



STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue • P.O. Box 42702 • Olympia, Washington 98504-2702

July 23, 2018

TO: Potential Bidders
FROM: RFP Coordinator
SUBJECT: RFP 2722 – SEBB Group Vision Plans

The purpose of Amendment eight (8) to RFP 2722 is as follows:

- Clarify RFP Section A.6 (Statement of Work) Account Management (3) and Exhibit I (Draft Contract) that Performance Guarantees will be addressed as part of negotiations with the Apparent Successful Bidder(s).
- Update RFP Section A.8(4) (Minimum Qualifications) to clarify the necessary insurance rating.
- Update RFP Section D to clarify scoring.
- Update scoring for Exhibit E, and add an additional question.
- Add a page limit of three (3) pages to Exhibit F, Section 5 (Member Engagement).
- Update Exhibit F, Section 9 (b)(iii) (Implementation Plan) to change the date when the Claims adjudication system must be operational from July 1, 2019 to September 2, 2019.
- Replace Exhibit H in its entirety, with Exhibit H-1, attached below.
- Delete Appendix 6 in its entirety and replace it with Table 1 in Exhibit H-1.
- Delete Appendix 7 in its entirety and replace it with Table 2 in Exhibit H-1.

- Provide Round 2 Questions and Answers.

Please note:

- All communication regarding this RFP must be directed to the RFP Coordinator at contracts@hca.wa.gov. All other communication will be considered unofficial and non-binding on HCA. Communication directed to parties other than the RFP Coordinator may result in disqualification of the potential Bidder.

- Proposals are due **July 30, 2018 by 5:00 pm (PT)**.

Thank you,

Ellen Wolfhagen
RFP Coordinator
contracts@hca.wa.gov

8. Minimum Qualifications

Within the Letter of Submittal, section C.4, Bidders are asked to explain and demonstrate compliance with the following eligibility requirements to participate as a Bidder in response to this RFP. Bidder must meet these minimum requirements at the time their Proposal is submitted to HCA.

1. Must have been issued or applied for a UBI number to operate as a licensed business in Washington State; preferably in Idaho and Oregon as well.
2. Must comply with all Washington Office of the Insurance Commissioner's (OIC) regulations about Complaints and Appeals processes.
3. Must comply with all state and federal privacy and security laws, statutes, and regulations for protecting Member data, including HIPAA.
4. Must meet an A.M. Best financial rating of A- or comparable rating from an independent agency who rates the financial strength of insurance companies, at the time of Proposal submittal. (Bidder to provide a copy of their most recent A.M. Best-rating report.)
5. Must comply with Washington State Office of the Chief Information Officer (OCIO) security standards and agree to undergo a Security Design Review conducted by Washington Technology Solutions (see Appendix 1 – *OCIO Standard 141.10 – Securing IT Assets*). Describe the Bidder's ability to comply with the Washington State OCIO standards.

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D. EVALUATION AND CONTRACT AWARD

1. Evaluation Procedure

All Proposals received by the stated deadline, section A.2, *Procurement Schedule*, will undergo an administrative review to be completed by the RFP Coordinator. Proposals that pass the administrative review are considered responsive and will move on to be evaluated by the evaluation team. A Bidder submitting any Proposal that does not pass administrative review will be notified by the RFP Coordinator, and the Proposal will be rejected as non-responsive.

4.1 Administrative Review

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

4.2 Evaluation of Proposals

- a. Responsive Proposals will be evaluated and scored in accordance with the requirements stated in this RFP and any addenda issued. Evaluations will only be based upon information provided in the Bidder's proposal.
- b. The evaluation of Proposals will be accomplished by an evaluation team, to be designated by HCA.
- c. The scores assigned by individual evaluation team members will be used in calculating the total number of points awarded to each Bidder. Included in section D.2, *Evaluation Weighting and Scoring*, is a listing of all the scored Exhibits broken out by section, and the associated weights and the maximum points possible for each (Evaluation Table). Also included in this section is the scale of scores used by individual team members (0-10) and a brief statement about the scoring criteria associated with each of the scores (Scoring Methodology).
- d. Points awarded to a Bidder will first be calculated by section. The scores assigned by individual evaluation team members will be summed and averaged for an average score that will then be multiplied by the weight assigned to the section. Individual section scores will then be combined to result in the Bidder's total weighted written score. The written score will then be added to either the fully insured cost score OR the self-insured cost score. If the Bidder submits both a fully insured plan and a self-insured plan, the written score will be added to the cost score for EACH plan. The maximum number of points a Bidder can earn for all exhibits fully insured proposals is 1,000. The maximum number of points a Bidder can earn for self-insured proposals is 1,000.
- e. HCA reserves the right to award the Contract(s) to the Bidder(s) whose Proposal(s) are deemed to be in the best interest of HCA and the state of Washington. HCA, at its sole discretion, may elect to select the top-scoring firms as finalists for an oral presentation.

2. Evaluation Weighting and Scoring

Each of the *Evaluation Elements* included in section C.5 has been assigned a weight. Points will be assigned to each section based upon the average of all evaluation team member scores for the section (0 – 10) multiplied by the weight indicated below. The weight and maximum points for each section are as follows:

Evaluation Table			
Exhibit / Section No.	Title	Weight	Maximum Points
D	Organizational Structure and Vision Plan Experience		50
1	Organization	2.5	25
2	Vision Plan Experience	2.5	25
E	Provider Panel and Network		200
1	Provider Panel and Network	20	200
F	Operations		300
1	Claims Services	4	40
2	Member and Customer Services	4	40
3	Communications	3	30
4	Online Services	3	30
5	Member Engagement and Experience	3	30
6	Appeals and Complaints	2.5	25
7	Account Management	3	30
8	Emergency Response Account Management	2.5	25
9	Implementation Plan	4	40
10	Annual Renewal Process	1	10
G	Technical and Data Requirements		100
1	Data, Reporting, and Analytics	3	30
2	Data File Transfer and Access	3.5	35
3	Eligibility System Requirements	3.5	35

H	Plan Design, Covered Services, and Costs		350
1	Plan Design(s)Bids	530	50300
2	Covered ServicesRate Guarantee	52.5	5025
<u>3</u>	<u>Warranty</u>	<u>2</u>	<u>20</u>
<u>34</u>	<u>CostsExclusions</u>	<u>250.5</u>	<u>2505</u>
Total Maximum Points			1000

TOTAL

1000 POINTS

Scoring Methodology		
Score	Description	Scoring Criteria
0	No Value	The Response does not address any component of the requirement or no information was provided.
1	Poor	The Response only minimally addresses the requirement and is missing components or components were missing
3	Below Average	The Response only minimally addresses the requirement and the Bidder's ability to comply with the requirement or simply has restated the requirement.
5	Average	The Response shows an acceptable understand or experience with the requirement. Sufficient detail to be considered "as meeting minimum requirements."
7	Good	The Response is thorough and complete and demonstrates firm understanding of concepts and requirements.
10	Excellent	The Response 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.

Cost Proposal Scoring

Cost Proposals are not scored in the same manner as the written portions of the RFP. Proposals for Exhibits D, E, F, G or the Plan Design(s) and Covered Services elements of Exhibit H. Instead of evaluators assigning a score, points for Cost Proposals will be awarded according to the following formulas:

Fully Insured:

<u>Lowest PSPM Rate for Fully Insured</u>					
<u>Bidder's PSPM Rate for Fully Insured</u>	<u>x</u>	<u>300 points</u>	<u>=</u>	<u>Bidder's Fully Insured PSPM Rate Points</u>	

Self-Insured:

<u>Lowest Claims Cost for Self-Insured</u>				<u>Lowest PSPM Cost for Self-Insured</u>				
<u>Bidder's Claims Cost for Self-Insured</u>	<u>x</u>	<u>150 points</u>	<u>+</u>	<u>Bidder's PSPM Cost for Self-Insured</u>	<u>x</u>	<u>150 points</u>	<u>=</u>	<u>Bidder's Self-Insured Total Cost Points</u>

Exhibit E – Provider Panel and Network (200 points total)

Please limit response to five (5) pages, excluding any requested flow charts, examples, etc.

- a. Please provide Bidder's provider list by county using Appendix 4, Provider List. (30 points)
- b. Please describe whether the Bidder's network allows for provider access in the following areas (3025 points):
 - i. Washington State?
 - ii. Oregon?
 - iii. Idaho?
 - iv. Other states in the U.S? Please list.
 - v. In the District of Columbia?
 - vi. Other U.S Territories? Please List.
 - vii. Internationally? Please list areas and what resources are offered to Members traveling abroad that need vision care or hardware.
- c. Describe any standards Bidder has for geographic access and appointment availability for care. What is the average wait time for a Member to see a provider from their initial call to request an appointment to actual visit? (3020 points).
- d. If there is a need for additional providers, can they be added to Bidder's provider network(s)? If "yes," please describe the process and the approximate length of time it takes for a provider to be added to the network. How many providers has the Bidder added and how many have disenrolled in the past 12 months? (3020 points).
- e. What are the established standards of care the Bidder's contracted providers are required to adhere to when providing eye care services? Describe Bidder's provider credentialing and re-credentialing process. Include whether or not Bidder's provider credentialing process meets any specific standards and list what the standards are. (3020 points)
- f. What are the top three (3) primary reasons providers have disenrolled from the Bidder's network? (2015 points)
- g. Describe in detail how network providers are reimbursed (2015 points).
- h. What percent of Bidder's current membership uses network providers as compared to out-of-network providers? (2015 points)
- i. Submit a copy (or screenshots) of a provider directory. (20 points)
- i.j. How does the Bidder control the Member's out-of-pocket costs? (20 points)

Exhibit F – Operations (300 points total)

1. Claims Services (40 points)

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

- a. Claims processing office. Including (6 points):
 - i. Location.
 - ii. Hours of operation (converted to Pacific Time).
 - iii. Number of employees working there.
 - iv. How long the office has been in service.
 - v. Is there a back-up Claims center and where is it located?
 - vi. What measures are taken to deliver a consistently high degree of Claims payment accuracy and timeliness?
- b. Willingness to propose dedicated Claims processing staff to serve the SEBB account. (2 points)
- c. Claims processing system. How long has the Bidder used the current Claims system? Provide a flow chart of the Claims adjudication process for both in- and out-of network claims. Include details from receipt of Claim to issuance of payment and EOB for a typical Clean Claim. If Subcontractors adjudicate any Claims, include separate flow charts for those entities. Are there any plans to change systems in the next five (5) years? (4 points)
- d. Internal performance standards. This should include what is being measured, the target, and the 2017 measurement results. (3 points)
- e. Claims runout time period, in months. (2 points)
- f. Ability to make revisions to benefits or benefit design prior to the new plan year starting. What is the average amount of time needed to make such revisions? (3 points)
- g. Provide a detailed disaster recovery plan for the SEBB Program account for vision care services, customer service, and Claims adjudication. Include where back up office locations, account management, Claims adjudication, and customer services would be provided from, and the number of back-up personnel available in emergency situations, and their location. (5 points)
- h. Fraud, waste, and abuse processes. (3 points)
- i. Ability to accept the customized HIPAA 834 compliant eligibility file found in Appendix 3 – *HIPAA 834 Compliant Eligibility File*. If the Bidder is unable to accept this format currently, will the Bidder be able to accept it by February 28, 2019? If not, provide an estimated date by when the Bidder will be able to accept the HIPAA 834 file. (6 points)
- j. Ability to deliver Member identification (ID) cards and other welcome materials to Members after the SEBB Annual Open Enrollment ends, no later than December 20 of each year. (3 points)
- k. Average turnaround time for member ID cards from the time the Bidder receives the updated eligibility file with newly enrolled Members to when the ID card is mailed, by completing Table 3 (3 points):

Table 1 – Average Turnaround Time

	Plan Standard	2017 Actual
New Member		
Replacement card		

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

2. Member and Customer Services (40 points)

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

- a. Customer service center and staff including (5 points):
 - i. Proposed SEBB Program customer service center location;
 - ii. Hours of operation (converted to Pacific Time);
 - iii. Size of SEBB Program support staff and to what extent the Bidder will commit dedicated customer service representatives to the SEBB account;
 - iv. Whether customer service staff would perform other roles, such as processing Claims;
 - v. Number of Covered Lives the Bidder's customer service center currently supports.
 - vi. How long the customer service center has been in service.
 - vii. Is there a back-up customer service center and where is it located?
- b. Current customer service staffing ratio (staff to customers/members) and its annual customer service staff turnover rate (2 points).
- c. Ability to participate in-person in the SEBB Program's Annual Open Enrollment benefit fairs, covering topics such as benefits and cost-sharing, network providers, Claim procedures, Member services, and informational tools and resources (3 points).
- d. Customer service phone system. Check all features currently offered by Bidder's customer service phone system (3 points):
 - i. Toll-free Customer Service number
 - ii. Call triage process (i.e., a phone tree)
 - iii. Members' calls are queued in the order received
 - iv. Call-back feature (so members don't have to wait on hold)
 - v. Access to Customer Service after hours
 - vi. Message system; member can leave a message with a call back the next Business Day
 - vii. Recorded messages (i.e. hours of operation, in case of emergency instructions, etc.)
 - viii. Interactive Voice Response System (IVR)
 - ix. Other (specify): _____
- e. Support for culturally linguistic and diverse population through online and telephone communications. Describe the primary language(s) served and the availability of translation services for other languages. (2 points)
- f. Accommodations for members who are sight, hearing, and/or speech impaired, in accordance with the ADA. (2 points)

- g. Methods offered to members to communicate with the Bidder for general and billing questions, communication with a provider, or anything else. How does the Bidder respond to the communications? Describe what types of transactional activities members can conduct via the Bidder's website. If members are able to submit questions to the Bidder's customer service center via email, what is the average response time? (3 points)
- h. Business processes, policies, and procedures used to ensure safeguards are in place for PHI when communicating with members by email. Include in the answer whether emails are secure. (3 points)
- i. Process for how the Bidder would provide customer service coordination with other HCA vendors. For example, in the event services provided need billed to the Member's medical benefit instead of their vision benefit. (2 points)
- j. Current methods of communicating and coordinating on clinical conditions and/or diagnosis with a Member's primary care physician or specialty care provider(s). (2 points)
- k. Customer service training program, Quality Control monitoring, and auditing processes. Describe the customer service representative account onboarding process. Include additional proposed annual customer service training on Annual Open Enrollment. (3 points)
- l. Process to provide feedback from Members to HCA. What cadence does the Bidder propose? What if feedback was urgent (needs reviewed within 24 hours) and needed escalation to HCA? (3 points)
- m. Customer service Performance Standard measures by completing Table 4 (5 points):

Table 2 – Customer Service Performance Standards

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

- n. Process for conducting a Member satisfaction survey. Who conducts the survey? What is the frequency? How are the results used to make improvements? (2 points)

3. Communications (30 points)

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

- a. Ability and resources to write, design, print and distribute the following customized materials for each of the Bidder's potential contracted SEBB Vision Plans and provide an example of each (5 points):
 - i. Enrollment welcome packet

- ii. ID cards
 - iii. Explanation of Benefits (EOB)
 - iv. Benefit summary comparison documents and other coverage documents
 - v. Claims denial letters
 - vi. Disenrollment letter
 - vii. Appeal denial letters
- b. Communication with Members over a calendar year to educate them about vision care services. Provide two (2) examples. (2 points)
 - c. Bidder must agree to comply with WAC 182-08-220 (c) and obtain advance written approval from HCA before distributing media announcements or advertising materials which includes any mention of SEBB or any group of enrollees covered by SEBB benefits. (1 point)
 - d. Ability and resources to write the COCs for the Bidder's potential contracted SEBB Vision Plans annually, in collaboration with HCA, so they are compatible with the Bidder's administration of the plan and HCA's responsibility for defining eligibility and enrollment terms. (3 points)
 - e. Process for distributing hard copies of the annual COC or other materials to Members, HCA staff, and Enrollees upon request. (Providing a postcard to Members to submit for a print version is acceptable.) (1 point)
 - f. Ability and resources to write, design, print, and provide an internet-ready and ADA-compliant electronic documents for each of the Bidder's potential contracted SEBB Plans. (2 points)
 - g. Ability and resources to write, design, print, and distribute a hard copy welcome packet for new Members (within thirty (30) Business Days of enrolling) and in future years, reenrolling Members (no later than December 20 of each year). These materials may include (4 points):
 - i. Cover letter
 - ii. Notice of Privacy Practices (print and distribute only)
 - iii. Web services promotional piece
 - iv. Postcard to request a hard copy of the COC
 - v. Other materials, including other vendor materials, as requested by the HCA
 - h. Ability and resources to design, print and distribute identification cards or replacement cards at no charge to all Members. Identification cards shall display an HCA-approved logo, the Bidder's log, and any other information needed by providers and Members to access benefits.(2 points)
 - i. Ability to reissue identification cards to all Members at no charge to Members or the state, when significant information changes are needed. (2 points)
 - j. Willingness to dual brand communications with the HCA and the appropriate plan or network logo and name, unless HCA requests single branding. (2 points)
 - k. Current methods of communicating with members electronically, including but not limited to email, mobile applications, and other methods. (3 points)
 - l. Ability to ensure all communications sent will relate directly to the Bidder's contracted SEBB Vision Plans. The Bidder may not send, help or allow any other person or entity to send any communications to Subscribers, Members, or Enrollees except those relating directly to the Bidder's contracted SEBB Vision Plans, unless authorized in writing in advance by the HCA. (3 points)

4. Online Services (30 points)

Please limit response to five (5) pages. Describe the following:

- a. How the Bidder complies with ADA requirements for online services. (2 points)
- b. HCA wants a Contractor who can provide a microsite for the SEBB Vision Plans. Please indicate whether the Bidder can provide a dedicated microsite for its SEBB Vision Plans, or if Members can only access plan information through the Bidder's Book-of-Business online services page. (10 points)
- c. Whether Enrollees can access public information regarding the Bidder's contracted SEBB Vision Plans online. If yes, describe the kinds of information that would be publically available. (5 points)
- d. Bidder's capability to provide Members with secure access to account information online. This would require secure sign-in, and a portal that includes PHI, such as services a Member has received. Describe the Bidder's capability to meet the following (10 points):
 - i. Sign-in security approach that achieves the OCIO security standards (see, Appendix 1 – *OCIO Standard 141.10 – Securing IT Assets*) and in coordination with other vendors that provide Member online services to ensure a single sign-on across sites.
 - ii. Ability for Members to login from the Bidder's SEBB Program-specific microsite.
 - iii. Personal and family Claims history that complies with HIPAA privacy requirements (e.g., some family members may need to be masked on diagnosis or age-related Claims), accumulator status, deductible status, and out-of-pocket maximum status.
 - iv. Secure email to and from customer services.
- e. How the Bidder ensures dependents age 13 and older have their diagnoses and vision care services kept private from the subscriber? (3 points)

5. Member Engagement and Experience (30 points)

Please limit response to three (3) pages.

- a. Describe the Bidder's member-oriented websites, including desktop and mobile optimization. (8 points)
 - i. Is the website built and maintained by the Bidder or by an external vendor?
 - ii. How often are maintenance updates conducted?
 - iii. Do maintenance updates disrupt member access? If yes, what does the Bidder do to try to limit disruption?
- b. Describe Member-oriented website features, capabilities, and information that Members can access through the website. Provide **the link** to where members can access their information, along with a **dummy login** and **password** credential so HCA evaluators can test the features and capabilities of the resource. Check all of the features, capabilities, and information below that apply to the Bidder's website (10 points):
 - Appeals and Complaints
 - Benefits and coverage
 - Bidder's contact information
 - Claims look-up
 - Costs for services owed by subscriber

- Cost transparency tool (cost estimates; cost by provider, etc.); provide the link if available to the public:
- Customer service messaging, such as instant messaging with the Bidder
- Discount programs
- Explanation of Benefits (EOB) look-up/print
- FAQ
- Member accumulators; describe which are available for the member to access through the Bidder's website (i.e. remaining allowance)
- Member forms and documents; describe which forms and documents are available for members to view and or download:
- Member notices (check the box if "yes."):
 - Members review Appeal/Grievance status
 - Message from Bidder
 - Claim(s) processed
- Patient rights
- Payments to providers
- Print or order new cards
- Provider messaging and/or text messaging (member to provider)
- Up-to-date provider directory search. If applicable, check all of the information available to Members:
 - Accepting new patients
 - Language(s) provider speaks
 - Provider contact information (physical address, phone number)
 - Provider name
 - Provider network status
 - Provider ratings (quality, review, etc.)
- Others; describe each:

c. Describe promotion of tools and applications that make it easier for patients to conduct vision related transactions, including the ability to (4 points):

- i. Schedule appointments online.
- ii. Communicate with a provider online.

d. Describe the process for purchasing vision hardware online. (8 points)

- i. Are there specific website(s) the member can purchase vision hardware through? If yes, how does the member access them and how do they know if the provider is considered in-network?
- ii. Are the website(s) for purchasing hardware secure? Describe their security.
- iii. Can the member upload their prescription via their computer, smart phone, or tablet?

- iv. Is there free shipping when purchasing online?
- v. Is there free returns if the product is not of satisfaction to the member?
- vi. Can the member see a network provider in person to have adjustments made to their glasses, even if the glasses were purchased online? If yes, is there a cost to the member?

Tools available for use by employers through the Bidder's website; such as the use of reporting dashboards.

6. Appeals and Complaints (25 points)

Please limit response to four (4) pages, excluding any requested flow charts, examples, etc.

- a. Provide an overview of the Bidder's Appeals process. Please include the following in the response (10 points):
 - i. Under which circumstances a member can submit an Appeal to the Bidder (medical necessity, non-covered services, claim denial, etc);
 - ii. How Appeals are received;
 - iii. How decisions are made;
 - iv. Who is involved in the decision making process (include the title, credentials, and qualifications for each person involved);
 - v. Completion timelines;
 - vi. In which circumstances clients are notified of Appeals being processed by the Bidder, such as in the event of an Appeal that is being escalated.
- b. Describe the Bidder's department responsible for processing Appeals and its location (e.g., locally or nationally). If Appeals will not be handled locally, describe how processes will be coordinated to assure compliance with applicable timelines defined by the Washington Patient Bill of Rights and potentially other requirements, such as contractual requirements? (5 points)
- c. Provide an overview of the Complaint process. Please include the following in your response (5 points):
 - i. How a Complaint is received;
 - ii. How Complaints are differentiated from Appeals;
 - iii. Who is involved in the decision making process (include the titles and qualifications of each person);
 - iv. Completion timelines;
 - v. How and when members are notified that their Complaints have been received and their results, and in which circumstances HCA would be notified.
- d. Describe and provide two (2) examples of how Complaint and Appeal results and information are used to improve the Bidder's Claims processing, Member services, and business processes, such as staff training and member experience when the ratio of overturned Appeals is high in a particular area or for a specific service or benefit. Describe how the Bidder uses Complaint and Appeals data to improve performance of network-provider feedback and training. (5 points)

7. Account Management (30 points)

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

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

- a. Full time employees who will be dedicated to this account, and provide (5 points):
 - i. Name, title, phone number, and email address;
 - ii. Full professional biographies for each employee, to include any licenses held, credentials, educational levels, years of experience, etc.;
 - iii. The location of each employee.
- b. Experienced subject matter experts assigned to manage all contracted functions for the size and complexity of this account including (10 points):
 - i. Participation in quarterly account management meetings with HCA staff to be held at the HCA headquarters in Olympia, WA.
 - ii. Participation in activities to analyze plan performance, identify improvement opportunities, design interventions, and coordinate implementation with the HCA.
 - iii. Ensure the account management team is responsive to the HCA's inquiries, contacts and requests, and keeps the HCA informed of new and outstanding issues.
 - iv. Report monthly and quarterly performance on utilization and SEBB Vision Plan costs. Present analyses and recommendations in response to reported performance outcomes.
 - v. Process to inform the HCA Account Manager(s) of state and federal law changes within fifteen (15) Days of notification, which the Bidder will be obligated to do.
 - vi. Account management team's location(s).
 - vii. Attend meetings of the SEB Board either in person or by phone.
- c. Capacities and approaches to customer relations, provider relations, and public relations when administering public sector vision plans in a highly transparent and politically active environment. Specifically address Bidder's past experience and successes in managing situations involving negative media exposure about plan policy and operations, oppositional lobbying efforts or special interest groups, provider associations, etc. and direct reporting of Complaints and Grievances to the Governor, Governor's senior staff, or cabinet-level agency heads regarding your entity's performance. (7 points)
- d. Ability to respond to legislative requests for written information, budget analysis, and data for HCA within a 24-hour timeframe. (8 points)

8. Emergency Response Account Management (25 points)

Please limit response to three (3) pages.

- a. Describe the Bidder's emergency response approach to maintain uninterrupted core business and operations during natural disasters or other system outages. (8 points)

- b. Describe the kinds of abnormal events to which the Bidder's emergency response applies. (3 points)
- c. Define what the Bidder classifies as core business and operations and give specific information that clearly relates the emergency response approach to the Bidder's Book-of-Business operations. (6 points)
- d. Describe the Bidder's emergency records management/back-up. (8 points)

9. Implementation Plan (40 points)

Bidder(s) must provide a comprehensive implementation plan for the time-period from November 1, 2018 through December 31, 2019. Below is a description of the work that must be included in the Bidder's implementation plan as well as expected milestone deadlines for completion of the different phases. Please provide a detailed implementation plan that addresses all key operational areas necessary to implement a program of this size.

Please limit response to ten (10) pages, excluding any requested flow charts, examples, etc.

- a. Describe the structure of Bidder's implementation team:
 - i. Names, roles, responsibilities, and experience level of team members. Identify which team members will be dedicated to the implementation of the SEBB account.
 - ii. Staffing plan for implementation team and key account team members listed in section 7, *Account Management* of this Exhibit. All must be active on the account during the RFP evaluation phase, including oral presentations. (15 points)
- b. Provide a detailed project management and implementation plan, including assigned staff and other resources, project management support, work breakdown structures, contingencies, strategies, and tactics. The implementation plan must address the following key areas and meet the key milestone due dates listed below (25 points):
 - i. On December 3, 2018, start OCIO Design Review process for the Bidder's technical implementation (For more information, see Appendix 1, *OCIO Standard 141.10 – Securing IT Assets* and Appendix 2 – *WATech OCS Design Review Checklist*).
 - ii. By June 3, deliver Claims data to HCA:
 - 1. If Contract is for fully insured Vision Plan(s) and Contractor is willing to participate in providing Claims data to HCA, then by June 3, 2019, build and successfully transfer a test data file to the HCA's data warehouse.
 - 2. If Contract is for self-insured Vision Plan(s), then Contractor will need to build and successfully transfer a test data file to the HCA's data warehouse
 - ~~iii. By July 1, 2019, ensure the Claims adjudication (benefits and plan provisions) system is fully operational.~~
 - ~~iv.iii.~~ By July 15, 2019 finalize:
 - All elements necessary to integrate the SEB Board approved wellness plan are operational (if applicable).
 - ~~v.iv.~~ By August 1, 2019, submit:
 - Identification of key knowledgeable staff to support and attend benefit fairs.
 - Detailed project disaster plans for customer service and Claims adjudication.
 - A change management plan that addresses the impact of network changes on both the provider and Member community.

- A completed Claims Payment Audit that adheres to the following:
 - A professional audit of sample Claims after the ASB completes its system programming for 2020 benefits and Claim processing, and before live Claim processing commences January 1, 2020.
 - The ASB will perform a series of sample Claim adjudications of various types of Claims (comprehensive eye exam, lenses, frames, etc.) so auditors may confirm the ASB's Claim system is ready to accurately process SEBB Vision Plan Claims, all necessary plan features are correctly programmed, and accumulators are working.
 - Cooperation with auditors and expedition of the audit as needed. This audit will be performed by independent, professional auditors contracted at the expense of the ASB and completed (including corrective actions) by this date.
 - Additional processes, such as Appeals and Complaints, may be added to this implementation audit at HCA's sole discretion.

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

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

vii.vi. By September 2, 2019, finalize:

- A fully operational customer service center and system that meets the required customer service standards available for Members, or for Enrollees that have questions regarding the ASB's contracted SEBB Vision Plan(s), or who may be considering joining the ASB's contracted SEBB Vision Plan(s).
- ~~ensure the~~The -Claims adjudication (benefits and plan provisions) system to ensure it is fully operational.
- Open Enrollment items including communication materials.

viii.vii. By September 30, 2019, ensure that:

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

10. Annual Renewal Process (10 points)

The RFR process will be on an annual basis to adjust employee benefits in response to (a) new requirements under the ACA or other federal requirements; (b) changes requested by the SEB Board, or other internal policy drivers; (c) benefit design strategies promulgated by HCA; and/or (d) state legislative mandates and other changes. The purpose of the RFR is not to extend or re-negotiate the

Contract, but for both parties to determine resources necessary to implement possible benefit changes and other potential changes to any of the plans. These changes may result from a mandate from either within or outside HCA.

Please limit response to one (1) page. Describe the Bidder's:

- a. Resources for responding to and implementing annual proposals through the RFR process. (5 points)
- b. Process for absorbing any costs of these implementations each year within the premium. (5 points)

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Exhibit H-1 – Plan Design, Covered Services and Cost (350 points total)

HCA will evaluate and present to the SEB Board the plan design options and rates of the ASB's. Ultimately, it is the SEB Board's decision on the type of plan(s) (fully insured, self-insured, or both) they decide to offer to SEBB Members. The plans submitted must meet the needs of the SEBB Member population based on your previous School Employee and/or other market experience. Bidders may propose fully insured and/or self-insured plans based on the parameters and assumptions outlined in sections 1 and 2 below for completing section 3. Fully insured plan proposals will be scored against fully insured plan proposals only. Self-insured plan proposals will be scored against self-insured plan proposals only.

1. Plan Design Parameters

- a. One (1) routine comprehensive eye health exam for each Member per Calendar Year, covered at one-hundred percent (100%) by the plan when the Member sees an in-network provider. If the Member sees an out-of-network provider, the plan pays sixty percent (60%) of the allowed amount and the provider may balance bill the Member.
- b. Up to one-hundred and fifty dollar (\$150) allowance per Member every two Plan Years for prescription eyeglass lenses, frames, and contact lenses, including repairs and any filters, tinting, etc. added to the eyeglass lenses. The one-hundred and fifty dollar (\$150) limit is renewed on January 1 of even years (2022, 2024, etc.). Any unused amount does not carry over into the next even Plan Year (i.e. what isn't used between 2020 and 2021 does not carry over into 2022). The plan will not pay more than the Member's actual cost for these items and services. The Member is fully responsible for any costs above the one-hundred and fifty dollar (\$150) limit.
- c. One (1) pair of Pediatric hardware covered at one-hundred (100%) of the carrier's allowed amount, is covered by the plan per Plan Year, to include the frames, eyeglass lenses, repairs, and any eyeglass lens filtering, tinting, etc., or a year supply of contact lenses (in lieu of eyeglasses).

2. Assumptions

- 134,000 Subscribers
- 100,000 Dependents
- 18% Member annual utilization rate

3. Bids

- a. Bids: Using the parameters and assumptions (provided in sections 1 and 2 above) complete the bids in the Tables provided for the fully insured (Table 1) and/or self-insured (Table 2) plans.

The cost score for fully insured plan proposals will be a maximum of 300 points. The cost score for self-insured plan proposals will be a maximum of 300 points. Fully insured and self-insured plan proposals will be scored separately.

All fee components must be rounded to the whole penny. The enrollment assumptions provided within the RFP will be used uniformly across all Bidders for evaluation of fee

Proposals relative to a target cost. The enrollment assumptions are non-binding and used for evaluation purposes only.

Table 1 (Total: 300 points)

Fully Insured Bid	Fully Insured
Proposed Bid PSPM Rate	

Table 2 (Total: 300 points)

Self-Insured Bid	Self-Insured
Estimated Claims Costs (total annual paid) (150 points)	
Proposed PSPM Administrative Fee (150 points)	

- b. Rate Guarantee:
 - i. Will the Bidder offer a rate guarantee? If yes, for how many years is the rate guaranteed? (25 points)
- c. Warranty: Do eyeglasses have a warranty? If so, what is it? (20 points)
- d. Exclusions: List the Bidder’s Vision Plan exclusions. (5 points)

4. Mandatory Non-Scored

- a. Fully insured: What would the Bidder’s benefit design include (i.e. allowance, how often allowance is renewed, in-network vs. out-of-of network cost share, etc.) if your insured product cost \$13.4 – 17.6 million per Plan Year. Include any exclusions.
- b. Self-insured: What would the Bidder’s benefit design include (i.e. allowance, how often allowance is renewed, in-network vs. out-of-of network cost share, etc.) if Claims costs were between \$13 – 17 million per Plan Year with an annual administrative cost between \$400,000-600,000. Include any exclusions.

Amendment 8

RFP 2722- SEBB Group Vision Plans – Round 2 Questions

#	RFP Section	Bidder Question	HCA Response
1	A.2	Given that the HCA will not be providing several key items to bidders prior to July 23rd, is it possible for HCA to extend the due date on the RFP?	Yes, HCA has extended the deadline to July 30 at 5:00 pacific standard time. See Amendment seven (7), which was posted on July 20, 2018 for the updated procurement schedule.
2	Exhibit B	Is there a goal associated with the MWBE requirements in Exhibit B - Diverse Business Inclusion Plan?	There is no specific goal associated with these requirements.
3	Exhibit H	For the plan pediatric benefit, is SEBB looking to add to an ACA rider, or is SEBB looking for the ACA benefit to be written into the stand-alone plan?	HCA is looking for the ACA benefit to be written into the stand-alone group plan so that pediatric vision would mirror what would essentially be covered if the vision benefit remained in the group medical plan(s).
4	Exhibit H	<p>In regards to the requested pediatric vision benefits under ACA:</p> <p>A) In regards to eyeglasses and the allowed amount, can a dollar amount retail frame allowance apply (i.e. \$150 retail frame allowance)?</p> <p>B) In regards to contact lenses and the allowed amount, can a dollar amount retail contact lens allowance apply (i.e., \$150 retail contact lens allowance)?</p> <p>C) Can copays apply to vision exams, contact lens exams/fitting and/or materials (frames/lenses)?</p>	HCA has updated the information provided for the pediatric vision benefit under Exhibit H-1. See changes in Amendment 8. B) HCA has updated the information provided for the pediatric vision benefit under Exhibit H-1. See changes in Amendment 8. C) HCA is unsure if this question is supposed to apply to the pediatric vision benefits under the ACA as well. If so, there can be no copays for pediatric vision, unless the parameters for the Plan Year have already been met (i.e., one (1) pair of pediatric standard frames and prescription lenses or one (1) year's supply of contact lenses has already been covered by the plan for the Plan Year). If this question does not apply to the pediatric ACA requirements, then HCA has updated the plan design to provide more direction. See changes in Amendment 8.
5	Exhibit H	Exhibit H states that "Bidders propose up to two (2) fully insured and two (2) self-insured plan options for	Confirmed. HCA wants to have different plan designs to present to the Board for their approval,

		<p>the 2020 plan year." Please confirm if these can be distinct plan designs. For example, two different fully insured plan designs and 2 different self-insured plan designs, for a total of 4 distinct plan options.</p>	<p>and would also like, if possible, to provide Members with more than one plan design choice.</p>
<p>6</p>	<p>Exhibit I</p>	<p>Please provide Enrollment Reconciliation Language for Exhibit I Draft Contract.</p>	<p>This language will not be added to the Exhibit I, Draft Contract until the special terms and conditions are added during the negotiation process. But, HCA will provide the standard language for review by the Bidders, so Bidders will know what they should expect to see, if announced as an ASB, in the next draft contract:</p> <p>E. Enrollment Reconciliation Contractor will perform a full file enrollment match not less frequently than monthly. Contractor will:</p> <p>I. Initiate full file match process by:</p> <p>a. Comparing the 834 monthly audit file that gets automatically created on the morning of the 1st of each calendar month; or</p> <p>b. Sending an email to ispebbsr@hca.wa.gov to request an 834 audit file on a specific date.</p> <p>II. Use the 834 monthly audit file to compare (not update) the Contractor's enrollment with SEBB enrollment to ensure that every Member's enrollment match.</p> <p>III. Create a file in txt format of only main Subscriber SSN(s) that didn't match (do not include the Dependent SSN even if the mismatched Member is the Dependent). Mismatch condition is either:</p> <p>a. Member is not in SEBB's system, but in the Plan's system; or</p> <p>b. Member is not in the Plan's system, but in is SEBB's system.</p> <p>IV. Upload the txt file of Subscriber SSN to https://sft.wa.gov.</p>

			<p>V. Send email to ispebbsr@hca.wa.gov with notification that mismatch file is available. Once Contractor has completed steps I-V above, HCA will download the file and create a separate 834 file with appropriate information with dates, as close as possible to the original date, to process against Contractor's file to bring Contractor's file in synchronization with HCA's file. For example: If Contractor's database has a Member that HCA does not have, HCA will send Contractor a "delete" record. If Contractor's database is missing a Member that HCA's database does have, HCA will send Contractor an "add" record. HCA will reply to the email from step V of this section when the mismatch 834 file is ready for Contractor pick-up.</p>
7	Appendix 1	<p>If a bidder is not currently in full compliance with all components of Appendix 1, OCIO standards, but is working toward compliance, can this be noted in the RFP response?</p>	<p>Yes. HCA understands that these standards may be new to vendors HCA has not worked with before. HCA is asking the Bidders to attest that they can work towards meeting the standards, knowing there will be a process in which the Bidder will need to work with HCA and the Office of the Chief Information Officer (OCIO) for approval by the OCIO, prior to any eligibility or other sensitive information files being shared with the Bidders who are awarded a Contract.</p>