Retirees and their dependents that are members of any Future Plan. Therefore, all references to the PEBB Program include any Future Program that includes Medicare eligible Retirees.

HCA is looking to contract with one (1) or more experienced, fully-insured MA-PD Carrier(s) to provide National PPO coverage and may also contract with one (1) or more experienced, fully-insured MA-PD Carrier(s) to provide Regional PPO coverage in at least every county in Washington State. The intended Benefits Start Date will be January 1, 2021.

The PEB Board retains the authority to decide the type(s) and number of Health Plan(s) to offer to Medicare-eligible Retirees. HCA and the PEB Board are under no obligation to offer any Health Plan(s) proposed under this RFP.

HCA's objectives for this RFP are as follows:

A. Expand PEBB Program Medicare Retiree Health Plan options, with an emphasis on innovative solutions to providing high quality, affordable, and accessible medical and pharmacy coverage to Members.

B. Execute Contract(s) with qualified Carrier(s) for fully insured group MA-PD Health Plan(s) for a Benefits Start Date of January 1, 2021. One (1) or more Contract(s) may be awarded to the following plan type(s):

   1. A National PPO;

   2. A Regional PPO that offers coverage in every county in Washington State; or

   3. A Carrier that will offer both.

C. Partner with the awarded Apparent Successful Bidder(s) ASB(s) to improve cost efficiency and sustainability of the PEBB Program Medicare Retiree Health Plans by maximizing opportunities for APMs, innovative benefit design, and federal subsidies.

D. Partner with the awarded ASB(s) to promote positive Member health outcomes through state-of-the-art, evidence-based health care, Supplemental Benefits, and Member experience initiatives.

HCA will select one (1) or more ASB(s) that demonstrate:

1. Commitment to person-centered care and advanced Member engagement, with benefits, communications, and services tailored to the needs of people eligible for Medicare;

2. Integration of innovative approaches to benefit design and provider contracting that emphasize coordination, access, prevention, and personalization;

3. Agility and adaptation to changes in the Medicare market while providing stability in access, quality, and cost of medical and prescription drug benefits for Members;

4. Capacity and flexibility to implement HCA-directed benefit design modifications and other initiatives specific to PEBB Program Medicare Retiree Health Plans;

5. Strong alignment with and commitment to HCA's purchasing and health transformation vision, including HCA's Value-based Roadmap[3]; and

6. Commitment to active partnering and engagement with HCA and other key health partners to drive innovation in health care purchasing and delivery system reform in Washington State.

Prior to launching new MA-PD Health Plan(s) on January 1, 2021, an ASB will be expected to perform the following services:

1. Begin a structured Contract implementation as early as December 2019;

2. Support the Annual Open Enrollment activities in the fall of 2020 for the 2021 plan year as specified and approved by HCA; and

3. Be ready to provide all contracted insurance and administrative services beginning January 1, 2021.

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 HCA, 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.

This RFP does not cover benefits available to non-Medicare-eligible Retirees or their dependents. At this time, non-Medicare-eligible Retirees have access to the same plan offerings made available to public employees.

HCA intends to award one (1) or more Contracts to provide the services described in this RFP in order to provide an adequate portfolio of health care coverage options for Medicare-eligible Retirees. Members may live in Washington State, throughout the United States, or internationally. At this time, Bidders are required to provide a full proposal for one or both of the Health Plan(s) they would like to bid: (i) National PPO and/or (ii) Regional PPO. The final decision for the number of Carriers and MA-PD Health Plans offered will be determined by HCA and/or the PEB Board at a later date.

The funding and offering of PEBB Program benefits is dependent on Washington State Legislature appropriations and PEB Board actions. Changes to benefit funding could occur during any legislative session. Future action is required by at least the PEB Board in order for MA-PD benefits to be offered in the PEB Program. HCA reserves the right to modify the implementation timeline surrounding any resulting Contract(s).

[3] https://www.hca.wa.gov/assets/program/vbp_roadmap.pdf

1.4. **BACKGROUND**

HCA is a cabinet-level agency within the Washington State executive branch and governed by chapter 41.05 RCW. HCA is the largest health care purchaser in Washington State, providing care for over 2.2 million Washingtonians through Apple Health (Medicaid) and the PEBB Program. HCA spends $12 billion dollars annually between the two programs. This purchasing influence will expand with the implementation of the School Employees Benefits (SEB) Program, which will begin offering benefits January 1, 2020 to approximately 300,000 members. The ERB Division of HCA will administer benefits designed for both the PEBB and SEBB Programs.

The PEBB Program offers insurance benefits for all eligible Washington State employees and their eligible dependents from 522 participating state agencies, higher education institutions (universities, colleges, etc.), counties, municipalities, political subdivisions, tribal governments, and some ESDs that contract with HCA for PEBB Program Benefits. The SEBB Program will offer insurance benefits for all eligible school district, charter school, and represented ESD employees and their eligible dependents.

In addition, the PEBB Program offers voluntary medical insurance, dental insurance, auto and home insurance, and in some cases term life insurance to Retirees from both the PEBB and SEBB Programs. When a public employee or school employee retires and meets eligibility and procedural requirements, they may enroll in PEBB Program Retiree Insurance Coverage. Retirees who are not yet eligible for Medicare may select from health insurance options available to employees under the PEBB Program. When a Retiree becomes eligible for Medicare, they must disenroll from their existing PEBB coverage, and may enroll in a PEBB Program Medicare Retiree Health Plan. The pooling arrangement for retirees could change during the term of any Contract(s) resulting from this procurement.

Eligibility Administration of the Plan(s)

At the time this RFP is being issued, determination of eligibility for coverage of all PEBB Program Medicare Retiree Health Plans, which includes enrollment in Parts A and B of Medicare, is the statutory responsibility of the PEB Board and HCA, and is not open for suggestion under this RFP. More information on eligibility for PEBB Program Medicare Retiree insurance coverage can be found on HCA's website (https://www.hca.wa.gov/employee-retiree-benefits/retirees/how-determine-eligibility).

HCA retains administrative responsibility for individual eligibility determinations for enrollment in a PEBB Program Medicare Retiree Health Plan and handles Appeals related to eligibility and enrollment. In addition, HCA reserves the right to authorize audits by third parties.

PEBB Program Medicare Retiree Population

The PEBB Program currently offers five distinct Medicare insurance plans to Retirees organized into three plan categories: two Original Medicare Coordination of Benefit (COB) plans with Creditable Prescription Drug Coverage, two Medicare Advantage (Part C) plans with Creditable Prescription Drug Coverage, and one Medicare Supplement Plan F without prescription drug coverage. Beginning January 1, 2020, the PEBB Program Medicare portfolio will also include a Medicare Supplement Plan G through Premera.

As of March 2019, there are over 96,000 Members enrolled in the PEBB Program Medicare insurance plans with an average age of 74.4 years. Approximately 59% of Members are female. Approximately 89,000 Members are residents of Washington State, followed by Arizona, Idaho, Oregon, California, Montana, Texas, Florida, Nevada, Utah, and Colorado. Members live in all 50 states, and 24 Members live outside of the United States.

The most recent enrollment figures (as of May 2019) are offered below:

Plan Name	Dependent	Spouse	Subscribers	Total
Uniform Medical Plan Classic – Medicare[1]	84	15,115	38,680	**53,879**

Kaiser WA Classic – Medicare[1] and Kaiser WA Medicare Advantage[2]	40	6,886	17,427	**24,353**
Kaiser NW Senior Advantage[2]	1	703	1,807	**2,511**
Premera Medicare Supplement Plan F	0	4,763	11,295	**16,058**
Total	**125**	**27,467**	**69,209**	**96,801**

1. Original Medicare Coordination of Benefits with Creditable Prescription Drug Coverage
2. Medicare Part C (aka Medicare Advantage) with Creditable Prescription Drug Coverage

Medicare Explicit Subsidy

In 2005, the Washington State Legislature established a prescription drug subsidy to reduce the health care insurance premiums charged to retired or disabled school district and educational service district employees, or retired state employees, who are eligible for parts A and B of Medicare (RCW 41.05.085). Under the same law, the Legislature has authority to establish a *separate* health care subsidy to reduce insurance premiums for individuals who select a Medicare supplement policy offered through HCA. The Legislature did not distinguish between these two subsidies in the 2019-20 budget. Instead, HCA must provide subsidies for health benefit premiums to all Medicare-eligible Retirees. This is what HCA refers to as the "Medicare Explicit Subsidy," which describes both the prescription drug subsidy for Medicare Retirees enrolled in a PEBB Medicare Health Plan that covers prescription drugs, and the health care subsidy for individuals enrolled in a PEBB Medicare Supplement plan (which do not cover prescription drugs).

Per RCW 41.05.085, the Medicare Explicit Subsidy is set by the Legislature and adopted by the PEB Board. The subsidy is always set at a fixed amount, but it may never exceed more than 50% of the cost of the applicable plan(s)' premiums.

ERB Regulatory Environment

ERB operates in a unique regulatory environment. Bidders should be familiar with all statutory requirements pertaining to the PEB Board, including but not limited to the provisions of chapter 41.05 RCW (State Health Care Authority) and chapters 182-08, 182-12, and 182-16 WAC (PEBB Program). Any Health Plan(s) offered as a result of this RFP will not be subject to all provisions of Employee Retirement Income Security Act (ERISA). Instead, they will be subject to Washington State insurance licensing laws under the Office of the Insurance Commissioner (OIC), Centers for Medicare and Medicaid Services (CMS) regulations for Medicare Advantage organizations, the Public Health Services Act (42 U.S.C. Chapter 6A), and Chapter 70.14 RCW, which sets requirements for health care services purchased by state agencies.

Marketing Benefit Participation

Each year, prior to the PEBB Program's Annual Open Enrollment (historically November 1 –30), HCA will publish and distribute a description of the PEBB Program Medicare Retiree Health Plans (and the Subscriber's premium cost for each plan), as well as plan or benefit changes for the following year.

The ASB will be responsible for marketing, advertising, educating, or soliciting participation in their PEBB Program Medicare Retiree Health Plans, with final approval of such efforts and materials from, and at the discretion of, HCA.

If the resulting Contractor(s) has other lines of business beyond the MA-PD Health Plan(s) they provide under the PEBB Program that relate to other benefits offered by the PEB Board or the SEB Board, the resulting Contractor(s) is/are prohibited from using any information obtained as a result of the Contract to solicit PEBB Program or SEBB Program Enrollees or Members to purchase the ASB's other products or services.

Other Contractors and Partners

The resulting Contractor(s) may be required to work with a number of other Contractors providing services to HCA. This work may involve sharing data—such as eligibility, clinical, and/or 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):

A. Tobacco cessation
B. Actuarial and consulting services
C. Health care consulting services
D. Online Member Claim and eligibility portal for providers (aka OneHealthPort)
E. Member experience surveys
F. e-Value8™ and Community Checkup (Washington Health Alliance)
G. All Payer's Claims Database
H. Clinical Data Repository (CDR)
I. Project Management Consulting Services
J. Life Insurance
K. Dental Insurance

This list is provided for illustrative purposes only as the resulting Contractor(s) 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 the resulting Contractor(s) may negotiate in good faith to incorporate such services into the Contract as permitted under Washington State law.

1.5. HCA'S STRATEGIC VISION

Healthier Washington, an initiative launched in January 2013, is Washington State's vision for health transformation: better health, better care, lower health care costs, and improved patient and provider experience (Quadruple Aim). Under the Healthier Washington initiative, Washington State agencies, led by HCA, are working with public and private partners to leverage their regulatory, policy and purchasing powers in three strategic focus areas:

1. Transition state-financed health care purchasing toward greater use of Alternative Payment Models (APMs), and work in tandem with other major purchasers and payers to move commercial market purchasing to include APMs;
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 and population health. Particular efforts include:

1. Emphasizing health care 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 them with appropriate and accessible 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. Assisting Carriers and providers with their transition to APMs.

5. Enabling comprehensive health data collection and reporting through improved analytic tools, interoperable systems, and standardized measurement strategies.
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.

1. Paying for Value – HCA's Purchasing Strategy

Under RCW 74.09.758, 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 value by 2021, as defined by Categories 2c through 4b in Appendix 1 – CMS Framework for Value-Based Payments of Alternative Payment Models (CMS LAN APM).

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 carriers), will support these payment goals. ASB(s) must agree to participate in designated Quality Improvement efforts and initiatives linked to measurement of HCA's APM attainment goals, as required in Exhibit L – Draft Contract. This includes incorporation of APMs into ASB's contracts with providers.

2. Health Transformation Vision: HCA Value-based Roadmap

HCA's Value-based Purchasing (VBP) commitment will support new models of care that drive population health improvements and fundamentally change how health care is provided. HCA produced the HCA Value-based Roadmap in June 2016 to articulate this purchasing vision. The Value-based Roadmap provides a single approach to HCA purchasing that aligns with the Healthier Washington initiative and other agency health transformation projects.

HCA's goal is to use the Value-based Roadmap to achieve the following agency-wide objectives by the end of 2021:

a. HCA programs implement VBP arrangements according to a unified purchasing philosophy;
b. HCA's purchasing business is entrusted to accountable delivery networks and contracting partners; and
c. HCA exercises significant oversight and quality assurance over its contracting partners and implements corrective action as necessary.

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 HCA's Medicaid, PEBB, and SEBB Program health plans and their contracted providers according to performance on cost, quality, and patient experience.
3. Align payment and delivery reform approaches with the Centers for Medicaid and Medicare Services (CMS) for greatest impact and to simplify implementation for providers.
4. Improve quality outcomes and patient experience.
5. Drive standardization in clinical care based on evidence, including best-practice recommendations from the Bree Collaborative, and use standards to design benefits according to value.
6. Increase long-term financial sustainability of state health programs.
7. Continually strive for the Quadruple Aim.
8. 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.

3. Innovative Leadership and Administrative Support

HCA seeks ASB(s) that share its health transformation vision and goals, and that are strongly positioned to move the Washington health care market toward the Quadruple Aim. ASB(s) must be able to operate effectively in two disparate systems—fee-for-service and APMs—while optimizing health care cost, quality and access.

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 HCA—ready to help HCA realize its health transformation vision and purchasing goals while offering creative ideas and strategies.

4. Support of APMs

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 APM Categories 2c through 4b (see Chart in Appendix 1 – CMS Framework for Value-Based Payments of Alternative Payment Models (CMS LAN APM)). HCA seeks ASB(s) that can develop, implement and administer a broad range of APMs, as well as work with other payers.

5. 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 culturally and linguistically appropriate services and materials to all patients.
2. Offering Patient Decision Aids that allow Members to learn about treatment options when engaged in Shared Decision Making on which treatment to seek. 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. 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.
3. Ensuring Member access to their own medical records. When used properly, Medical records allow patients see themselves through the eyes of their caregivers and give them insight into diagnoses and treatment options.
4. Participation in creating and updating advance care plans that are shared with Members and their family.
5. Providing cost and quality transparency tools that empower Members to make cost-effective selections for health care services.
6. Educating members on low value care so that they avoid treatments that are medically unnecessary and potentially harmful.

6. 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 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, patient demographics, 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. HCA will require the ASB(s) to have functional, comprehensive reporting systems that can support and integrate data collection and provide meaningful reports.

1.6. **STATEMENT OF WORK**

ASB(s) will need to provide the coverage, 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.

ASB(s) must have the capability to perform the following:

1. Health Plan, Network, and Service Areas

    1. Offer MA-PD coverage through a National PPO or Regional PPO Health Plan.
    2. At a minimum, ASB(s) must comply with all applicable CMS regulations for network adequacy for Medicare Advantage Organizations for all provider categories and service areas covered under the Contract.
    3. Use a network contracting and credentialing program consistent with National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Commission (URAC) accreditation standards.

2. Participate in Health Transformation

    1. Deploy Member education and engagement tools and strategies, including Patient Decision Aids, to support appropriate self-management and support Shared Decision Making. Promote broad adoption of these tools and strategies through provider agreements, Member communications, and Member resources.
    2. Provide and coordinate customized reporting of fully-insured MA-PD Health Plan offerings to HCA leadership at annual meetings on care transformation activities, VBP updates, and other reporting, as requested by HCA.
    3. Participate in multi-stakeholder Quality Improvement and transparency initiatives.
    4. 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.
    5. Implement strategic initiatives that offer similar or better results than those stated within Appendix 1 – CMS Framework for Value-Based Payments or Alternative Payments Model (CMS LAN APM) and the offering of said initiatives within the ASB's PEBB Program Medicare Retiree Health Plan(s); and/or
    6. Support and implement HCA strategic initiatives and demonstration projects, for example: Healthier Washington initiatives, bundled payments, tiered hospital networks, APM contracts, episode of care reimbursements, Value-based Insurance Design (VBID), and other value-based payment initiatives sanctioned by HCA for Members and across the ASB's Book-of-Business.
    7. Support linkages between communities and clinical care to address Social Determinants of Health and to promote Health Equity.
    8. Endorse community-wide transparency efforts on quality, utilization, pricing, and sharing medical Claims data, including metrics related to price and quality.
    9. 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).
    10. Utilize Claims and payment systems that can support and adapt to innovative strategies and new financial reimbursement models.
    11. Facilitate conversations between HCA and providers if needed.

3. Member Engagement and Experience

    1. Provide a robust, secure, and user-friendly 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:
    i. Cost information that considers Member's Health Plan design relative to copays and cost sharing, coverage exceptions and service limits, pharmacy benefits, accumulated deductibles and out-of-pocket maximums.
    ii. Medical costs searchable by procedure, drug, and episode of care that include both professional and facility fees.
    iii. Cost and outcome comparisons of alternative treatments; outcome comparisons should be linked to Shared Decision Making tools.
    iv. 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, their locations, and whether they are accepting new patients.
c. Important insurance documents such as Explanation of Benefits (EOBs), Certificates of Coverage (COCs), and Summaries of Benefits and Coverage that clearly differentiate between the PEBB Program Medicare Retiree 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. Provide tools to allow Members to navigate the cost of prescription drugs, including:
    i. View and search the MA-PD Health Plan's formulary and identify information about each drug, such as ingredient name, brand/generic name, strength, tier or cost-share, any restrictions (prior authorization, step therapy, quantity level limits, age limits, etc.), any links to relevant clinical policies, and any lower-cost therapeutic alternatives;
    ii. Check drug prices by pharmacy, and locate preferred alternative pharmacy networks; and
    iii. Calculate point-of-sale prescription amounts inclusive of accumulators, deductibles, and benefit information.

2. Communication Tools and Resources:
    a. Provide all materials and communication in keeping with standards for cultural and linguistic appropriateness and ADA requirements.
    b. Offer multiple channels for Member communication, including but not limited to telephone, in-person, and online communication as well as electronic chat, instant messaging, and texting.
    c. 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.
    d. 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.
    e. Offer Members an online expert medical option (EMO) or second opinion option.
    f. Provide Member assistance for managing billing and insurance systems to ensure bills are accurate and appropriate payments are made.
3. Tools and Resources for Self-Management:
    a. Offer Members the ability to monitor and track their own participation in health and wellness activities, including diet and nutrition, exercise and weight loss, mental health, tobacco cessation, financial wellness, and other areas most relevant to Medicare beneficiaries.
    b. Offer tools that give Members the ability to manage their chronic conditions in an evidence-based way that is convenient and customizable to their needs.

4. <u>Data Reporting and Analytics</u>

1. Provide both standard and ad hoc customized reports to HCA on Health Plan quality, cost and utilization performance; Member reported outcomes; provider performance; and

population health measures disaggregated by race/ethnicity, gender, age, zip code, and primary language to identify health disparities.

2. Maintain robust technology and core systems to accept, store, process and validate data from various sources (e.g., Claims, clinical data from EHRs and other HCA vendors).
3. Provide a routine report to HCA that gives a comprehensive overview of the ASB's PEBB Program MA-PD Health Plan cost drivers (including clinical factors) to inform HCA's internal operations and external stakeholders.
4. Coordinate with other HCA vendors regarding Member level Claims data, Member communication, behavioral outreach, and other programs or benefits.
5. Report measures as identified by HCA to address the needs of the population managed by the PEBB Program MA-PD Health Plans. Measures may be selected from the Common Measure Set; Healthcare Effectiveness Data and Information Set (HEDIS) measures for provider groups, including quality, Claims, Member reported outcomes, and hybrid measures; CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey data; and Medicare Access and CHIP Reauthorization Act (MACRA) clinical quality performance measures. Additionally, conduct analyses of sub-populations to identify health disparities so that providers have actionable data to care effectively for all Members. These 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.
6. Provide 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.
7. Submit data to the National Committee for Quality Assurance (NCQA) or URAC through the Interactive Data Submission System (IDSS) or other NCQA-approved methods.
8. Submit a summary of primary care expenditures to HCA using a template approved by HCA's Chief Medical Officer.
9. Submit data on low-value care services (including prescriptions) based upon a list of services selected by HCA's Chief Medical Officer from the Choosing Wisely Initiative.
10. Encourage provider participation in Washington State's CDR and Health Information Exchange.
11. Submit Claims data for the Bidder's PEBB Program MA-PD Health Plan(s) to the All Payer Claims Database (APCD).
12. Use innovative, state-of-the-art risk adjustment approaches in data work.
13. Certify that all information sharing is in full compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable regulations, with information and reporting structured to meet the needs of Members, providers, HCA, the community, and other identified stakeholders.
14. Provide data regarding Appeals and Complaints for a required annual legislative report that meets HCA specifications by July 31 of each year.
15. Submit de-identified claims-level data to ERB's secure claims database on a monthly basis. HCA will notify the ASB(s) when this requirement will take effect.

5. Plan Administration

1. Offer and maintain a fully operational customer services center with customer service staff that are knowledgeable, responsive, and deliver high quality and timely service to all Members.
2. 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 L – Draft Contract.
3. Offer and maintain a communications team (including writers, web team, and graphic designers) that will work directly with HCA communications staff. The ASB(s) will provide communications to Members and potential Members to enable them to make informed decisions in selecting a PEBB Program Medicare Retiree Health Plan, appropriately utilize available benefits, and actively engage in managing their health.
4. Provide a fully operational Claims payment service on January 1, 2021 that includes the ability to pay Claims electronically.

5. Perform other Claims-related functions necessary to provide a complete administration of Claims services, including:
    a. Accurate and timely payment to the ASB's contracted network of hospitals, professional providers, and other non-hospital providers;
    b. Processing and payment of out-of-network Claims, when applicable; and
    c. Payment of all emergency care, regardless of network restrictions.
6. Process Appeals and Complaints per CMS standards.
7. Process new certifications and re-certifications for a Dependent child with a disability on time so the Dependent does not lose coverage.
8. Generate a unique, permanently assigned, HIPAA compliant, non-social security number (SSN) based ID number for each Subscriber.
9. Complete a quarterly full eligibility file match with HCA (and HCA's business partners, if applicable) and reconciliation of any differences and reporting of any reconciled differences and any other discrepancies to HCA.
10. Accept and process PEBB Medicare Retiree Health Plan eligibility files daily in the format outlined in the PEBB Health Plan Eligibility File Format. ASB must agree to accept all changes in systems and files as directed by HCA.
11. Accept premium payments from HCA.
12. Provide medical policies and procedures to HCA so they may be publicly available online on the HCA website by no later than January 1, 2021; including, but not limited to, RCW 41.05.074 related to release of coverage criteria.
13. Participate in an annual Request for Renewal (RFR) process. The annual RFR process will enable the PEB Board to adjust Retiree benefits on an annual basis in response to (a) new requirements under the ACA, federal and state regulations, and/or by CMS; (b) changes requested by the PEB Board, HCA's Chief Medical Officer, or other internal policy drivers; (c) benefit design strategies promulgated by HCA; and/or (d) Washington State legislative mandates, changes to the WAC promulgated by HCA, 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.

6. Clinical Services

1. Comply with all of the CMS regulations for Utilization Management (UM).
2. Perform UM according to CMS regulations and NCQA standards.
3. Perform Complex Case Management, Chronic Condition Management, and Quality Management.

7. Pharmacy

1. Maintain a Pharmacy and Therapeutics (P&T) committee that includes physicians and pharmacists to manage the Plan's formulary, authorize or restrict new drugs for clinical use, evaluate how covered drugs are used, monitor and report adverse drug events, and approve guidelines for medication management.
2. Perform UM, Medication Therapy Management for complex and chronic conditions, and Quality Management.
3. Allow HCA access to the Bidder's prescription drug formulary, clinical policies, and clinical criteria on an as-needed basis.
4. Provide tools to allow Members to navigate the cost of prescription drugs including:

a. View and search the MA-PD Health Plan's formulary and identify information about each drug, such as ingredient name, brand/generic name, strength, tier or cost-share, any restrictions (prior authorization, step therapy, quantity level limits, age limits, etc.), any links to relevant clinical policies, and any lower-cost therapeutic alternatives;
b. Check drug prices by pharmacy, and locate preferred alternative pharmacy networks; and
c. Calculate point-of-sale prescription amounts inclusive of accumulators, deductibles, and benefit information.

8. Account Management

1. Provide and maintain 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 L – Draft Contract.
2. Attend (account management and executive level staff, including a CMO) regular and as-needed meetings with HCA. Regular meetings will include, but are not limited to:
   a. Annual account management meetings with HCA staff to be held at the HCA headquarters in Olympia, Washington.
   b. PEB Board meetings, either in person or by phone. Typically these are held monthly from January through July each year.
3. Provide support and resources for the PEBB Annual Open Enrollment as needed, including events held throughout Washington State. Support may include but is not limited to: trained staff to attend benefit fairs, communications to explain PEBB Program Medicare Retiree Health Plan offerings, and webinar and video support as requested. The representatives and materials must be able to cover topics such as benefits and cost-sharing, network providers, Claim procedures, Member services, and information tools and resources.

9. Eligibility and Systems

1. The working assumption is HCA will send the first full eligibility file (except for test files) after the PEBB Program Annual Open Enrollment ends in the fall of 2020. Any subsequent changes to the file will be sent over on a daily basis to the Contractor(s).
2. Maintain accurate information, and sharing of such information, with other Contractors working with HCA (i.e., HCA's actuary, etc.). This process may involve transmission of a daily and weekly eligibility files within HCA required timelines.
3. Integrate 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. Contractor(s) may be required to enter into data share agreements with other HCA contractors for data transfers.
4. Complete quarterly reconciliation file audits with other vendors (if data is passed between the Contractor(s) and other vendors) and HCA.
5. 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 Contractor(s) to generate them (in this scenario, Contractor(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.

10. Implementation

1. Provide an implementation plan for the time period from January 1, 2020 through December 31, 2020. 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 and final decisions on plan offerings will not be approved by the PEB Board until the summer of 2020. Action is required in 2020 by at least the PEB Board in order for MA-PD benefits to be offered in the PEB Program. 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, 2021. Implementation will conclude by September 1, 2020.
2. Provide a plan for facilitating transitions for new Members that have complex health care needs, have a current and active treatment plan (e.g., cancer treatment), or are

hospitalized between January 1 and March 31, 2021. As part of the transition plan, the ASB(s) must agree to honor previously approved prior authorization requests provided that: 1) the request was made by a provider within the ASB's network; and 2) the request is for covered services under the ASB's Health Plan.

3. Complete a readiness assessment of ASB's operations conducted by HCA. The timeframe to be agreed upon between HCA and ASB(s).

1.7. MINIMUM QUALIFICATIONS

The following are the minimum qualifications for Bidders:

A. Licensed to do business in the State of Washington or provide a commitment that it will become licensed in Washington within thirty (30) Calendar Days of being selected as the ASB.

B. Must comply with all state and federal privacy and security laws, statues, and regulations for protecting Member data, including HIPAA.

C. 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 report with this rating.

D. Bidders proposing National PPO coverage must have the ability to offer coverage throughout the United States.

E. Bidders proposing Regional PPO coverage must have the ability to offer coverage within all Washington state counties.

F. Bidders must have a minimum of three (3) years' experience administering Medicare Advantage plus Prescription Drug insurance.

1.8. FUNDING

Cost of services provided under any Contract that results from this RFP will be made based on the agreed upon amounts and legislative budget approval. Therefore, a maximum level of available funding is not being identified at this time. Any Contract awarded as a result of this RFP is contingent upon the availability of funding, which will be approved under the final state budget in 2020.

1.9. PERIOD OF PERFORMANCE

The period of performance of any Contract resulting from this RFP is tentatively scheduled to begin on or about January 1, 2021 with an initial term to end on December 31, 2025. Amendments extending the period of performance, if any, will be at the sole discretion of HCA.

HCA reserves the right to extend any such Contract for up to five (5) 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, but with mutual agreement with the Contractor.

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. 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:

RFP Coordinator	Laura Shayder
E-Mail Address	contracts@hca.wa.gov
Mailing Address	PO Box 42702 Olympia, WA 98501
Physical Address for Delivery	626 8th Ave SE Olympia, WA 98501

Any other communication will be considered unofficial and non-binding on HCA. Bidders are to rely 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. **LETTER OF INTENT TO PROPOSE (MANDATORY)**

Bidders must submit a Letter of Intent (LOI), and a signed Non-Disclosure Agreement (NDA) found in Exhibit C, to be eligible to submit a Proposal in response to this RFP. A signed NDA is required in order to receive data that Bidders may use to determine their cost proposals.

Bidders who do not submit an LOI and NDA will be disqualified from further consideration. The sooner the Bidder returns the NDA the sooner they may access the data files.

The LOI and NDA must be emailed to the RFP Coordinator, listed in Section 2.1, and must be received by the RFP Coordinator no later than the date and time stated in the Procurement Schedule, Section 1.2. The subject line of the email must include the following: [Procurement #] – Letter of Intent to Propose – [Your entity's name].

The LOI may be attached to the email as a separate document, in Word or PDF, or the information may be contained in the body of the email.

Information in the LOI should be placed in the following order:

A. Bidder's Organization Name;

B. Bidder's authorized representative for this RFP (who must be named the authorized representative identified in the Bidder's Proposal);

C. Title of authorized representative;

D. Address, telephone number, and email address;

E. Statement of intent to propose, including a statement of what plan type (National PPO, Regional PPO, or both) that the Bidder will be submitting a proposal; and

F. A description of how the Bidder meets ALL of the minimum requirements specified in Section 1.7 of this RFP.

HCA may use the LOIs as a pre-screening to determine whether Minimum Qualifications are met.

2.3. **BIDDER QUESTIONS PERIODS**

Bidders are provided one (1) scheduled opportunity to ask questions as set forth in Section 1.2, *Procurement Schedule*. Bidders are not required to participate in the Question and Answers, however if they elect to, the due date by which Bidders must submit their questions is listed in Section 1.2, *Procurement Schedule.*

Bidders may submit written questions 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 3872 Question(s) – [Bidder name]" to ensure timely review of the submitted question(s).

HCA is only obligated to answer questions received in writing by the dates/times stated in Section1.2, *Procurement Schedule*. HCA will post answers to the questions in WEBS as an RFP amendment.

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

2.4. **POSTING ON WEBS**

HCA will use the Washington Electronic Business Solution (WEBS) as the one official means to communicate with Bidders regarding activities related to this RFP. As required by RCW 39.26.150, HCA will post this RFP and all amendments to the WEBS website located at https://pr-webs-customer-des.wa.gov/. To ensure receipt of all RFP documents, the RFP and all attachments and amendments thereto must be downloaded from WEBS. 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 otherwise inadequate. Bidders accept full responsibility and liability for failing to receive any amendment 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 of such failure.

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.

2.5. **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 ASB(s) is/are announced; thereafter, the proposals will be deemed public records as defined in chapter 42.56 of the Revised Code of Washington (RCW).

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 by the words "Proprietary Information" printed on the lower right hand corner of 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 Information," 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 24 hours' notice to the RFP Coordinator is required. All requests for information should 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 1.2, unless HCA, in its sole discretion, determines that altering the schedule would be in HCA's best interests.

2.6. **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 page 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.

2.7. **DIVERSE BUSINESS INCLUSION PLAN**

Bidders will be required to submit a Diverse Business Inclusion Plan with their proposal. In accordance with legislative findings and policies set forth in chapter 39.19 RCW, 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.

2.8. **ACCEPTANCE PERIOD**

Proposals must provide one hundred eighty (180) Calendar Days for acceptance by HCA from the due date for receipt of proposals.

2.9. **COMPLAINT PROCESS**

A. Vendors may submit a complaint to HCA for any of the following reasons:

1. The RFP unnecessarily restricts competition;

2. The RFP evaluation or scoring process is unfair or unclear; or

3. The RFP requirements are inadequate or insufficient to prepare a response.

B. A complaint must be submitted to HCA prior to five business days before the bid response deadline. The complaint must:

1. Be in writing;

2. Be sent to the RFP Coordinator in a timely manner;

3. Clearly articulate the basis for the complaint; and

4. 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. A Bidder or potential Bidder cannot raise during a bid protest any issue that the Bidder or potential Bidder raised in a complaint. HCA's action or inaction in response to a complaint will be final. There will be no appeal process.

2.10. 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 at its sole discretion to waive minor administrative irregularities.

2.11. MOST FAVORABLE TERMS & BAFO

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.

Following the evaluation of the Written Evaluation, Cost Evaluation, Executive Order 18-03, and Oral Presentations (if any), HCA reserves the right to invite one (1) or more Bidders to participate in a "Best and Final Offer" (BAFO) process to determine the Proposal providing the best value to HCA. The BAFO process may include the contract terms and conditions, pricing, or any other appropriate subject in Bidder's final Proposal, as solely determined by HCA. Bidders will be responsible for their own costs and expenses related to the BAFO process. There is no guarantee that HCA will decide to use the BAFO process.

The objective of the BAFO is to allow selected Bidders to refine and document changes in their Proposals for submission to HCA for final review and evaluation. However, this process may not be used to turn a non-responsive Proposal into a responsive one. Each Bidder will be provided a document identifying areas, topics, or issues HCA would like to see refined by the Bidder (each a BAFO Request). HCA reserves the right for each BAFO Request to be different for each Bidder invited to participate as each Proposal will be unique, with its own strengths and weaknesses. The BAFO request will include additional details and instructions on the form, format, and timing for the Bidder to provide a response (BAFO Response).

At the conclusion of the BAFO process, HCA will evaluate the BAFO Responses and select an ASB. This evaluation approach described is intended to identify the Proposal that offers the greatest benefit to HCA based on consideration of the total best value, which may not necessarily be the Proposal with the highest score during the Written evaluation, Oral Presentation or Executive Order 18-03, or the lowest cost.

This RFP, the Bidder's proposal, materials provided during the BAFO process (if any), and oral presentations (if any), will be incorporated into the resulting Contract. The Proposal will become a part of the official procurement file on this matter without obligation to HCA.

2.12. 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 December 2019. Any Contract resulting from this RFP may be amended depending on whether the PEB Board approves the Health Plans, including rates and plan designs. 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 Retirees and Dependents are currently enrolled in.

The initial term of any such Contract will expire December 31, 2025. Thereafter Contract(s) may be extended for increments of one (1) year or more for no more than five (5) additional years. Extension of the Contract beyond the initial term is not guaranteed by HCA.

HCA's monthly premium payments to the Contractor(s) will begin following January 1, 2021, and the monthly premiums may be updated annually through the Request for Renewal (RFR) process. HCA is not obligated to make any other payment to Contractor(s) prior to January 1, 2021.

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

2.13. 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 L, 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 their proposals that shows the changes they propose be made if 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 31, 2019, 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) which may be included as part of this Contract.

2.14. CONTRACT DELAY CONTINGENCY

In the event the Benefits Start Date under a Contract is delayed 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 contractual relationship and to amend the Contract as necessary to address the delay.

2.15. 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 HCA staff, consultants, and other Contractors to build the infrastructure necessary to support the MA-PD Health 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 December 2019), and must be completed by September 30, 2020. 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 Health Plan(s) the ASB is contracted to provide. Specific services described in the Contract will begin on January 1, 2021, 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 implementation timeframe at any time.

2.16. COSTS TO PROPOSE

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

2.17. 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. HCA is under no obligation to tell the Bidder if it is the only Bidder.

2.18. NO OBLIGATION TO CONTRACT

This RFP does not obligate HCA to enter into any Contract for services specified herein.

2.19. REJECTION OF PROPOSALS

HCA reserves the right, at its sole discretion, to reject any and all proposals received without penalty and not to issue any Contract as a result of this RFP.

2.20. 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.

2.21. 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.

2.22. INSURANCE COVERAGE (ADD OTHER INSURANCE AS REQUIRED)

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 which 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 fifteen (15) days of the Contract effective date.

A. Liability Insurance

1. 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.

2. 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.

B. 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.

C. 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 chapter 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 Apparent 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:

1. 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;

2. Notification and call center services for individuals affected by a security incident, or privacy Breach;

3. 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

4. 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).

D. Additional Provisions

Above insurance policy must include the following provisions:

1. Additional Insured. The state of Washington, HCA, its elected and appointed officials, agents and employees must be named as an additional insured on all general liability, excess, umbrella and property insurance policies. All insurance provided in compliance with this Contract must be primary as to any other insurance or self-insurance programs afforded to or maintained by the state.

2. Cancellation. State of Washington, HCA, must be provided written notice before cancellation or non-renewal of any insurance referred to therein, in accord with the following specifications. Insurers subject to chapter 48.18 RCW (Admitted and Regulation by the Insurance Commissioner): The insurer must give the state 45 days advance notice of cancellation or non-renewal. If cancellation is due to non-payment of premium, the state must be given ten days advance notice of cancellation. Insurers subject to chapter 48.15 RCW (Surplus lines): The state must be given 20 days advance notice of cancellation. If cancellation is due to non-payment of premium, the state must be given ten days advance notice of cancellation.

3. Identification. Policy must reference the state's contract number and the Health Care Authority.

4. Insurance Carrier Rating. All insurance and bonds should be issued by companies admitted to do business within the state of Washington and have a rating of A-, Class

VII or better in the most recently published edition of Best's Reports. Any exception must be reviewed and approved by 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.

5. 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.

E. Workers' Compensation Coverage also known as Industrial Insurance

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

3.1. PROPOSAL CONTENTS OVERVIEW

National PPO plan proposals will be scored against other National PPO plan proposals only. Regional PPO plan proposals will be scored against other Regional PPO plan proposals only. For Bidders submitting both a National and a Regional PPO plan proposal, the Bidder **must** submit unique responses for a National and a Regional PPO plan type for the below listed exhibits. All other exhibits only need to be submitted once.

1. Exhibit K - Cost & Plan Design; and

2. Exhibit I - Provider Network

In order to have its Proposal evaluated by HCA, Bidder must provide the items listed below following the specific instructions outlined in the Sections noted below:

1. Letter of Submittal (See Section 3.4)

2. Evaluation Elements (See Section 3.5)

3. Additional Proposal Documents (See Section 3.7)

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:

1. Use standard 8.5" x 11" white paper, with no smaller than 11 point font. All page margins can be no less than one (1) inch. Font color responses should be black or blue.

2. Proposals must provide information in the same order as presented in this RFP 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. Items marked "Mandatory Not Scored" must be included as part of the Proposal for the Proposal to be considered responsive; however, these items are not scored. Items marked "Mandatory Scored" must be included as part of the Proposal for the Proposal to be considered responsive and are awarded points by the evaluation team. Items marked "Elective Not Scored" are not mandatory and not scored. HCA expects Bidders to respond to all Elective Not Scored elements of the RFP for which they are capable.

4. 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.

5. 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.

6. 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.

7. HCA is under no obligation to consider any supplemental materials submitted that have not been requested.

3.3. **SUBMISSION OF PROPOSALS**

Bidders are required to submit their Proposal both as an electronic copy via email, and a physical copy. Proposals must be organized as outlined in Section 3, Proposal Contents. Each response to a particular section or exhibit must be clearly organized and labeled.

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, RFP Coordinator. 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 Certificates of 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 allowance will be made.

2. Hard copy delivery (mail) – Bidders are required to provide five (5) 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. Bidder assumes the risk for the method of delivery chosen. HCA assumes no responsibility for delays caused by any delivery service.

3. Proposals may not be transmitted using facsimile transmission.

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.

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. **LETTER OF SUBMITTAL (MANDATORY)**

The Letter of Submittal 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 Exhibit A - Certifications and Assurances form 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 of 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:

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

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

   2. Name, address, and telephone number of each principal officer (President, Vice President, Treasurer, Chairperson of the Board of Directors, etc.).

   3. Legal status of the Bidder (sole proprietorship, partnership, corporation, etc.) and the year the entity was organized to do business as the entity now substantially exists.

4. Federal Employer Tax Identification number or Social Security number and the Washington Uniform Business Identification (UBI) number issued by the state of Washington Department of Revenue. If the Bidder does not have a UBI number, the Bidder must state that it will become licensed in Washington within thirty (30) calendar days of being selected as the Apparent Successful Bidder.

5. (Bidder only) Location of the facility from which the Bidder would operate.

6. (Bidder only) The type of MA-PD Health Plan coverage for which the Bidder is submitting their Proposal – National PPO, Regional PPO, or both.

7. (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.

8. (Bidder only) Identify any Washington State employees or former Washington State employees 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.

9. Any information in the proposal that the Bidder desires to claim as proprietary and exempt from disclosure under the provisions of chapter 42.56 RCW must be clearly designated, as described above in Section 2.5. The page must be identified and the particular exemption from disclosure upon which the Bidder is making the claim must be listed. Each page claimed to be exempt from disclosure must be clearly identified by the word "Proprietary" printed on the lower right hand corner of the page. In your Letter of Submittal, please list which pages and sections that have been marked "Proprietary" and the particular exemption from disclosure upon which the Bidder is making the claim.

B. 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 the Bidder uses Subcontracts 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.

C. A statement and explanation of how Bidder meets ALL of the minimum qualifications specified in Section 1.7, Minimum Qualifications 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.

D. A copy of the Certificate of Assurances form (Exhibit A) signed by a person authorized to bind the Bidder to a Contract.

E. A completed Diverse Business Inclusion Plan (Exhibit B). This is a requirement as described in Section 2.7.

F. Five (5) references for each Health Plan coverage type the Bidder is submitting a Proposal for—National PPO Plan and/or Regional PPO Plan—as listed in Exhibit E, Section 1, Health Plan Experience, Table 1. Please provide references using Exhibit D, Reference Form. Bidders submitting a Proposal for a National PPO Plan and a Proposal for a Regional PPO Plan must submit separate references that are relevant for each plan type.

G. A redlined copy of the Draft Contract (Exhibit L) identifying issues or proposed alternative text that reflects the actual content of the Bidder's Proposal (see Section 2.13).

3.5. **EVALUATION ELEMENTS (Mandatory and Scored)**

In this section, 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.

For Bidders submitting both a National and a Regional PPO plan proposal, the Bidder must submit unique responses for the following exhibits as described in Section 3.1:

- National PPO – submit one (1) each of the following
  - Exhibit I – Provider Network & Access
  - Exhibit K – Cost & Plan Design
- Regional PPO – submit one (1) each of the following
  - Exhibit I – Provider Network & Access
  - Exhibit K – Cost & Plan Design

Bidders must submit the scored portion of their Proposal in the following eight (8) separate exhibits. Each exhibit must be a separate electronic file.

1. Exhibit E – Operations
2. Exhibit F – Innovation & Health Transformation
3. Exhibit G – Pharmacy Management
4. Exhibit H – Clinical Management
5. Exhibit I - Provider Network & Access
6. Exhibit J – Technical Data Requirements
7. Exhibit K – Cost & Plan Design
8. Exhibit M – Executive Order 18-03

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, *Submission of Proposals*.

3.6. **ADDITIONAL PROPOSAL DOCUMENTS (Mandatory and Not Scored)**

1. Exhibit A – Certificates and Assurances

2. Exhibit B – Diverse Business Inclusion Plan

3. Exhibit C – Non-Disclosure Agreement

4. Exhibit D – Reference Form

5. Exhibit L – Draft Contract

6. Bidder is to provide one (1) sample Certificate of Coverage (COC) associated with the proposed Enhanced Alternative Medical and Enhanced Alternative Pharmacy plans with the highest level of covered benefits, as included in their submitted Exhibit K – Cost & Plan Design.

7. Bidder is to provide a supporting actuarial memorandum documenting data, methodology, and assumptions underlying all proposed bid rate assumptions in their submitted Exhibit K – Cost & Plan Design.

4. EVALUATION AND CONTRACT AWARD

4.1. **EVALUATION PROCEDURE**

Responsive Proposals will be evaluated strictly in accordance with the requirements stated in this RFP and any addenda issued. The evaluation of Proposals will be accomplished by an evaluation team(s), to be designated by HCA, which will determine the scoring of the Proposals. Evaluations will only be based upon information provided in the Bidder's Proposal.

All proposals received by the stated deadline, Section 1.2, will be reviewed by the RFP Coordinator to ensure that the Proposals contain all of the required information requested in the RFP. Only responsive Proposals that meet the requirements will be evaluated by the evaluation team. Any Bidder who does not meet the stated qualifications or any Proposal that does not contain all of the required information may be rejected as non-responsive.

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.

Responsive Proposals will be reviewed and scored by an evaluation team using a weighted scoring system, Section 4.2, *Evaluation Weighting and Scoring*.

HCA, at its sole discretion, may elect to select the top-scoring firms as finalists for an oral presentation. Any oral presentations that may be conducted for the purposes of this RFP will be evaluated as described in Section 4.2, *Evaluation Weighting and Scoring.*

4.2. EVALUATION WEIGHTING AND SCORING

A. Part 1 - Scoring of Written Evaluation

Bidders must pass Part 1, Written Evaluation, to advance to Part 2, Cost Evaluation.

For a Bidder to advance to the Cost Evaluation, they must meet the following:

- Bidder's total weighted score for the Written Elements, as outlined below in the *Evaluation Table – Written Elements*, is no less than 65% (663 points) of the total Written Evaluation maximum points; and
- Bidder's average score for each of the Key Sections, as listed below in Section B, must be no less than a score of five (5), as defined in the Scoring Methodology in Section C, below.

Each Exhibit under the Written Elements is divided into sections, and each section has been assigned a maximum weight value. Points will be assigned to each Exhibit section by the evaluators based upon the scoring matrix in Section C, below, and then multiplied by the section's weight.

The RFP Coordinator will compute the Bidder's final written score by totaling the section scores from all evaluators and then averaging.

If a Bidder's written score does not pass Part 1 and does not move onto Part 2, as described above, the RFP Procurement Coordinator will notify the Bidder in writing.

The weights and resulting maximum points per section are as follows:

Evaluation Table – Written Evaluation			
Exhibit/ Section No.	**Title**	**Weight**	**Maximum Points**
Exhibit E	**Operations**		**350**
1	Health Plan Experience	3.2	32
2	Claims Services	3.5	35
3	Customer Services	5.9	59
4	Communications	5.6	56
5	Online Services	5.3	53
6	Appeals and Complaints	2.5	25
7	Account Management	3.1	31

8	Emergency Response Management	2.8	28
9	Implementation Plan	1.0	10
10	Annual Renewal Process	2.1	21
Exhibit F	**Innovation & Health Transformation**		**60**
1	Innovative Leadership and Administrative Support	1.2	12
2	Support of APMs in Medicare Advantage and Part D	2.1	21
3	Clinical Transformation Activities	1.8	18
4	Multi-stakeholder Quality Improvement and Transparency Initiatives	0.9	9
Exhibit G	**Pharmacy Management**		**150**
1	Pharmacy Benefit Management	3.8	38
2	Benefit Design and Experience	3.8	38
3	Formulary	2.2	22
4	Pharmacy Utilization Management	1.5	15
5	MTM Programs	0.7	7
6	Customer Service	3.0	30
Exhibit H	**Clinical Management**		**150**
1	Clinical Objectives	1.3	13
2	Clinical Management	2.2	22
3	Quality Measurement and Reporting	1.8	18
4	Utilization Management (UM)	1.5	15
5	Quality Management (QM)	1.5	15
6	Complex Case Management	2.3	23
7	Chronic Condition Management	2.3	23
8	Other Clinical Management Services	0.9	9
9	Benefit Design and Experience	1.2	12
Exhibit I	**Provider Network & Access**		**210**
1	Provider Network Management & Access	14.0	140
2	Pharmacy Network Management & Access	7.0	70
Exhibit J	**Technical Data Requirements**		**100**
1	Data, Reporting & Analytics	3.0	30
2	Data File Transfer & Access	3.0	30
3	Online Security	2.0	20
4	Eligibility System Requirements	2.0	20
Written Maximum Points			**1020**

B. Key Sections

For a Bidder to advance to Part 2, the Bidder's average score for each of the following Key Sections must be no less than a score of five (5), as defined in the Scoring Methodology in Section C, below.

Key Sections	
Exhibit E	**Operations**
2	Claims Services
3	Customer Services
4	Communications
5	Online Services
Exhibit G	**Pharmacy Management**
1	Pharmacy Benefit Management
Exhibit H	**Clinical Management**
6	Complex Case Management
7	Chronic Condition Management
Exhibit I	**Provider Network & Access**
1	Provider Network Management & Access
2	Pharmacy Network Management & Access
Exhibit J	**Technical Data Requirements**
2	Data File Transfer and Access
3	Online Security
4	Eligibility System Requirements

C. Scoring Methodology for Written Elements

Evaluators will assign a score from 0-10 to each section of the exhibit based on the scoring matrix below.

Scoring Methodology		
Score	**Description**	**Scoring Criteria**
10	Far Exceeds Requirements	The Bidder has provided an innovative, detailed, and thorough response to the requirement, and clearly demonstrates a high level of experience with, or understanding of the requirement.
7	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	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	Below Requirements	The Bidder has established some capability to perform the requirement but descriptions regarding their approach are not sufficient to demonstrate the Bidder will be fully able to meet the requirements.
1	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 does not address any component of the requirement or no information was provided.

D. Part 2 - Scoring of Cost Elements

Bidders who have passed Part 1, Written Evaluation will have their Cost Elements listed in Exhibit K – Cost & Plan Design evaluated and scored by the HCA Procurement Coordinator according to the methodology described below. PMPM rates provided by Bidders are to be not-to-exceed (NTE) rates. The resulting ASB(s) will be required to honor their Proposal's NTE rates during contract negotiations.

Each of the Bidder's Cost Element subsections, listed in the Evaluation Table – Cost Elements, will be individually computed as described in this section below. Scores for each of the Cost Elements will be summed to provide the Bidder's total Cost Score.

While the Baseline FFS Medical, Baseline Pharmacy, and Minimum Supplemental Benefits will be scored for the purposes of evaluating the Bidder's cost proposal under this RFP, it should not be assumed that they will be selected by HCA for inclusion in the benefits portfolio. Following the ASB announcement, bid rates and proposed plan design features are subject to negotiation and PEB Board approval.

All fee components must be rounded to the whole penny/decimal points.

Evaluation Table – Cost Elements		
Exhibit/Section No.	*Title*	*Maximum Points*
Exhibit K – WS 2	Baseline FFS Medical Premium Per Member Per Month (PMPM)	530
Exhibit K – WS 2	Minimum Supplemental Benefits Premium PMPM	120
Exhibit K – WS 4	Baseline Pharmacy Premium PMPM	530
Exhibit K – WS 1	Baseline FFS Medical PMPM Bonus	50
Maximum Cost Elements Points (without Bonus)		**1180**
Maximum Cost Elements Points (with Bonus)		**1230**

A summary and example of each formula is also provided below.

Baseline FFS Medical Premium PMPM scoring

The lowest cost Bidder on Baseline FFS Medical Premium PMPM will receive the maximum of 530 points. For every 1% higher in cost from the lowest cost Bidder, each Bidder will lose 10% (53 points) of the total maximum points. The total amount of points lost may result in a Bidder receiving a score of 0, but will not result in a score of less than 0.

See below example (PMPM amounts are for illustrative purposes only):

Bidder	Bidder's Baseline FFS Medical Premium PMPM	Percent greater from lowest cost Bidder	% and points lost	Points awarded
Bidder 1	$100	N/A	0	530
Bidder 2	$101	1%	-10% or -53 points	477
Bidder 3	$105	5%	-50% or -265 points	265
Bidder 4	$111	11%	-100% or -530 points	0
Bidder 5	$115	15%	-100% or -530 points	0

Minimum Supplemental Benefits Premium PMPM scoring

The lowest cost Bidder for Minimum Supplemental Benefits Premium PMPM will receive the maximum of 120 points. For every 1% higher in cost from the lowest cost Bidder, each Bidder will lose 10% (12 points) of the total maximum points. The total amount of points lost may result in a Bidder receiving a score of 0, but will not result in a score of less than 0.

For example (PMPM amounts are for illustrative purposes only):

Bidder	Bidder's Minimum Supplemental Benefits Premium PMPM	Percent greater from lowest cost Bidder	% and points lost	Points awarded
Bidder 1	$100	N/A	0	120
Bidder 2	$101	1%	-10% or -12 points	108
Bidder 3	$105	5%	-50% or -60 points	60
Bidder 4	$111	11%	-110% or -120 points	0
Bidder 5	$115	15%	-150% or -120 points	0

Baseline Pharmacy Premium PMPM scoring

The lowest cost Bidder for Baseline Pharmacy Premium PMPM will receive the maximum of 530 points. For every 1% higher in cost from the lowest cost Bidder, each Bidder would lose 10% (53 points) of the total maximum points. The total amount of points lost may result in a Bidder receiving a score of 0, but will not result in a score of less than 0.

For example (PMPM amounts are for illustrative purposes only):

Bidder	Bidder's Baseline Pharmacy Premium PMPM	Percent greater from lowest cost Bidder	% and points lost	Points awarded
Bidder 1	$100	N/A	0	530
Bidder 2	$101	1%	-10% or -53 points	477
Bidder 3	$105	5%	-50% or -265 points	265
Bidder 4	$111	11%	-110% or 530 points	0
Bidder 5	$115	15%	-150% or 530 points	0

Baseline FFS Medical Premium PMPM Bonus points Scoring

Bidders will receive 25 bonus points if they include an Annual Physical Exam in their Baseline FFS Medical Premium PMPM and another 25 points if they include a Health Education program in their Baseline FFS Medical Premium PMPM. Bonus points will be added to the Bidder's total cost score.

E. Part 3 – Executive Order (EO) 18-03 – Supporting Worker's Rights to Effectively Address Workplace Violations

Pursuant to RCW 39.26.160(3) and consistent with Executive Order 18-03 – Supporting Workers' Rights to Effectively Address Workplace Violations (dated June 12, 2018), HCA will evaluate bids for best value and provide a bid preference in the amount of 50 points to any Bidder who certifies, pursuant to the certification attached as Exhibit M, that their firm does NOT require its employees, as a condition of employment, to sign or agree to mandatory individual arbitration clauses or class or collective action waiver. Bidders that do require their employees, as a condition of employment, to sign or agree to mandatory individual arbitration clauses or class or collective action waiver will not be disqualified evaluation of this RFP, however they will receive 0 points for this section.

F. Total Score

Scores for Part 1, Written Elements, Part 2, Cost Elements, and Part 3, EO 18-03 will be summed to determine the Bidder's total score for the Proposal. If HCA elects to move forward with the BAFO and/or the Oral Presentations as described in Sections 2.1 and 4.3, HCA may elect one (1) or more of the top scoring Bidders to participate in the BAFO and/or Oral Presentations. One (1) or more of the highest scoring Bidders for the National PPO Plan may be named ASB and invited to begin Contract negotiations. One (1) or more of the highest scoring Bidders for the Regional PPO Plan may be named ASB and invited to begin Contract negotiations.

Evaluations Elements – Combined Total	
Written Elements	1020
Cost Elements (without Bonus)	1180
Cost Elements (with Bonus)	1230
Executive Order 18-03	50
Maximum Points Possible (without Bonus)	2250
Maximum Points Possible (with Bonus)	2300

HCA reserves the right to award the Contract to the Bidder whose Proposal is deemed to be in the best interest of HCA and the state of Washington.

4.3. ORAL PRESENTATIONS MAY BE REQUIRED

After evaluating Part 1-Written Elements, Part 2-Cost Elements, and Part 3-EO 18-03 HCA may elect to schedule Oral Presentations to be made by one (1) or more finalists to make one (1) or more Oral Presentations to HCA representatives to provide additional details on specific services or capabilities of the Bidder. HCA may provide questions to selected Bidders in advance of the Oral Presentation(s) and, when specified by HCA, the Bidder must provide the RFP Coordinator written responses to the questions no later than one (1) Business Day before the scheduled Oral Presentation. HCA may also determine the types and numbers of personnel from the Bidder that will be allowed to participate in the Oral Presentations.

The Bidder's scores from the Written, Cost Elements, and Executive Order 18-03 will carry forward to the scoring of the Oral Presentations.

Bidders invited to make an Oral Presentation must provide one (1) digital and five (5) hard copies of all materials the Bidder wishes to distribute at its Oral Presentation. Digital materials should be shared consistent with instructions in Section 3.3 Submission of Proposals. Commitments made by the Bidder during the Oral Presentations will be considered binging and all such materials will be included as part of the Bidder's proposal, and will be an exhibit, attachment, or schedule to a resulting Contract. HCA reserves the right to record both audio and video of the Oral Presentations and include such recordings as an exhibit, attachment, or schedule to a resulting contract. The RFP Coordinator will notify Bidders of any additional arrangements regarding oral presentations.

The Oral Presentations will be held at HCA's headquarters in Olympia, Washington.

The Health Care Authority
626 8th Avenue SE
Olympia, WA 98501

For Bidder(s) who advance to Oral Presentations, Bidders will be requested to provide five (5) references for each Health Plan coverage type (National PPO or Regional PPO) in its Letter of Transmittal. For a Bidder that submits a Proposal for a National PPO Plan and a Proposal for a Regional PPO Plan, references will be evaluated independently for each plan type. HCA will send each Bidder reference a questionnaire in which the references will score the Bidder (on a scale of 0-5, 5 as the highest and 0 as the lowest) and return the questionnaire to the RFP Coordinator. The first three (3) reference responses received by HCA that follow the instructions will be used to calculate the Bidder's reference score. The fourth and fifth references received will not be used for scoring purposes. Any reference that does not follow the instructions may receive a score of 0. The RFP

Coordinator will then calculate the average reference score for each Bidder. This average will then be multiplied by the weight assigned to the references.

HCA may not be used as a reference for any Bidders.

Topics to be addressed in the Oral Presentations will be based upon the Written and Cost Evaluations and other issues determined by HCA in its sole discretion. The Bidder(s) who advance to this phase will be provided more information by the RFP Coordinator. The Bidder(s)' Oral Presenters are expected to have both management and technical expertise to provide additional details regarding the Written and Cost Elements, and Executive Order 18-03.

The HCA evaluation team will unanimously assign a score for each Oral Presentation. As with the Written Evaluation, this score will then be multiplied by the weight for the Oral Presentation.

The combined score for the Oral Presentation and References will represent the final scores for this stage of the evaluation.

ASB(s) may be determined based on the Bidder with the highest cumulative score for the Written Evaluation, Cost Evaluation, Executive Order 18-03, and Oral Presentations (including references), unless HCA elects to move forward with the BAFO process as described in Section 2.11.

4.4. **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.

4.5. **DEBRIEFING OF UNSUCCESSFUL BIDDERS**

Any Bidder who has submitted a Proposal and been notified it was not selected for Contract award may request a debriefing. The request for a debriefing conference must be received by the RFP Coordinator no later than 5:00 p.m., local time, in Olympia, Washington, within three business days after the Unsuccessful Bidder Notification is e-mailed to the Bidder. 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:

A. Evaluation and scoring of the Bidder's Proposal;

B. Critique of the Proposal based on the evaluation; and

C. 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 2.10) cannot be discussed as part of the debriefing conference, even if the Bidder did not submit a complaint.

Comparisons between proposals, or 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.

4.6. **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., local time, in Olympia, Washington 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 specific facts, (3) complete statements of the action(s) being protested, and (4) the relief or corrective action being requested.

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

1. A matter of bias, discrimination, or conflict of interest on the part of an evaluator;

2. Errors in computing the score; or

3. 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 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.

B. The final determination of the protest will:

1. Find the protest lacking in merit and uphold HCA's action; or

2. Find only technical or harmless errors in HCA's acquisition process and determine HCA to be in substantial compliance and reject the protest; or

3. Find merit in the protest and provide options to the HCA Director, which may include:

   a. Correct the errors and re-evaluate all Proposals; or

   b. Issue a new solicitation document and begin a new process; or

   c. 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. RFP EXHIBITS

Exhibit A	Certifications and Assurances – separate document
Exhibit B	Diverse Business Inclusion Plan – separate document
Exhibit C	Non-Disclosure Agreement (NDA) – separate document
Exhibit D	Reference Form – separate document
Exhibit E	Operations – separate document
Exhibit F	Innovation & Health Transformation – separate document
Exhibit G	Pharmacy Management – separate document
Exhibit H	Clinical Management – separate document
Exhibit I	Provider Network & Access – separate document
Exhibit J	Technical Data Requirements – separate document
Exhibit K	Cost & Plan Design – separate document
Exhibit L	Draft Contract – separate document
Exhibit M	Executive Order 18-03 – separate document

6. RFP APPENDICIES

Appendix 1	Alternative Payment Model (APM) Framework
Appendix 2	OCIO Standard 141.10 – Securing IT Assets
Appendix 3	Exhibit K – Cost & Plan Design Instructions
Appendix 4	Paying for Value Survey
Appendix 5	Provider Network Adequacy