STATE OF WASHINGTON
HEALTH CARE AUTHORITY

REQUEST FOR PROPOSALS (RFP)

RFP NO. 3866

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: External Quality Review Organization (EQRO)

PROPOSAL DUE DATE: September 9, 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, 2020 to December 31, 2023

The Health Care Authority reserves the right to extend the contract for up to three (3) additional years 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.

Washington State Health Care Authority

1. INTRODUCTION

1.1. PURPOSE AND BACKGROUND

1.1.1. Purpose

The Washington State Health Care Authority, hereafter called "HCA," is issuing this Request for Proposals (RFP) to invite qualified and experienced organizations interested in serving as the External Quality Review Organization (EQRO) for the Washington Apple Health (Medicaid) Integrated Managed Care (AH-IMC) program. This RFP includes External Quality Review activities required or allowed under C.F.R., as well as Washington State legislatively driven Value-Based Purchasing (VBP) work (Sections 1.2.7), and settlement-driven quality review for the Wraparound with Intensive Services (WISe) (Section 1.2.9). The State is required by federal regulation, 42 C.F.R. Chapter IV, Part 438, to develop and implement a quality assessment and improvement strategy for services it furnishes to its managed care enrollees. HCA approaches this quality assessment of our MCOs' administration of the Medicaid benefit through the various means, including validation of Healthcare Effectiveness Data and Information Set (HEDIS®) and non-HEDIS measures, CAHPS® survey, external quality review of quality, timeliness, and accessibility of health care services furnished to the state's Medicaid enrollees. HCA intends to award one contract to provide the services described in this RFP. This RFP includes deliverables pertaining to physical and behavioral health through the following Medicaid contracts:

- Apple Health – Integrated Foster Child (AH-IFC) Managed Care program
- Apple Health – Integrated Managed Care (AH-IMC) program

The specifications for deliverables required under this RFP may evolve from year-to-year in response to program changes, Legislative direction, MCO participation, new pilot projects, and Managed Care enrollment levels. During the contract period, additional work requests may be made of the Contractor(s) at the sole discretion of HCA if state, federal, or grant funding becomes available for optional activities described in 42 C.F.R. § 438.358(c) or comparable activities that assess the quality of care of HCA's managed care programs. HCA also reserves the right to seek other qualified entities to conduct such work.

1.1.2. Background

HCA purchases health care for more than two million Washington residents through Apple Health (Medicaid), the Public Employees Benefits Board (PEBB) Program, and, beginning in 2020, the School Employees Benefits Board (SEBB) Program. Most of Washington's 1.8 million Medicaid Enrollees are enrolled in a Managed Care Organization (MCO) with a smaller fee- for-service program serving select populations (e.g., dual-eligible Medicare/Medicaid clients, American Indian/Alaskan Native clients). Managed Care serves approximately 84% of Medicaid-eligible residents, including 50% of Medicaid children, and is responsible for 50% of deliveries Washington State.

Washington State is committed to whole-person care, integrating physical health, mental health, and substance abuse services for quality results and healthier residents. Currently HCA contracts with five MCOs to deliver care to Medicaid Enrollees under the Apple Health Managed Care (AHMC), Apple Health Integrated Managed Care (AH-IMC), and Apple Health – Integrated Foster Child (IAHFC) Managed Care contracts. By January 1, 2020, integrated managed care will be the model statewide, with each MCO responsible for administering physical health, mental health, and substance use disorder treatment benefits, and coordinating care under one health plan.

Federal Medicaid managed care regulations require states to conduct compliance monitoring and oversight of Medicaid managed care, which may be delegated to the EQRO or performed by the state. Washington State has performed the compliance review function for the MCO line of business since 2003. The HCA's Medicaid Compliance Review and Analytics (MCRA) Section coordinates this work in partnership with other subject matter experts within HCA. This cross-agency function is called TEAMonitor. TEAMonitor includes annual compliance review, on-site visits, corrective action, performance improvement project (PIP) validation, and some deliverables monitoring.

1.1.3. History of Managed Care in Washington State

The purchasing of behavioral health services has changed in recent years to support the legislative direction regarding integrated care. In 2015, the legislature authorized the DSHS to contract with new entities called Behavioral Health Organizations (BHOs) to purchase and administer publicly-funded mental health and substance use treatment services (jointly called "behavioral health services") under managed care. BHOs are single, local entities that assumed responsibility, in April 2016, for providing these services, previously managed by counties and Regional Support Networks (RSNs). These include inpatient and outpatient treatment, involuntary treatment and crisis services, jail proviso services, and services funded by the federal block grants.

DSHS and HCA jointly designated Regional Service Areas (RSAs) in June 2015, following legislative direction in 2014. RSAs defined new geographical boundaries for the state to purchase behavioral and physical health care through managed care contracts. HCA currently use RSAs for MCO contracting. On July 1, 2018, staff from the Division of Behavioral Health and Recovery (DBHR) previously within DSHS, joined HCA to continue behavioral health oversight.

1.1.4. Apple Health - Integrated Managed Care

Apple Health - Integrated Managed Care (AH-IMC) is an initiative to bring together the payment and delivery of physical and behavioral health services for people enrolled in Medicaid. The Southwest Washington RSA (at the time, only Clark and Skamania counties) was the first region in the state to adopt AH-IMC (previously termed "Fully Integrated Managed Care" or "FIMC"), as of April 2016. The next region to implement this model was North Central RSA (at the time, only Chelan, Douglas, and Grant counties) in January 2018. The largest shift to the AH-IMC model was in January 2019 when four regions implemented: Pierce RSA, Greater Columbia RSA, King RSA, and Spokane RSA, as well as Klickitat and Okanogan counties. At that time, Klickitat County became part of the Southwest RSA, and Okanogan County became part North Central RSA. North Sound RSA implemented the integrated model in July 2019. The remaining regions will implement AH-IMC on January 1, 2020:

- Great Rivers RSA (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties)
- Salish RSA (Clallam, Jefferson, and Kitsap counties)
- Thurston-Mason RSA (Mason and Thurston counties)

Attachment 4, July 2019 Apple Health – Integrated Managed Care Model Contract, is attached for reference.

Attachment 6, Apple Health Managed Care Service Area Matrix, and Attachment 7, Apple Health Regional Service Area, show which MCOs serve Enrollees in each Region and County.

1.1.5. Apple Health - Integrated Managed Care Behavioral Health Services Wraparound (IMC Wraparound)

All AH-IMC plans are required to hold a second contract to address state-funded services for Apple Health (Medicaid) enrollees, called "IMC Wraparound" or "Apple Health – Integrated Managed Care

Behavioral Health Services Wrap-around" Contract. The services covered within the IMC Wraparound contract is not covered within the scope of this RFP as it is not funded by Medicaid services; however, the MCOs contracted for this service are the same MCOs referenced throughout this RFP.

1.1.6. Apple Health - Integrated Foster Care

The Apple Health - Integrated Foster Care (AH-IFC) program provides integrated managed physical and behavioral health coverage to children and youth in foster care statewide, with benefits equivalent to AH-IMC. HCA contracts with one MCO, Coordinated Care of Washington, Inc., to provide this program, called Apple Health Core Connections. The AH-IFC program administers benefits and provides care coordination specifically focused to support children and youth who are:

- Under the age of 21 in foster care (out-of-home placement) through Department of Child, Youth, and Family (DCYF) placement
- Under the age of 21 receiving adoption support
- Young adults in extended foster care (18-21 year olds)
- Young adults 18-26 who aged out of foster care on or after their 18th birthday (alumni)
- Children and youth reunified with their families (eligible for 12 months after foster care ends)

Children in foster care are auto-enrolled into this plan. Adoption support and alumni have the ability to opt out this program and into Fee-For-Service. If these clients opt out, Fee-For-Service provides their physical health services and they must opt into one of the five MCOs to provide Behavioral Health Services Only (BHSO). Foster care coverage became integrated on January 1, 2019.

Attachment 5, July 2019 Apple Health – Integrated Foster Care Model Contract, is attached for reference.

1.1.7. Apple Health – Integrated Foster Care Behavioral Health Services Wrap-around (IFC Wraparound)

The AH-IFC plan is required to hold a second contract to address state-funded services for Apple Health (Medicaid) IFC enrollees, called "IFC Wraparound" or "Apple Health – Integrated Foster Care Behavioral Health Services Wrap-around" Contract. The services covered within the IFC Wraparound contract is not covered within the scope of this RFP as it is not funded by Medicaid services; however, the MCO contracted for IFC Wraparound services is the same IFC MCO (currently Coordinated Care of Washington) referenced throughout this RFP.

1.1.8. Behavioral Health Services Only (BHSO)

Apple Health offers Behavioral Health Services Only (BHSO) in all integrated regions for clients who are eligible for Apple Health, but not enrolled in managed care for physical health benefits. Clients enrolled in the Fee-For-Service program may select an MCO to provide their Behavioral Health Services Only. HCA will automatically enroll clients in BHSO coverage when a person is eligible for behavioral health services under Apple Health but receives their physical health coverage outside the managed medical care program (Fee-For-Service). This includes:

- Individuals with primary insurance through Medicare (traditional or Part C).
- Individuals in foster care who receive their medical care through the fee-for-service program (also referred to as coverage without a managed care plan).

- Certain individuals who have private insurance coverage.
- Clients who have met their spenddown
- Dual-eligible American Indian/Alaska Native (AI/AN) clients may opt in or out of BHSO coverage at any time.

The BHSO services are offered by the same MCOs administering Integrated Managed Care with BHSO marked as an enrollee program code designation. Washington State operates BHSO services under a 1915B waiver and classifies these as Prepaid Inpatient Health Plan (PIHP) services; these enrollees and services provided to them are included in the scope of this RFP. All mandatory EQR activities are addressed: Annual technical report (Section 1.2.1), PIP validation by HCA staff, compliance review by HCA staff, performance measure validation (Section 1.2.4), and validation of network adequacy (Section 1.2.7). The Apple Health – Integrated Managed Care Contract covers services for both IMC and BHSO enrollees (Attachment 4).

1.1.9. Behavioral Health Administrative Service Organization (BH-ASO)

The crisis system managed previously by the BHO is operated by a new entity in integrated regions called a Behavioral Health Administrative Service Organization (BH-ASO). BH-ASOs provide crisis services to any individual in the region, including MCO-enrolled individuals experiencing a behavioral health crisis. Crisis services are provided regardless of residence, income, insurance status, or ability to pay. These entities administer services such as:

- 24/7 regional crisis hotline for mental health and substance use disorder crises
- Mobile crisis outreach teams
- Short-term substance use disorder crisis services for individuals who are intoxicated or incapacitated in public
- Application of behavioral health involuntary commitment statutes, available 24/7 to conduct Involuntary Treatment Act (ITA) assessments and file detention petitions
- Regional Ombuds

Within available funding, a BH-ASO entity also has the discretion to provide outpatient behavioral health services or voluntary psychiatric inpatient hospitalizations for individuals who are not eligible for (non-Medicaid) or enrolled in Apple Health. Services provided through the BH-ASO to individuals not eligible for Apple Health are not covered under the scope of the EQRO review. Services provided through the BH-ASO to Apple Health enrollees are covered under the scope of the EQR activities through the MCO-focused work as formally delegated entities; no direct review by the EQRO of the BH-ASO is required. The BH-ASO may be included in quality improvement activities and education at the sole discretion of HCA.

1.1.10. Wraparound with Intensive Services (WISe)

1.1.10.1. WISe is a service delivery model that coordinates Medicaid-funded state plan services to serve children and youth (aged 0 through 20) with complex behavioral health needs in their homes and communities. WISe provides intensive behavioral health services and supports, care coordination, 24/7 crisis and stabilization interventions, and peer support. The goal of WISe is for youth to live and thrive in their homes and communities, as well as to avoid or reduce costly and disruptive out-of-home placements while receiving behavioral health treatment services. WISe is a result of a Settlement Agreement under

T.R. vs. Birch & Strange (formerly known as T.R. vs. Quigley & Teeter, referred here as T.R. Settlement), which the State is working to exit. Services were phased in to be available statewide, both within the Fee-For-Service system and managed care systems, starting within the Regional Services Network contracts, then transitioned to Behavioral Health Organization contracts in 2016, and will be fully within the MCO contracts statewide as of January 2020. The T.R. Settlement requires the quality reviews covered within this RFP comply with the WISe Program, Policy and Procedure Manual (Attachment 11) and the WISe Quality Plan (Attachment 12).

1.1.10.2. The EQRO role within the WISe work is to perform on-site provider chart reviews using the online Quality Improvement Review Tool (QIRT) from individual WISe client files and report summary of findings and any themes or concerns identified during the review not captured by the QIRT tool. The EQRO produces a provider-focused report for each provider reviewed to assist the provider in understanding their specific opportunities for improvement. The EQRO also produces a quarterly report rolling up the QIRT reviews conducted during that quarter to summarize themes across the system to inform MCOs and HCA about opportunities to improve the quality of the WISe program. The HCA WISe team separately analyzes the QIRT data input by the EQRO during the provider chart reviews. QIRT quality review data and recommendations are reviewed quarterly within the Quality Improvement Infrastructure described within the WISe Quality Plan.

1.1.11. Current Managed Care Organizations

The table below describes the current MCOs and the populations served in managed care arrangements.

Managed Care Organization	Washington Headquarters	Location of HEDIS® Audit	AH-IMC	AH-IFC
Amerigroup Washington, Inc. (AMG)	Seattle, Washington	Virginia Beach, Virginia	X	
Coordinated Care of Washington, Inc. (CCW)	Tacoma, Washington	Tacoma, Washington	X	X
Community Health Plan of Washington (CHPW)	Seattle, Washington	Seattle, Washington	X	
Molina Healthcare of Washington, Inc. (MHW)	Bothell, Washington	Long Beach, California	X	
UnitedHealthcare of Washington, Inc. (UHC)	Seattle, Washington	Seattle, Washington	X	

1.1.12. Eligibility and Enrollee Distribution

As of June 2019, there were 1,614,048 clients enrolled in managed care. Eligibility category descriptions and the June population distribution described below. Note: this distribution will change with the January 2020 integration.

Eligibility Category Descriptions	AMG	CHPW	CCW	MHW	UHC	June 2019 Enrollment	Percent (Program/ Total)
Adult Expansion (AHAC)	21,395	30,898	14,276	61,414	30,241	**158,224**	9.8%
Children's Health Insurance Program (CHIP)*	1,257	3,633	1,088	9,115	2,971	**18,064**	1.1%
AH-IMC (FIMC)**	119,961	154,741	126,516	561,522	98,877	**1,061,617**	65.8%
Women and Children Apple Health (AH/HO/TANF)	20,433	47,391	14,448	109,734	32,883	**224,889**	13.9%
Blind/Disabled Children and Adults (AHBD/HOBD)	3,321	6,226	2,670	11,529	4,474	**28,220**	17.5%
AH-IFC (AHFC)	0	0	23,855	0	0	**23,855**	14.8%
BHSO	21,761	20,182	17,331	27,647	12,258	**99,179**	6.1%
Total	**188,128**	**263,071**	**182,853**	**780,961**	**181,704**	**1,614,048**	**100%**

*Premium-based Washington Apple Health for Kids (AHK) or Children's Health Insurance Program (CHIP) provides healthcare for children up to age nineteen (19) in households with incomes above 210% of the Federal Poverty Level (FPL) but no more than 312% FPL who do not have other creditable coverage. CHIP clients receive MCO benefits through Apple Health - Integrated Managed Care and are included in the reference to the Apple Health program.

**The AH-IMC eligibility category (programming code FIMC) includes enrollees eligible for Apple Health through CHIP, AHAC, AH, and AHBD.

Newly eligible Medicaid clients and renewing clients choose or are auto-assigned into an MCO the day they become eligible. Their managed care enrollment is backdated to the beginning of the current month, a process HCA initiated in 2016 called "Earlier Enrollment". The intent of the change was to close the fee-for-service (FFS) gap between eligibility and enrollment. This change decreased the time on FFS with quicker health care coordination. Instead of having to wait a month or possibly two months before being enrolled, the client enrolls with the plan on the first day of the month that they became eligible.

In 2017, HCA began enrolling most fee-for-service Apple Health clients who have other primary health insurance into an MCO.

In July 2017, HCA implemented Medicaid suspension of eligibility for people who are institutionalized, allowing a Medicaid case to be suspended while an eligible recipient is in an institution, including jails or prisons. HCA is continuing to phase in implementation of this policy. Previous policy required eligibility to end during periods of institutionalization. Coverage does not end but a specific Recipient Aid Category (RAC) is applied allowing coverage through Apple Health for only inpatient hospitalizations lasting over 24 hours. When such individuals are released, their cases automatically shift to full-scope Medicaid coverage, increases access to coverage and facilitating better care coordination and health outcomes. This eligibility category affects work within the HEDIS® compliance audit (Section 1.2.4) due to NCQA rules about inclusion in the performance measure denominator.

1.1.13. Fee-for-Service (FFS) Program Services

The following healthcare services are covered by fee-for-service (FFS) for MCO enrollees:

- Dental care

- Orthodontia care (children only)
- Vision hardware (children only)
- Long-term care (covered by DSHS)

1.1.14. Washington Apple Health Primary Care Case Management (PCCM) and PCCM Entities

HCA contracts with PCCMs and PCCM Entities to provide services for American Indian/Alaska Native (AI/AN) clients. Tribal Clinics are contracted as PCCMs and both Tribal Clinics and Urban Indian Health Organizations are contracted as PCCM Entities per 42 C.F.R. 438.310(c)(2). No currently contracted Apple Health PCCM Entity provide for shared savings, incentive payments or other financial reward for the PCCM entity for improved quality outcomes; therefore, none meet C.F.R. requirements for EQR (42 C.F.R. 438.358 (b)(2)).

1.1.15. Value-Based Purchasing (VBP)

1.1.15.1. Value-based payment is a reimbursement method for health care services aimed at rewarding value (quality of health care), not volume (payment for each service). The traditional health care reimbursement path contributes to unnecessary spending and fragmented care. The state is using its purchasing power to lead by example and accelerate the adoption of value-based reimbursement and alternative payment strategies. HCA is working with other private and public health care purchasers to further spread the paying for value strategy and accelerate market transformation. HCA implemented this strategy in multiple lines of business, including Medicaid managed care. In 2017, HCA initiated VBP within the HCA-MCO Medicaid contracts to incentivize MCOs to implement value-based contracting and paying for quality outcomes within MCO-provider contracts. In 2019, legislation passed to further guide this work, including specifying the role of the EQRO within the VBP work and require two types of VBP measures. The two types of VBP measures specified are shared measures (called common measures within the Proviso) which are the same measure for all MCOs and MCO-specific measures (called qualify focus measures) focused on individual MCOs and areas needing improvement. The legislation is Engrossed Substitute House Bill (ESHB) 1109, Section 211 (50), State of Washington, 66th Legislature, 2019 Regular Season (the Proviso), excerpted for reference in Attachment 9 and available at: http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/1109-S.PL.pdf.

1.1.15.2. The EQRO role within HCA's VBP strategy is to annually recommend VBP measures for the upcoming contract year and then annually evaluate MCO performance of the previous year measures. The first year the EQRO participated in the recommendations aspect of the VBP work was 2019; the evaluation component by the EQRO as described in the Proviso will start in 2020. Thus far, HCA evaluated the VBP performance measure outcomes of the MCOs using the validated HEDIS® performance data reported through the EQRO process. The performance measure evaluation (and related payment for quality outcomes) is one component of HCA's VBP reimbursement strategy; the overarching strategy also incentivizes MCOs for contracting with providers using alternative payment methodologies. This work is validated through a different subcontractor process and all VBP outcomes are compiled at HCA for reimbursement of MCOs.

1.1.15.3. The expectations for the VBP Recommendation work are to assess, analyze, and recommend performance measures. The EQRO will assess available measures, analyze whether the measures meet the criteria specified in the Proviso, determine whether there are any measure considerations for HCA to be aware of in selection of the measures (e.g., measure retiring, data maturity concern), evaluate measures for VBP work in light of HCA

guiding principles, and make recommendations to HCA of priority measures. Analysis and recommendations may include HEDIS and non-HEDIS measures. EQRO measure recommendations must address both measure types, shared and MCO-specific; be data-driven; and be sufficient selection of each type for HCA to comply with the Proviso for determining the measures in the upcoming contract year. HCA will select and assign the final measures to the MCOs.

1.1.15.4. The expectations for the VBP Evaluation work are to analyze VBP performance measures by plan and report on whether the criteria were met. The EQRO will collect and analyze the previous year's performance measure data for each MCO, perform statistical significance testing, compare the performance to the national NCQA 75th percentile, and report on this performance in writing. The results of the performance measure evaluation have a direct effect on the reimbursement to the MCOs.

1.2. OBJECTIVES AND SCOPE OF WORK

In order to comply with federal regulations under Subpart E, External Quality Review, 42 C.F.R. § 438.310 through 42 C.F.R. § 438.370, this Request for Proposal (RFP) seeks responses from organizations to provide External Quality Review (EQR) activities that will enable HCA to comply with federal EQR requirements issued as part of the final rule for the Balanced Budget Act (BBA) of 1997. The Apparent Successful Bidder (ASB) awarded by this RFP will serve as the State of Washington's EQRO as required by 42 C.F.R. § 438.356 for the Medicaid managed care programs.

The EQRO is expected to perform the following work with associated deliverables detailed in the Contract (Draft Sample Contract is attached as Exhibit F):

1.2.1. External Quality Review Annual Technical Report (42 C.F.R. § 438.364):

1.2.1.1. Annually produce an External Stakeholder Report describing the manner in which data from all activities conducted in accord with 42 C.F.R. § 438.358 are collected and aggregated. Data related to the quality, timeliness, and access to care furnished by Medicaid managed care will be analyzed and synthesized into an annual report.

1.2.1.2. The technical report will be written in accord with 42 C.F.R. § 438.364, External Quality Review Results. This report must include EQRO-contracted findings as specified by C.F.R. as well as EQR activities conducted by the state, such as compliance monitoring and PIP validation. HCA will provide annual TEAMonitor reports with findings from HCA compliance monitoring and PIP validation activities. The technical report shall include all EQR-activities conducted regarding the PIHP-contracted BHSO enrollees.

1.2.1.3. As of January 2020, the HCA intends to contract with five MCOs that meet the C.F.R. requirements to include in the Annual Technical Report, within both AH-IMC and AH-IFC contracts. Any future managed care entities contracted with HCA, which meet the C.F.R. requirement for inclusion are assumed to be included within this deliverable.

1.2.1.4. The report shall include:

1.2.1.4.1. An assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Apple Health recipients;

1.2.1.4.2. Recommendations for improving the quality of health care services furnished by each MCO.

1.2.1.4.3. Methodologically comparative information about all MCOs.

1.2.1.4.4. An assessment of quality of data collected and recommendations regarding improving data collection and usability to improve performance improvement both for the state and MCOs.

1.2.1.4.5. Attachment 1, 2018 Technical Report, provides an example using the most recent publication.

1.2.2. Performance Measure Comparative Analysis (42 C.F.R. § 438.364):

1.2.2.1. Produce the Performance Measure Comparative Analysis Report with regional analysis. Conduct analyses of MCO performance measures including comparisons amongst the MCOs, comparisons with a calculated MCO state average, and state or national benchmarks, such as NCQA ninetieth (90th) percentile for Medicaid managed care organizations; and produce charts and tables displaying the data.

1.2.2.2. Performance will include a between-program comparison (e.g. Blind/Disabled and CHIP) and race/ethnicity/language sub-analysis. Narrative will include recommendations regarding racial/ethnic/language break-out when data supports specific intervention to address health equity.

1.2.2.3. Performance measure data will be compared to Washington State peer MCOs, the state average, and national Medicaid all plan HEDIS® performance or other benchmarks if there is regional or national benchmark data by which to compare performance.

1.2.2.4. Performance measure data will be analyzed regionally to identify differences in regional performance across all MCOs using HCA RSA geographic boundaries. Narrative to include recommendations regarding specific RSAs when data supports specific intervention to address regional disparity. Additionally, when disparity identified, further analysis provided to detail findings and recommendations by MCO, by region, race, ethnicity, language.

1.2.2.5. Tables and charts shall include plan-to-plan comparison, plan-to-state all MCO average, and MCO to national or regional MCO benchmarks all depicted in graphs and charts. An appendix containing all data must be part of the Comparative Analysis Report; as in Appendix B in the attached sample report.

1.2.2.6. Any narratives accompanying charts and graphs should be based on the most current, peer-reviewed literature and national and regional trends for Apple Health (Medicaid) enrollees.

1.2.2.7. The target audience is HCA, MCOs, Washington State legislature, and other interested stakeholders. The report is publically posted on HCA's website.

1.2.2.8. Attachment 2, 2018 Comparative Analysis Report, provides an example using the most recent publication. Note: Attachment 2 does not include the regional analysis within the same document; rather, the regional analysis is provided within a separate report, Attachment 3, 2018 Regional Analysis Report, is an example.

1.2.3. Enrollee Quality Report

1.2.3.1. Produce annual enrollee quality report (informally termed the Star Report) showing MCO performance on a subset of Performance Measures and Consumer survey data for the

Washington State Health Benefit Exchange (HBE) website, called Healthplanfinder (HPF). This report will be used by Apple Health recipients to select a MCO for enrollment.

1.2.3.2. The report will be produced annually in September. Survey data will be included based on availability, at HCA's direction.

1.2.3.3. Attachment 1, 2018 Technical Report, provides a sample of the current Apple Health enrollee quality report. (See the last page of the 2018 Annual Technical Report for the most recent publication, called 2018 Washington Apple Health Plan Report Card). Note: The sample provided does not include survey data.

1.2.3.4. Once the performance measures and methodology is released by CMS, the Bidder will work with HCA to ensure compliance with the Medicaid managed care quality rating system as required by 42 C.F.R. § 438.334.

1.2.4. Validation of Performance Measures (438.358(b)(2)):

1.2.4.1. Annual validation of MCO methods used to collect Healthcare Effectiveness Data and Information Set (HEDIS®), and non-HEDIS Performance Measures as agreed upon by the Contractor and HCA.

1.2.4.1.1. The validation process for HEDIS® data will be accomplished through methods described in the most recent version of the National Committee for Quality Assurance (NCQA) HEDIS® Compliance Audit™. Specifications shall be complemented by the Centers for Medicare and Medicaid Services (CMS) Validating Performance Measures. The External Quality Review Protocols can be found at Quality of Care External Quality Review | Medicaid.gov: (https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html).

1.2.4.1.2. An audit will be conducted annually. All Apple Health MCOs are subject to these requirements, which are inclusive of ACA Adults, TANF/Apple Health, Blind/Disabled, CHIP, and AH-IFC populations.

1.2.4.1.3. If an MCO is required to produce both HEDIS® and non-HEDIS Performance Measures, methods combining both the NCQA and CMS auditing approaches will be employed so as to reduce MCO burden and meet the specifications required in regulation.

1.2.4.1.4. The following assumptions for conducting the audit include:

1.2.4.1.4.1. All current, contracted Apple Health MCOs (five [5] MCOs), are NCQA-accredited, as required by contract. Plans entering the market will be required to become NCQA accredited within three (3) years of entering the Apple Health market. These MCOs will be required to produce the full set of HEDIS® Performance Measures according to NCQA fully accredited plans and submit to a full accreditation audit following achievement of accreditation status.

1.2.4.1.4.2. All contracted MCOs will be required to submit Performance Measures according to NCQA specifications for reporting, unless otherwise defined by Apple Health Contracts.

1.2.4.1.4.3. All MCOs will be subject to an annual, full HEDIS® audit.

1.2.4.1.4.4. For the single MCO (currently Coordinated Care of Washington, Inc.) contracted for both AH-IMC and AH-IFC, both populations (AH-IFC and AH-IMC) will be included within the annual, full HEDIS® audit.

1.2.4.1.4.5. Children enrolled in the CHIP program are not subject to separate performance measure requirements, as this population is included within the HEDIS® audit.

1.2.4.1.4.6. A copy of the list of performance measures required in each contract is found in Attachment 4, July 2019 Apple Health – Integrated Managed Care Model Contract, and Attachment 5, July 2019 Apple Health – Integrated Foster Care Model Contract, Section 7, and the contracts' *Attachment 2*.

1.2.4.1.4.7. The audit meets the C.F.R. requirements for compliance monitoring of Health Information Systems (42 C.F.R. § 438.242).

1.2.4.2. Performance measure validation for the PIHP-contracted work. The assumptions for this work are:

1.2.4.2.1. BHSO enrollees receive care through the five MCOs. Federal classification requires these services to operate as a PIHP, requiring performance measure validation.

1.2.4.2.2. Validation shall be per MCO at the statewide level, conducted annually, and may include up to four non-HEDIS, behavioral health performance measures. The data is analyzed by Research and Data Administration (RDA) staff within the Department of Social of Health Services. HCA and RDA are training MCOs on the measure specifications for individual MCO measure tracking and reporting.

1.2.4.2.3. The Bidder shall meet with HCA and Research and Data Administration (RDA) staff within the Department of Social of Health Services (DSHS) to facilitate the transfer of data necessary to complete the validation between August and November annually.

1.2.5. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) (42 C.F.R. § 438.358(c)(2)):

1.2.5.1. Analyze and report on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, which may include administering the survey, validating MCO survey samples, and/or aggregating MCO CAHPS® data for either Apple Health contract. Survey may be Medicaid CAHPS® Adult, Child, or Child with Chronic Conditions survey.

1.2.5.1.1. Collect raw data, aggregate MCO CAHPS® survey data, and produce a statewide report of the CAHPS data conducted by the MCO CAHPS vendors. The survey may be Medicaid CAHPS® Adult or Child with Chronic Conditions survey, as determined by the Apple Health contract and rotated every year between Adult and Child with Chronic Conditions.

1.2.5.1.2. Administer statewide Medicaid Child CAHPS® survey every other year, specific to the CHIP population. The survey will be conducted in even years beginning in 2020. The population meeting CAHPS® specifications will be drawn by HCA and provided to the Contactor. A statewide sample will be selected from the

population by the Contractor. The Contractor will conduct the survey and produce a survey report.

1.2.5.1.3. Review and report results for the IFC-specific CAHPS® survey annually, when the contract requires the IFC MCO to conduct a CAHPS specific to this population. Provide a summary of strengths and recommendation to the HCA. Summary level results and reporting shall be included within the Technical Report.

1.2.5.2. The following tasks will be performed by the Contractor when administering a CAHPS® survey:

1.2.5.2.1. Conduct the MCO sample validation; or when the Contractor conducts the survey for HCA, verify clean, survey sample data.

1.2.5.2.2. Follow Mixed Mode Methodology of survey administration, consisting of a minimum of: two (2) questionnaire mailings, two (2) reminder post cards, and up to six (6) phone attempts.

1.2.5.2.2.1. The Contractor may administer surveys using on-line survey capability if email contact information is available and known by survey vendor; and

1.2.5.2.2.2. Use enrollee incentives or similar approaches to increase survey response.

1.2.5.2.3. Administer the survey in English with the option to complete the survey in Spanish.

1.2.5.2.4. Complete administrative forms (e.g., survey introductory letter and post card reminders to enrollees).

1.2.5.2.5. Submit weekly survey disposition reports to the HCA Contract Manager.

1.2.5.2.6. Prepare member level data files and dictionaries for each population surveyed.

1.2.5.2.7. Produce MCO reports that include each population surveyed.

1.2.5.2.8. Raw data (frequency tables in EXCEL) on each completed survey question to send to each MCO and HCA;

1.2.5.2.9. Case mix adjusted ratings (below average, average, and above average) for each Managed Care program. Average is the statewide mean;

1.2.5.2.10. SAS flat file that contains all responses in the original sample, both responders and non-responders with identifiers removed, including a data dictionary;

1.2.5.2.11. CAHPS® Database report following the data submission requirements; include a copy to HCA of a flat file in SAS and/or other appropriate format on all completed survey questions for adult and child samples;

1.2.5.2.12. Production of annual CAHPS® stakeholder report provided in electronic format only, in PDF and Word file formats.

1.2.6. Value-Based Purchasing (VBP) Performance Measure Recommendation and Evaluation

1.2.6.1. This work shall be consistent with Engrossed Substitute House Bill (ESHB) 1109, Section 211 (50), State of Washington, 66th Legislature, 2019 Regular Season (the Proviso), excerpted for reference in Attachment 9 and available at: http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/1109-S.PL.pdf.

1.2.6.1.1. For the first year of the contract in 2020, the first stage of implementing the Proviso will require evaluation to be of the previously determined VBP performance measures as contracted with the MCOs in 2019 Apple Health contracts. Beginning in 2021 and thereafter, evaluation of performance measures will be consistent with the Proviso, using the measures selected by HCA following recommendations by the EQRO.

1.2.6.2. This work may include non-HEDIS measures, at the sole discretion of HCA. The Proviso allows selection of up to two MCO-specific measures without top Medicaid quartile performance data. Measures in this category require discussion and planning for VBP evaluation with HCA and EQRO data staff prior to selection.

1.2.6.3. VBP Performance Measure Recommendation: Analyze and make recommendations to HCA annually for the selection of the VBP measures to be used for the upcoming year Apple Health contracts.

1.2.6.4. The assumptions for the VBP Performance Measure Recommendation work are:

1.2.6.4.1. Assess all available measures for inclusion in the Recommendation, including HEDIS®, State Common Measure Set, and State-specific RDA behavioral health measures as directed by HCA.

1.2.6.4.2. Recommend at least 8 shared measures meeting the requirements of the legislation: "…four common measures across each managed care organization, including: (A) At least one common measure must be weighted towards having the potential to impact managed care costs; and (B) At least one common measure must be weighted towards population health management, as defined by the measure;…"

1.2.6.4.3. Recommend at least 6 measures for each MCO, called MCO-specific measures meeting the requirements of the legislation: "…an additional three quality focus performance measures specific to a managed care organization. Quality focus performance measures chosen by the authority must: (A) Be chosen from the statewide common measure set; (B) Reflect specific measures where a managed care organization has poor performance; and (C) Be substantive and clinically meaningful in promoting health status."

1.2.6.4.4. Recommendations will be in alignment with current HCA Quality Management, Monitoring and Improvement (QMMI) Guiding Principles for Measure Selection for Contracts, summarized below:

1.2.6.4.4.1. Improve health outcomes

1.2.6.4.4.2. Increase alignment across state contracts

1.2.6.4.4.3. Decrease the administrative burden of measurement

1.2.6.4.4.4. Decrease/avoid unintended consequences

1.2.6.4.5. Recommendations will be based on analysis of the most recent performance measure data, such as current year HEDIS® results, finalized in June each year.

1.2.6.4.6. Meet with HCA between June and September annually regarding the status of work. Meetings scheduled on a weekly basis until selection of measures is complete.

1.2.6.4.7. Provide VBP Performance Measures Recommendation Narrative Report and Data Tool by the end of July annually. The Narrative Report shall address assumptions; rationale for each performance measure selected; whether selected measures meet criteria; definitions and framework for criteria; and recommended and prioritized measures. The accompanying Data Tool shall provide detailed data reflecting the evaluation of performance measures and MCO performance of those measures in table format (e.g., using Microsoft Excel). The Data Tool shall address all measures evaluated, measures not selected with rationale, recommended measures indicated by type of measure (shared vs. MCO-specific) with rationale.

1.2.6.4.8. Present recommendations to HCA Quality Leadership at the Clinical Quality Council meeting in August in-person at HCA, including PowerPoint presentation and visual display of data. Summarize the VBP recommendations, present rationale and supporting data, and respond to questions to assist HCA in completing the final selection of measures.

1.2.6.5. VBP Performance Measure Evaluation: Evaluate individual MCO VBP performance annually.

1.2.6.5.1. The EQRO will collect and analyze the previous year's performance measure data for each MCO, perform statistical significance testing to determine if statistically significant improvement was made over the year, compare the performance to the national NCQA Medicaid 75th percentile to determine if the MCO reached that threshold, and report on this performance in writing by measure per MCO. The assumptions for the VBP Performance Measure Evaluation work are:

1.2.6.5.1.1. Collect, analyze, and report on individual MCO performance in VBP measures, as selected by HCA. Analysis must include:

1.2.6.5.1.1.1. Standard tests of statistical significance to show if there has been statistically significant improvement

1.2.6.5.1.1.2. Comparison to the top national Medicaid quartile of performance measure to determine if the MCO reached this threshold. The current year 75th percentile Medicaid HMO values will be used within the NCQA Quality Compass® for HEDIS® measures. Where top national Medicaid quartile performance data is unavailable, an alternative methodology is to be used to approximate top national quartile performance for no more than two MCO-specific measures.

1.2.6.5.2. Provide VBP Performance Measures Evaluation Report annually, including narrative and supporting data in tables and charts for both the shared measures and the MCO-specific measures. Display data for each MCO and collectively for shared measures.

1.2.7. Validation of Network Adequacy (42 C.F.R. § 438.358 (b)(iv)

1.2.7.1. HCA complies with network adequacy standards required by 42 C.F.R. 438.68. The EQRO is required to validate MCO network adequacy, per 42 C.F.R. § 438.358, when the methodology for validation is released by CMS in a revised EQRO protocol. CMS has not yet released their protocol, and HCA will work with the ASB to define the processes after the protocol is released.

1.2.8. Communication and Education

1.2.8.1. Provide Quality Improvement Education to MCOs, BH-ASOs, and HCA to support system-wide quality improvement and HCA quality initiatives. The Contractor will provide in-person, educational quality forums to keep key stakeholders informed and involved in quality initiatives.

1.2.8.2. In-person quality forums events held annually in Olympia, WA. The location and catering must accommodate stakeholder attendance of up to three per entity, in addition to HCA staff, to equal approximately 50 attendees.

1.2.8.3. Develop a plan to elicit input from MCOs and other stakeholders about their educational needs and how this information will be used to develop the educational meetings.

1.2.8.4. Lead agenda preparation, topic selection, and speaker arrangement, with consultation and approval from HCA to inform this work.

1.2.8.5. Submit written materials intended for MCO communication or education activities to HCA for approval in advance of distribution to stakeholders.

1.2.9. Wraparound with Intensive Services (WISe) Quality Improvement Review Tool (QIRT) Reviews (42 C.F.R. § 438.358(c)(5)). HCA is currently funded for these activities for the first 18 months of the contract (January 2020 through June 2021).

1.2.9.1. Perform and report on WISe provider chart reviews using the on-line Quality Improvement Review Tool (QIRT) from documentation within individual WISe client files.

1.2.9.2. The WISe quality review work contracted through this RFP shall be in alignment with the Settlement Agreement under T.R. vs. Birch & Strange (formerly known as T.R. vs. Quigley & Teeter), the HCA's *WISe Program, Policy and Procedure Manual*, and the *WISe Quality Plan*.

1.2.9.2.1. The current version of the *WISe Program, Policy and Procedure Manual* can be found at https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf and is in Attachment 11 for reference.

1.2.9.2.2. The current *WISe Quality Plan* is available at https://www.hca.wa.gov/assets/program/WISe%20Quality%20Plan%20Final.pdf and is in Attachment 12 for reference.

1.2.9.3. The following assumptions for conducting the QIRT activities include:

1.2.9.3.1. The reviews are quality improvement-focused activities intended to inform providers, MCOs, the HCA, and other stakeholders about how to improve the WISe delivery system for clients and families.

1.2.9.3.2. The WISe providers and individual records to be reviewed will be selected by HCA. HCA will perform corresponding client and family interviews to complement the chart review to complete the quality review feedback.

1.2.9.3.3. On-site review of provider charts is necessary to complete the QIRT. Providers are located throughout the state. Each on-site review will be over a two (2) day period.

1.2.9.3.4. Approximately 20-25 providers will be reviewed each fiscal year.

1.2.9.3.5. QIRT reviews will use the on-line tool to focus on specific modules to provide quality improvement feedback regarding specific aspects of the delivery system.

1.2.9.3.6. Reviews will utilize three (3) reviewers who have been trained in the QIRT review tool by HCA, and who have met QIRT reliability assessment standards. For reviewers without previous QIRT experience, HCA will provide QIRT training and reliability assessment. Training requires reviewers to attend two full days in-person.

1.2.9.4. The Contractor shall produce Individual Provider QIRT Reports identifying recommendations for provider improvement, summary of the findings, and provider strengths. Reports should focus on themes and issues not captured within the QIRT data during chart review. Expected length for each Individual Provider QIRT Report is three (3) pages.

1.2.9.4.1. The Contractor shall use and include QIRT-generated dashboards and information identified during the provider QIRT reviews.

1.2.9.4.2. The primary audiences of the Provider QIRT Reports are the individual providers in order to support practice improvement. The Contractor shall submit a draft to HCA for approval and then HCA will distribute the final report to providers and MCOs.

1.2.9.5. The Contractor shall produce quarterly QIRT Summary Reports to provide trends in findings and make recommendations to HCA and MCOs on areas of improvement on the quality of WISe services. Expected length for each quarterly QIRT Summary Report is five (5) pages.

1.2.9.5.1. The Contractor shall use and include an aggregated QIRT-generated dashboard and information identified during the individual QIRT reviews.

1.2.9.5.2. The primary audiences of the quarterly QIRT Summary Reports are the HCA and MCOs in order to support system change and quality improvement. The Contractor shall submit a draft to HCA for approval and then HCA will distribute the final report to the MCOs and through the WISe Quality Improvement Infrastructure.

1.2.9.6. The QIRT quality reviews meets C.F.R. EQR activities for to conduct studies on quality that focus on a particular aspect of clinical services at a point in time (438.358(c)(5)).

1.3. MINIMUM QUALIFICATIONS

The following are the minimum qualifications for Bidders:

1.3.1. Licensed to do business in the State of Washington or provide a commitment that it will become licensed in Washington within 30 calendar days of being selected as the Apparent Successful Bidder.

1.3.2. Compliance with HIPAA Security, Privacy, and Breach Notification Rules (45 C.F.R. § 164).

1.3.3. Compliance with Washington State Office of Chief Information Officer (OCIO) Security Standard 141.10 (https://ocio.wa.gov/policy/securing-information-technology-assets-standards). Compliance will be determined in HCA's sole discretion. Submit the following as evidence of compliance:

1.3.3.1. Most recent Service and Organization Controls (SOC) 2 Report (or equivalent); and

1.3.3.2. Response indicating how Bidder will meet requirements of OCIO 141.10, Sections 4, 5, 6, 7, 8, 10, and 11.

1.3.4. Agree to undergo and pass a Security Design Review conducted by HCA or Washington Technology Solutions (WaTech), if required. Office of CyberSecurity (OCS) Design Review Checklist, Attachment 8.

1.3.5. Organizations must have submitted a Letter of Intent to Propose by August 15, 2019, 2:00 p.m. in order to be eligible to submit a response to this RFP.

1.3.6. A minimum of five (5) years' experience performing External Quality Review activities under federal regulations 42 C.F.R. Subpart E.

1.3.7. Have leadership staff (CEO, CMO, Contract Manager, and Analytical Lead; including any subcontractor lead staff) with skills, experience, and knowledge of:

1.3.7.1. Medicaid beneficiaries, policies, and processes;

1.3.7.2. Managed care regulations, program, and data systems;

1.3.7.3. Managed Care delivery systems, organizations, and financing;

1.3.7.4. Both physical and behavioral health care services;

1.3.7.5. Quality assessment and performance improvement methods;

1.3.7.6. Survey methods;

1.3.7.7. Research design and methodology, including statistical analysis; and

1.3.7.8. Writing and publication skills.

1.3.8. Be independent from the State Medicaid agency and from the MCOs that they review. "Independence", as defined in §438.354(c) means:

1.3.8.1. If a State agency, department, university or other State entity: may not have Medicaid purchasing or managed care licensing authority and, must be governed by a Board or similar body the majority of whose members are not government employees.

1.3.8.2. An EQRO may not:

1.3.8.2.1. Review any MCO, PIHP, PAHP, or PCCM entity, or a competitor operating in the State, over which the EQRO exerts control or which exerts control over the EQRO ("control" has the meaning given the term in 48 C.F.R. § 19.101) through: (A) stock ownership; (B) stock options or convertible debentures; (C) voting trusts; (D) common management, including interlocking management; and (E) contractual relationships.

1.3.8.2.2. Deliver any health care services to Medicaid beneficiaries.

1.3.8.2.3. Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO, PIHP, PAHP, or PCCM entity services, except for the related activities specified in 42 C.F.R. § 438.358.

1.3.8.2.4. Review any MCO, PIHP, PAHP, or PCCM entity for which it is conducting or has conducted an accreditation review within the previous three (3) years.

1.3.8.2.5. Have a present, or known future, direct or indirect financial relationship with an MCO, PIHP, PAHP, or PCCM entity that it will review as an EQRO.

1.3.9. The Bidder must have experience working with a governmental agency within the past five (5) years.

1.3.10. The Bidder must be a National Committee for Quality Assurance (NCQA)-certified Consumer Assessment of Health Plans Survey (CAHPS®) vendor, or subcontract with a vendor with this certification/qualifications.

1.3.11. The Bidder must be an organization, or subcontract with a vendor, that is NCQA-Licensed licensed to conduct HEDIS® audits.

1.3.12. Have at least 70% of staff located in Washington State with dedicated office space and experienced with Washington health care, culture, and geography dedicated to this Contract. Minimum availability of day-to-day business operations must be Monday through Friday from 8:00 a.m. to 5:00 p.m.

1.3.13. The Bidder must have staff assigned to the on-site Quality Improvement Review Tool (QIRT) reviews who are experienced in behavioral health services, research collection, clinical chart review, and trained to use the QIRT. HCA recognizes that bidders may not have experience with the WISe program or the Washington-specific QIRT. The *WISe Program, Policy, and Procedure Manual* and *WISe Quality Plan* are included as attachments in this RFP (Attachments 11 and 12, respectively). Training on use of the QIRT is provided by HCA or its subcontractors, and must be completed in-person within 15 days of Contract signature. The Bidder must attest to being willing to comply with QIRT training requirements and commit to meeting this requirement.

Bidders who do not meet and demonstrate these minimum qualifications, in HCA's sole discretion, will be rejected as non-responsive and will not receive further consideration. Any Proposal that is rejected as non-responsive will not be evaluated or scored.

1.4. FUNDING

HCA has budgeted an amount not to exceed $1,229,047.00 for this Contract per fiscal year, plus an amount not to exceed $805,945.00 specifically devoted to the WISe QIRT reviews for January 2020 to July 2021. Proposals in excess of $1,784,992.00 for the first calendar year (which includes funding of $1,229,047 for EQRO and $555,945 for WISe QIRT) will be considered non-responsive and will not be evaluated. See the below table for further clarification.

Funding Available	FY20 for January 2020 – June 2020	FY21: July 2020 – June 2021	Each FY thereafter
EQRO, excluding WISe QIRT Funding	$614,523.50	$1,229,047.00	$1,229,047.00
WISe QIRT Funding	$305,945.00	$500,000.00	Currently Not Funded
Total	$920,468.50	$1,729,047.00	$1,229,047.00

Any contract awarded as a result of this procurement is contingent upon the availability of funding.

1.5. PERIOD OF PERFORMANCE

The period of performance of any contract resulting from this RFP is tentatively scheduled to begin on or about January 1, 2020 and to end on December 31, 2023. Amendments extending the period of performance, if any, will be at the sole discretion of HCA.

HCA reserves the right to extend the contract for up to three (3) additional years.

1.6. CONTRACTING WITH FORMER OR CURRENT 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.

1.7. DEFINITIONS

Definitions for the purposes of this RFP include:

Accountable Communities of Health (ACH) means regionally governed, public-private collaborative or structure tailored by the region to align actions and initiatives of a diverse coalition of partners in order to achieve healthy communities and populations. For the purposes of this RFP, ACH is interchangeable with the term Communities of Health or COH.

Apparent Successful Bidder (ASB) means 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.

Balanced Budget Act (BBA) means a congressional law and set of statutes that amends and modifies Apple Health regulations. The rules can be found in 42 C.F.R. § Part 438, Subparts A through J.

Behavioral Health Organization (**BHO**) means a single or multiple-county authority or other entity operating as a prepaid inpatient health plan through which the agency or the agency's designee contracts for the delivery of community outpatient and inpatient mental health and Substance Use Disorder services in a defined geographic area to Enrollees who meet Access to Care Standards. BHOs meet the C.F.R. definition of Prepaid Inpatient Health Plan (PIHP) as BHOs provide services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.

Bidder means an individual or company interested in the RFP that submits a proposal in order to attain a contract with the Health Care Authority.

Blind or Disabled (B/D) means Washington Apple Health program serving individuals who are blind or disabled, including those seeking disability determinations.

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.

Business Days and Hours means Monday through Friday, 8:00 a.m. to 5:00 p.m., Pacific Time, except for holidays observed by the State of Washington.

CAHPS® Database (previously known as National CAHPS® Benchmarking Database or NCBD) means a national repository for data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The database facilitates comparisons of CAHPS® survey results by survey sponsors. Data is compiled into a single national database, which enables NCBD participants to compare their own results to relevant benchmarks (i.e., reference points such as national and regional averages). The NCBD also offers an important source of primary data for specialized research related to consumer assessments of quality as measured by CAHPS®.

Centers for Medicare and Medicaid Services (CMS) means the federal agency within the U.S. Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

Children's Health Insurance Program (CHIP) means a program to provide access to medical care for children under Title XXI of the Social Security Act, the Children's Health Insurance Program Reauthorization Act of 2009, RCW 74.09.470 and WAC 388-505.

Code of Federal Regulations (C.F.R.) means the codification of the general and permanent rules and regulations (sometimes called administrative law) published in the Federal Register.

Communities of Health (COH) means a term used by the Washington State Legislature in Chapter 223, Laws of 2014 (E2SHB 2572) and interchangeable with Accountable Communities of Health.

Confidential Information means information that is exempt from disclosure to public or other unauthorized persons under 42.56 RCW or other federal or state laws. Confidential Information includes, but is not limited to, Personal Information and Protected Health Information.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) means a suite of commercial and Apple Health standardized survey instruments used to measure client experience of health care.

Data means information that is disclosed or exchanged between HCA and Apparent Successful Bidder. Data includes Confidential Information.

Department of Children, Youth, and Families (**DCYF**) means the Washington State agency responsible for keeping Washington children safe, strengthening families and supporting foster children in their communities.

Department of Social and Health Services (**DSHS**) means the Washington State agency responsible for providing a broad array of health care and social services. DSHS administrations with which the Contractor may interface include, but are not limited to:

- Aging and Long-Term Support Administration is responsible for providing a safe home, community, and nursing facility array of long-term supports for Washington citizens.

- Developmental Disabilities Administration is responsible for providing a safe, high quality, array of home, community, and facility-based residential services and employment support for Washington citizens with disabilities.

Division of Behavioral Health and Recovery (**DBHR**) means the HCA-designated state behavioral health authority to administer state only, federal block grant, and Medicaid funded behavioral health programs.

Division of Medicaid Program Operations and Integrity (MPOI) means the division within HCA that works to develop and manage high-quality, evidence-based health care programs and purchase services that enhance Medicaid enrollees' ability to access appropriate, quality health care. Functions in the division include: processing of claims, monitoring managed care organizations, maintaining and monitoring contracts, and developing and implementing new programs. Program Integrity is responsible for oversight of the Medicaid program with focus on payment system accountability and detection of fraud, waste and abuse. The division also manages community services such as Maternity Support Services, Family Planning programs, interpreter and transportation services.

DUNS® Number means a Data Universal Numbering System which is a unique nine-digit sequence of numbers issued by Dun and Bradstreet to a business entity. Any organization that has a Federal contract or grant must have a DUNS Number.

Dun and Bradstreet (D&B) means a commercial entity, which maintains a repository of unique identifiers (D-U-N-S Numbers) recognized as the universal standard for identifying business entities and corporate hierarchies.

Enrollee means an individual who is enrolled in managed care through a Managed Care Organization (MCO) having a Contract with HCA (42 C.F.R. § 438.10(a)).

External Stakeholder Report means an annual, technical report synthesizing data from all Medicaid managed care quality oversight activities which includes conclusions regarding the quality, timeliness, and access to care furnished by the MCO to Medicaid eligibles enrolled in state managed care arrangements.

External Quality Review (EQR) means the review and evaluation by an External Quality Review Organization of information on quality, timeliness, and access to the health care and services that a Managed Care Organization (MCO) or their contractor(s) furnish to Apple Health recipients (42 C.F.R. § 438.320).

External Quality Review Organization (EQRO) means an organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354, and performs external quality review, other EQR-related activities as set forth in 42 C.F.R. § 438.358, or both (42 C.F.R. § 438.320).

External Quality Review Protocols means a series of nine (9) procedures or rules to monitor, measure, and document information on quality, timeliness, and access to the health care and services that an MCO or their contractors furnish to Apple Health recipients (42 C.F.R. § 438.350(e)).

Federal Poverty Level (**FPL)** means poverty guidelines issued each year in the Federal Register by the federal Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds for use for administrative purposes; for instance, determining financial eligibility for certain federal programs.

Fee-for-Service (FFS) means health care delivery program whereby Washington Apple Health clients are served by health care providers reimbursed on a per service or point of service basis.

Health Benefit Exchange (HBE) means a quasi-governmental Washington agency where an individual or small business can compare the costs of various health plans and different types of health coverage benefits.

Health Care Authority (HCA) means the Washington State Health Care Authority, an executive agency of the state of Washington that is issuing this RFP.

HCA Contract Manager means the HCA employee identified as the Staff Development Manager designated to manage and provide oversight of the day-to-day activities under this Contract. The HCA Contract Manager shall be the primary contact with Contractor concerning Contractor's performance under this Contract; Provided that, the HCA Contract Manager does not have authority to accept legal notices on behalf of HCA or amend this Contract.

Healthcare Effectiveness Data and Information Set (**HEDIS®)** means a set of standardized Performance Measures designed to ensure that health care purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. HEDIS® also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS® is sponsored, supported, and maintained by National Committee for Quality Assurance (NCQA).

HEDIS® Compliance Audit means a set of standards and audit methods conducted by a NCQA licensed organization used by an certified HEDIS® compliance auditor to evaluate information systems (IS) capabilities assessment (IS standards) and a Contractor's ability to comply with HEDIS® specifications (HD standards).

Healthplanfinder (HPF) means the official ACA-compliant Health Benefit Exchange on-line marketplace where a Washington citizen can shop for free and low-cost health plans.

Managed Care means a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty, and ancillary health services.

Managed Care Organization (MCO) means an organization having a certificate of authority or certificate of registration from the State of Washington Office of the Insurance Commissioner that contracts with HCA under a comprehensive risk contract to provide prepaid health care services to eligible HCA enrollees under HCA Managed Care program.

Mandatory (M) means the Bidder must comply with the requirement, and the Response will be evaluated on a pass/fail basis.

Medical Necessity or **Medically Necessary** means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. "Course of treatment" may include mere observation or, where appropriate no treatment at all.

Mixed Mode Methodology means a survey process where multiple methods are used to contact and survey respondents. Methods may include use of mail, phone or email to make contact with survey respondents to complete the intended survey.

National Committee for Quality Assurance (NCQA) means a private 501(c)(3) not-for-profit dedicated to improving health care quality. NCQA develops health care measures that assess the quality of care and services that commercial and Apple Health Managed Care clients receive.

Patient Protection and Affordable Care Act (PPACA) means Public Laws 111-148 and 111-152 (both enacted in March 2010).

Peer-Reviewed Medical Literature means medical literature published in professional journals that submit articles for review by experts who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

Performance Improvement Project (PIP) means activities conducted by Managed Care Organizations designed to improve the quality of care or services received by Apple Health enrollees (42 C.F.R. § 438.358).

Performance Measures means measures of the quality, timeliness, and access of care provided by Managed Care Organizations.

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.

Prepaid Inpatient Health Plan (PIHP) means an entity that—(1) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates. (2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract (42 C.F.R. § 438.2). The BHSO services contracted to the MCOs are classified as PIHP.

Proposal means a formal offer submitted in response to this solicitation.

Proprietary Information means information owned by Bidder to which Bidder claims a protectable interest under law. Proprietary Information includes, but is not limited to, information protected by copyright, patent, trademark, or trade secret laws. Bidder must mark all Proprietary Information as required in Section 2.6.

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.

Quality means the degree to which a Managed Care Organization increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Compass® means a report produced annually by NCQA which provides MCO-specific and national averages for HEDIS® measures and benchmark data for the Apple Health program.

Quality Improvement Review Tool (**QIRT**) means a WISe monitoring tool, either paper or on-line format, to assess the quality of services provided to children and youth served in the WISe model. The QIRT uses a case file review process to measure core practice components related to positive outcomes for children, youth and their families. The QIRT includes assessment of providers' capacity to implement child family teams and other WISe service components, via a module that reviews documentation of cross-system Child and Family Team

membership and participation in care planning. The online QIRT platform generates reports that match data about WISe services and practices, obtained from documentation reviews, with Child Adolescent Needs and Strengths (CANS) Screen outcome data. The QIRT facilitates aggregation and comparison across multiple levels (e.g. within and across provider agencies and regions, as well as statewide). The QIRT online platform matches practice data, including length of episode of care, with CANS data from BHAS.

Quality Strategy means a written document that describes methods HCA uses to assess and improve the quality of Managed Care services offered by all Managed Care Organizations (42 C.F.R. § 438.340).

Revised Code of Washington (**RCW)** means laws passed by the Washington State Legislature. All references to RCW chapters or sections shall include any successor, amended, or replacement statute.

Regional Service Area (RSA) means a single county or multi-county grouping formed for the purpose of health care purchasing.

Request for Proposals (RFP) means a 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.

Scored (S) means the Bidder must comply with the requirement, and the Response will be scored.

State of Washington Unless otherwise restricted, includes all members of the State of Washington, State Purchasing Cooperative including where applicable: State agencies, political subdivisions of Washington qualified non-profit corporations, institutions of higher education (e.g., colleges, universities, community & technical colleges) who choose not to purchase independently under RCW 28.B.10.029.

Statement of Work (SOW) means a statement of the work or services which the Contractor is to perform under any contract awarded, and which is generally in the form of an exhibit attached to the contract.

Statistical Analysis Software (SAS) or **SAS file** means a file extension for an ASCII file used with Statistical Analysis Software. SAS files contain the source code for a program or sub-program used for data modeling and analysis. SAS files can be opened by Statistical Analysis Software.

Subcontractor means one not in the employment of Contractor, who is performing all or part of the business activities under this RFP under a separate contract with Contractor. The term "Subcontractor" means Subcontractor(s) of any tier.

TEAMonitor means an interagency team of reviewers responsible for monitoring Managed Care plans' compliance with standards for healthcare quality management, provider access and availability, credentialing, utilization management, enrollee grievances and appeals, contractual requirements, and applicable state and federal laws. TEAMonitor conducts the monitoring review required in § 438.358(b)(1)(iii). Additionally, TEAMonitor staff conduct yearly performance improvement project validation as described in § 438.358(b)(1)(i).

Validation means the review of information, data, and procedures to determine the extent to which they are accurate, reliable and free from bias and in accord with standards for data collection and analysis.

Washington Administrative Code (WAC) means the rules adopted by agencies to implement legislation and RCWs. All references in this RFP to WAC chapters or sections shall include any successor, amended, or replacement regulation. Pertinent WAC chapters or sections can be accessed at: http://www.leg.wa.gov/LawsAndAgencyRules/Pages/default.aspx.

Washington Apple Health or **Apple Health** (**AH)** means a title that expresses the rebranding name of the Washington State Medicaid program.

Washington Apple Health – Managed Care (**AHMC)** means a managed care program that coordinates physical health and low complexity mental health services prior to integration. The term is also used to reflect a subpopulation of Managed Care enrollee, i.e., Temporary Assistance for Needy Families (TANF) and TANF eligibles, Blind and Disabled, CHIP, and Patient Protection and Affordable Care Act (PPACA) expansion population.

Washington Apple Health – Integrated Managed Care (AH-IMC) means a managed care program that coordinates physical health, mental health, and substance use disorder treatment services to help provide whole-person care under one health plan. This program includes a subpopulation of Managed Care enrollees, including Temporary Assistance for Needy Families (TANF) and TANF eligibles, Blind and Disabled, CHIP, BHSO, and Patient Protection and Affordable Care Act (PPACA) expansion population.

Washington Apple Health – Integrated Foster Care (**AH-IFC**) means a managed care program developed specifically to meet the needs of children and youth in foster care and adoption support programs, and former foster children between the ages of 18 and 26 who are eligible for physical health, mental health, and substance use disorder treatment services to help provide whole-person care under one health plan.

Washington Apple Health Primary Care Case Management (PCCM) means a managed care program provided through tribal clinics and urban Indian centers. The State consults with American Indian/Alaska native tribal organizations and clinics on all program aspects, including the Department of Social and Health Services' Indian Policy Advisory Committee (IPAC) and the American Indian Health Commission (AIHC).

Wraparound with Intensive Services (**WISe**) means intensive mental health services and supports, provided in home and community settings, for Medicaid eligible individuals, up to 21 years of age, with complex behavioral health needs and their families. WISe provides behavioral health services and supports in home and community settings, care coordination, 24/7 crisis and stabilization interventions and peer support which are all required components of the delivery model. The goal of WISe is for youth to live and thrive in their homes and communities, as well as to avoid or reduce costly and disruptive out-of-home placements while receiving behavioral health treatment services.

1.8. **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:

Name	Angela Hanson
E-Mail Address	contracts@hca.wa.gov
Mailing Address	PO Box 42702 Olympia, WA 98504-2702
Phone Number	(360) 725-1683

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. ESTIMATED SCHEDULE OF PROCUREMENT ACTIVITIES

Issue Request for Proposals	August 5, 2019
Pre-Bidder Conference	August 9, 2019 – 4:00 to 5:00 p.m.
Response to Questions from Pre-Bidder Conference	August 13, 2019
Bidder Questions Due	August 14 2019 – 2:00 p.m.
Letter of Intent Due	August 15, 2019 – 2:00 p.m.
Answers Posted	August 22, 2019
Bidder Proposals Due	**September 9, 2019 – 2:00 p.m.**
Evaluate Proposals	September 11 – 27, 2019
Conduct Oral Interviews with Finalists, if required	October 1 – 4, 2019
Announce "Apparent Successful Bidder" and send notification via e-mail to unsuccessful Bidders	On or Before October 8, 2019
Hold Debriefing Conferences (if requested)	October 9 – 11, 2019
Final Contract(s) Signed	November 15, 2019
Begin Contract Work	January 1, 2020

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

2.3. PRE-PROPOSAL CONFERENCE

A pre-proposal conference is scheduled to be held on **August 9, 2019 at 4:00 p.m.**, Pacific Time in Olympia, Washington. The location of the pre-proposal conference is 626 8th Avenue SE, Olympia, WA 98504. HCA will also provide a call-in option to all Bidders that submit a request to the RFP Coordinator for meeting invite information. All prospective Bidders should attend; however, attendance is not mandatory.

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

2.4. LETTER OF INTENT TO PROPOSE

To be eligible to submit a Proposal, a Bidder must submit a Letter of Intent to Propose. The Letter of Intent to Propose 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 2.2. The subject line of the email must include the following: RFP 3866 – Letter of Intent to Propose – [Your entity's name].

The Letter of Intent to Propose 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 Letter of Intent to Propose should be placed in the following order:

2.4.1. Bidder's Organization Name;

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

2.4.3. Title of authorized representative;

2.4.4. Address, telephone number, and email address;

2.4.5. Statement of intent to propose; and

2.4.6. Exhibit A, Certification of Minimum Qualifications, and required attachments and responses.

HCA may use the Letters of Intent to Propose as a pre-screening to determine whether Minimum Qualifications are met.

2.5. SUBMISSION OF PROPOSALS

The electronic proposal must be received by the RFP Coordinator no later than the Proposal Due deadline in Section 2.2, *Estimated Schedule of Procurement*.

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. Attachments to e-mail should be in Microsoft Word format or PDF. Zipped files cannot be received by HCA and cannot be used for submission of proposals. The cover submittal letter and the Certifications and Assurances form must have a scanned signature of the individual within the organization authorized to bind the Bidder to the offer. HCA does not assume responsibility for problems with Bidder's e-mail. If HCA e-mail is not working, appropriate allowances will be made.

Proposals may not be transmitted using facsimile transmission.

Bidders should allow sufficient time to ensure timely receipt of the proposal by the RFP Coordinator. Late proposals will not be accepted and will be automatically 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.

2.6. 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 Apparent Successful Bidder is 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. 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. Bidder must also identify each page containing information claimed to be exempt from disclosure as required in the Letter of Submittal (Section 3.1.5). 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 2.2, unless HCA, in its sole discretion, determines that altering the schedule would be in HCA's best interests.

2.7. REVISIONS TO THE RFP

If HCA determines in its sole discretion that it is necessary to revise any part of this RFP, then HCA will provide addenda via e-mail to all individuals who have made the RFP Coordinator aware of their interest. Addenda will also be published on Washington's Electronic Bid System (WEBS), at https://fortress.wa.gov/ga/webs/. For this purpose, the published questions and answers and any other pertinent information will be provided as an addendum to the RFP and will be placed on the website.

HCA also reserves the right to cancel or to reissue the RFP in whole or in part, prior to execution of a contract.

2.8. 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 RCW 39.19, the state of Washington encourages participation in all contracts by firms certified by the Office of Minority and Women's Business Enterprises (OMWBE), set forth in RCW 43.60A.200 for firms certified by the Washington State Department of Veterans Affairs, and set forth in RCW 39.26.005 for firms that are Washington Small Businesses. Participation may be either on a direct basis or on a subcontractor basis. However, no preference on the basis of participation is included in the evaluation of Diverse Business Inclusion Plans submitted, and no minimum level of minority- and women-owned business enterprise, Washington Small Business, or Washington State certified Veteran Business participation is

required as a condition for receiving an award. Any affirmative action requirements set forth in any federal governmental regulations included or referenced in the contract documents will apply.

2.9. ACCEPTANCE PERIOD

Proposals must provide one hundred twenty (120) calendar days for acceptance by HCA from the due date for receipt of proposals.

2.10. COMPLAINT PROCESS

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

2.10.1.1. The RFP unnecessarily restricts competition;

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

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

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

2.10.2.1. Be in writing;

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

2.10.2.3. Clearly articulate the basis for the complaint; and

2.10.2.4. 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.

2.11. 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.

2.12. MOST FAVORABLE TERMS

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

HCA also reserves the right to use a Best and Final Offer (BAFO) before awarding any contract to further assist in determining the ASB(s).

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

2.13. CONTRACT AND GENERAL TERMS AND CONDITIONS

The ASB will be expected to enter into a contract which is substantially the same as the draft sample contract and its general terms and conditions attached as Exhibit F. HCA will not accept any draft contracts prepared by any Bidder. The Bidder may submit exceptions as allowed in the Certifications and Assurances form, Exhibit C to this RFP. All exceptions must be submitted as an attachment to Exhibit C. HCA will review requested exceptions and accept or reject the same at its sole discretion.

If, after the announcement of the ASB, and after a reasonable period of time, the ASB and HCA cannot reach agreement on acceptable terms for the Contract, the HCA may cancel the selection and Award the Contract to the next most qualified Bidder.

2.14. 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.

2.15. 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.

2.16. NO OBLIGATION TO CONTRACT

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

2.17. 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.

2.18. 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.

2.19. 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.

2.20. INSURANCE COVERAGE

As a requirement of the resultant contract, the ASB is to furnish HCA with a certificate(s) of insurance executed by a duly authorized representative of each insurer, showing compliance with the insurance requirements set forth below.

The ASB must, at its own expense, obtain and keep in force insurance coverage 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 15 days of the contract effective date.

2.20.1. Liability Insurance

2.20.1.1. Commercial General Liability Insurance: ASB will 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.

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

2.20.2. Employers Liability ("Stop Gap") Insurance

In addition, the ASB will buy employers liability insurance and, if necessary, commercial umbrella liability insurance with limits not less than $1,000,000 each accident for bodily injury by accident or $1,000,000 each employee for bodily injury by disease.

2.20.3. Privacy Breach Coverage. 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::

2.20.3.1. 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;

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

2.20.3.3. 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

2.20.3.4. 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).

2.20.4. Additional Provisions

Above insurance policy must include the following provisions:

2.20.4.1. 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.

2.20.4.2. 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 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 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.

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

2.20.4.4. 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.

2.20.4.5. 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.

2.20.5. Workers' Compensation Coverage

The ASB will at all times comply with all applicable workers' compensation, occupational disease, and occupational health and safety laws, statutes, and regulations to the full extent applicable. The state will not be held responsive in any way for claims filed by the ASB or their employees for services performed under the terms of this contract.

3. PROPOSAL CONTENTS

Proposals must be written in English and submitted on eight and one-half by eleven inch (8 ½" x 11") paper, with no smaller than 10 point font, with tabs separating the major sections of the proposal. Charts and graphs may be submitted on eleven by seventeen inch (11" x 17") paper. The major sections of the Proposal are to be submitted in the order noted below:

A. Letter of Transmission, including:
   a. Letter of Submittal (Exhibit B);
   b. Signed Certifications and Assurances (Exhibit C);
   c. Red-lined copy of Draft Sample Contract (Exhibit F);
   d. Completed Diverse Business Inclusion Plan (Exhibit G); and
   e. Completed Executive Order 18-03, Workers' Rights Certification (Exhibit I).

B. Technical Proposal (Section 3.2)

C. Management Proposal (Section 3.3)

D. Cost Proposal (Exhibit D to this RFP)

E. Business References (Exhibit E to this RFP)

Proposals must provide information in the same order as presented in this document with the same headings.

Items marked "Mandatory" or "(M)" must be included as part of the proposal for the proposal to be considered responsive; however, these items are not scored. Items marked "Scored" or "(S)" are those that are awarded points as part of the evaluation conducted by the evaluation team.

3.1. LETTER OF TRANSMISSION (MANDATORY)

The Letter of Transmission is a cover letter to the Proposal that provides introductory remarks and a summary of the Proposal. Bidder must attach the following to the Letter of Transmission:

3.1.1. The Letter of Submittal, Exhibit B, including all required attachments, must be signed and dated by a person authorized to legally bind the Bidder to a contractual relationship, e.g., the President or Executive Director if a corporation, the managing partner if a partnership, or the proprietor if a sole proprietorship.

3.1.2. The Certifications and Assurances, Exhibit C, must be signed and dated by a person authorized to legally bind the Bidder to a contractual relationship.

3.1.3. A red-lined copy of the Draft Sample Contract, Exhibit F, identifying issues or proposed alternate text that reflects the actual content of the Bidder's proposal.

3.1.4. Completed Diverse Business Inclusion Plan, Exhibit G.

3.1.5. Completed Executive Order 18-03 – Workers' Rights Certification, Exhibit I.

3.1.6. Any information in the proposal that the Bidder desires to claim as proprietary and exempt from disclosure under the provisions of RCW 42.56 must be clearly designated. 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,

list which pages and sections that have been marked "Proprietary" and the particular exemption from disclosure upon which the Bidder is making the claim.

3.2. TECHNICAL PROPOSALS (SCORED – MAXIMUM 500 POINTS)

The Bidder shall number each response so that it corresponds to the question number below. The response must begin with a restatement of the question followed by the Bidder's response to the question. A reference to another section will not suffice, each answer must stand alone.

Attachments must be labeled, and the question number to which it responds must be designated.

3.2.1. **[S, 63 points]** Work Plan and Timeline **(page limit: 20)**

3.2.1.1. Provide a detailed work plan and timeline for completion of the scope of all the work described in this RFP and attached Draft Sample Contract. Reference Exhibit H, Deliverables Table, when responding to this question. Outline plans before the contracted work begins to ensure the Contractor is prepared for the start of the contract and through the end of the first calendar year (December 31, 2020) of the Contract. Include the following:

3.2.1.1.1. Report development, production of draft, and final report production, in accordance with required deliverables in the Deliverables Table, Exhibit H, attached.

3.2.1.1.2. Deadlines for sub-contractor(s) required to complete the work listed in the scope

3.2.1.2. Risks. Identify potential risks that are considered significant to the success of the work. Include how the Bidder would propose to effectively monitor and manage these risks, including reporting of risks to the HCA contract manager.

3.2.1.3. Describe the Bidder's approach to analyzing, synthesizing, and presenting information in a stakeholder report, in a way that encompasses accuracy and completeness while making the report understandable and useful to the audience.

3.2.1.4. Explain how the Bidder will be prepared for the start of the Contract, HEDIS®, and CAHPS® season, including pre-contract preparation and securing appropriately qualified staff in a timely manner. Provide detail to demonstrate the Contractor will be prepared to perform duties required at the start of the Contract without delay or impact to the MCOs or HEDIS® and CAHPS® timelines.

3.2.1.5. Identify plan for staffing of HEDIS® auditors, including any subcontractual relationships. Explain how the Bidder will be prepared for the start of the contract and for HEDIS® season, including pre-contract preparation and the method to secure a HEDIS® auditor.

3.2.1.6. Identify plan for staffing of CAHPS® CHIP survey, including any subcontractual relationships. Explain how the Bidder will be prepared for the start of the contract and for CAHPS® season, including pre-contract preparation and the method to secure an NCQA-certified CAHPS survey vendor.

3.2.1.7. Describe the Bidder's experience executing EQRO efforts rapidly in other states implementing health systems transformation. Describe the Bidder's recommendations to Washington on effective execution and use of EQRO resources and capacity to improve implementation of health systems transformation.

3.2.2. **[S, 63 points]** External Quality Review Annual Technical Report (42 C.F.R. 438.364) **(page limit: 4, excluding technical reports required in 3.2.2.2)**:

3.2.2.1. Describe the Bidder's skills, knowledge and experience with External Quality Review Technical reports. Describe aspects of the analyses and report production activities conducted by the Bidder and which aspects will be sub-contracted, if any. If sub-contracted, describe the oversight role of the Bidder. Include a list of all technical reports completed over the last five years.

3.2.2.2. Submit two technical reports completed within the last five years to demonstrate previous work in this area. (Not included in page limit)

3.2.2.3. Describe the Bidder's approach to analyzing, synthesizing, and presenting information in an External Stakeholder Report, in a way that encompasses accuracy and completeness while making the report understandable and useful to the audience.

3.2.2.4. Describe sources of data recommended to assess the quality, timeliness, and access to care of MCO enrollees. Describe the Bidder's ideas for improving quality analysis for MCOs, and for presenting the recommendations.

3.2.2.5. Describe the process the Bidder uses to determine which recommendations for improvement to make to the HCA and contracted MCOs.

3.2.3. **[S, 63 points]** Performance Measure Comparative Analysis **(page limit: 8, excluding sample tables/charts in 3.2.3.6)**

3.2.3.1. Describe the Bidder's skills, knowledge and experience with using performance measure data for comparative analysis and report production.

3.2.3.2. Describe the methods for data analysis and report production. Describe the Bidder's approach to analyzing, synthesizing, and presenting information in performance measure reporting, in a way that encompasses accuracy and completeness while making the report understandable and useful to the audience. Describe the methods used for conducting analysis, including comparison analysis and assessment of trend data over time.

3.2.3.3. Describe how Bidder will examine the impact of variables such as: socioeconomic status, healthcare services utilization, demographics (race/ethnicity, gender, spoken language) on respondents versus non-respondents. Describe recommendations for comparative analysis using demographic information available to HCA (e.g., gender, Medicaid program type, ethnicity, race, language, MCO-enrolled, RSA) to provide useful and actionable data. Identify the Bidder's strategy to identify and analyze healthcare disparities.

3.2.3.4. Explain how regional analyses will be analyzed and presented, supporting MCOs and regional stakeholders, and how the Bidder distinguishes a significant difference from normal variation. Give examples of how regional analyses may be performed within the HEDIS® structure.

3.2.3.5. Describe how the Bidder uses comparative data to make recommendations to MCOs and HCA.

3.2.3.6. Submit four (4) sample tables or charts displaying performance measure-like data. Provide narrative descriptions of the sample tables or charts. Submit two (2) reports that best exemplify similar, previous work in this area.

3.2.4. **[S, 30 points]** Enrollee Quality Report **(page limit: 4, excluding 2 examples)**

3.2.4.1. Describe the Bidder's skills, knowledge and experience with developing enrollee quality rating systems, such as Washington's Enrollee Quality Report. Submit two examples if any previous work in this area has been conducted within the last five years.

3.2.5. **[S, 63 points]** Validation of MCO Performance Measures **(page limit: 5)**

3.2.5.1. Describe the Bidder's skills, knowledge and experience conducting HEDIS® compliance audits.

3.2.5.2. Describe what activities would be conducted by the Bidder and which aspects will be sub-contracted, if any. If sub-contracted, describe the oversight role of the Bidder.

3.2.5.3. Describe the Bidder's skills, knowledge and experience conducting validation of non-HEDIS measures.

3.2.5.4. Describe the framework for the report including a description of how benchmarks will be incorporated into the charts and tables.

3.2.6. **[S, 63 points]** Consumer Assessment of Healthcare Providers and Systems (CAHPS®) **(page limit: 5)**

3.2.6.1. Describe the Bidder's skills, knowledge, and experience conducting and analyzing data from Medicaid consumer surveys.

3.2.6.2. Give examples of actions the Bidder can take to increase consumer survey response rates and to convey the value of survey information to Enrollees.

3.2.6.3. Identify plan for staffing of CAHPS® surveys, including any subcontractor relationships. Address both staffing for conducting the survey and for conducting data analysis and report production.

3.2.6.4. Describe how the Bidder proposes to survey both the English and Spanish-speaking populations.

3.2.6.5. Describe the Bidder's methods for data analysis and report production. Describe how the Bidder will use the survey data and results to make recommendations to HCA.

3.2.7. **[S, 63 points]** Value-Based Purchasing **(page limit: 10)**

3.2.7.1. Describe the Bidder's skills, knowledge, and experience with using data to analyze and identify prioritized performance measures. Explain experience with performance measures used for value-based purchasing. Address expertise with HEDIS® and non-HEDIS measures.

3.2.7.2. VBP Performance Measure Recommendation

3.2.7.2.1. Describe the approach the Bidder will take in the methods of analysis for recommending performance measures. Address the following at minimum: data trends, change in collection/definition of performance measure, clinical analysis, weighting of factors, and measure prioritization. Describe staffing (e.g., data analyst, clinical leadership).

3.2.7.2.2. Describe the process the Bidder would use to ensure efficient development of the work from data analysis, clinical analysis, and final measure

recommendation. Provide a timeline demonstrating how the Bidder will meet the deadline within the timeframe allotted: HEDIS® data availability in June, through July Report deadline, and August presentation.

3.2.7.2.3. Describe the approach the Bidder will use to represent the measures recommended meet all relevant requirements:

- in the Washington Statewide Common Measure Set (Attachment 10),
- reflects MCO poor performance,
- is substantive and clinically meaningful,
- has the potential to impact managed care costs, and
- is a population health measure.

HCA acknowledges that some of the criteria in the Proviso (e.g., "substantive and clinically meaningful", "potential to impact managed care costs", "population health measure") is not defined by the legislation and requires the expertise of the EQRO and consultation by HCA to translate how this criteria applies to each measure. Describe what concepts the Bidder would incorporate in to the analysis for each of the criteria.

3.2.7.3. VBP Performance Measure Evaluation

3.2.7.3.1. Describe the approach the Bidder will take in evaluating the performance measures. Address the Proviso requirements at minimum: Statistical significance and Medicaid quartile for HEDIS® measures. Include any ideas to address the quartile comparison for non-HEDIS measures, such as Washington-specific measures. Describe staffing (e.g., data analyst, report production).

3.2.8. **[M]** Validation of Network Adequacy **(page limit: 2)**

3.2.8.1. Provide narrative description of skills, knowledge, and experience with network adequacy validation, including experiences with other states, if any. Provide Bidder's ideas on how to implement this EQRO C.F.R. scope of work.

3.2.9. **[S, 29 points]** Communication and Education **(page limit: 2)**

3.2.9.1. Describe the Bidder's approach for planning and organizing the annual quality forum.

3.2.9.2. Describe the Bidder's approach for topic selection and participant engagement and feedback. Identify and describe three (3) potential topics to address the educational needs of the audience.

3.2.10. **[S, 63 points]** Wraparound with Intensive Services (WISe) Quality Improvement Review Tool (QIRT) Reviews **(page limit: 6)**

3.2.10.1. Describe the Bidder's experience with and understanding of the purpose of quality improvement review and presentation of findings to support provider practice change as compared to a compliance review.

3.2.10.2. Describe the Bidder's skills, knowledge, and experience in on-site chart review within a provider office.

3.2.10.3. Describe the Bidder's approach to using quality review results to provide feedback in a way that it can be received by providers and agencies and they can use it to improve their programs. Provide your strategy for presenting findings that identify challenges and recommendations to identify themes, recognize the need for training, and assist organizations in changing practice.

3.2.10.4. Describe the Bidder's skills, knowledge, and experience, or describe how Bidder will implement processes for providing constructive feedback through written reporting to promote provider success and accomplishment of program expectations.

3.3. MANAGEMENT PROPOSAL (SCORED – MAXIMUM 200 POINTS)

In this section of the proposal, the Bidder is to discuss Bidder's organization and the knowledge, skills, abilities, and experience of the proposed team members. The contract resulting from this procurement will require that any change in key staff (as identified in Bidder's response to this procurement) will require one (1) month notice and prior written approval by HCA.

The Bidder must number each response so that it corresponds to the question number. The response must begin with a restatement of the question followed by the Bidder's response to the question. A reference to another section will not suffice, each answer must stand alone.

Attachments must be labeled and the question number to which the attachment corresponds must be clearly denoted.

3.3.1. **[M]** Describe the Bidder's full ownership structure. If the Bidder has a parent organization, provide the organizational structure and where the entities are incorporated. If there are any child organizations owned by the parent that have impact on this work, include this within the structure.

3.3.2. **[S, 100 points]** Submit the Bidder's organizational chart(s) and accompanying narrative of proposed team for this contract scope of work. This organizational chart should include reporting structure up to CEO. Provide a listing, with qualifications, of key personnel who will be working on this contract. Indicate the lines of authority for personnel (including subcontractors) involved in the performance of the proposed work. Organizational chart should reflect administrative, research, analytical, programming, and clinical personnel assigned to this contract scope of work. Specify the staff responsible for the on-site QIRT reviews, including the staff expertise in behavioral health programs. **(page limit: 5, excluding resumes and organizational chart(s))**

3.3.2.1. The response should include the names and titles of staff role and the percentage of time devoted to this Contract. Indicate compliance with the minimum qualifications and expertise with the scope of work described in this RFP, including recent Bidder and/or any subcontractor experience and knowledge of:

3.3.2.1.1. Medicaid recipients, policies, data systems, and processes;

3.3.2.1.2. Managed care delivery systems, organizations, and financing;

3.3.2.1.3. Quality assessment and improvement methods; and

3.3.2.1.4. Research design and methods, including data collection and statistical analysis

3.3.2.2. Include the resumes for main Contract team, including contract manager, project manager, lead analyst, programmer, and technical writer for required reports.

3.3.2.3. Include the resumes for key clinical members of the team for this contract scope of work, including their role within the organizational chart.

3.3.3. **[M]** A list of all anticipated subcontracts. Indicate subcontractors by name, location, address, telephone number, and contact person. Describe the specific task work of the subcontractor and oversight role of the contractor. The description must indicate if subcontractors have been doing business for similar proposed work prior to this RFP or whether this is new business for the subcontractor. Subcontractor changes during the duration of this contract must be prior approved by HCA. Provide documentation if any subcontractors are certified by the Office of Minority and Women's Business Enterprises.

3.3.4. **[M]** Indicate if the Bidder and/or any anticipated subcontractor has been, or is presently engaged in the provision of services under any HCA's programs. Identify the services provided to HCA clients by the Bidder or anticipated subcontractor. Provide contract and contact information, i.e., contract number, name of the HCA division, mailing address, telephone number(s), fax number(s), and no less than two (2) contact names at each HCA division.

3.3.5. **[S, 50 points]** Describe Bidder technical capacity to analyze data, including the computer systems or programs used, and any plans for change in technological capacity that may impact meeting work plan or timelines. **(page limit: 2)**

3.3.6. **[S, 50 points]** Provide the Bidder's processes for responding to concerns during the business day. Provide Bidder's plan for maintaining communication with HCA and completing issue-resolution in a timely manner, including response time, ticketing (if applicable), tracking, escalation processes, and resolution determination. **(page limit: 1)**

3.4. RELATED INFORMATION (MANDATORY)

3.4.1. If the Bidder or any subcontractor contracted with the state of Washington during the past 24 months, indicate the name of the agency, the contract number, and project description and/or other information available to identify the contract.

3.4.2. If the Bidder's staff or subcontractor's staff was an employee of the state of Washington during the past 24 months, or is currently a Washington State employee, identify the individual by name, the agency previously or currently employed by, job title or position held, and separation date.

3.4.3. If the Bidder has had a contract terminated for default in the last five years, describe such incident. Termination for default is defined as notice to stop performance due to the Bidder's non-performance or poor performance and the issue of performance was either (a) not litigated due to inaction on the part of the Bidder, or (b) litigated and such litigation determined that the Bidder was in default.

3.4.4. Submit full details of the terms for default including the other party's name, address, and phone number. Present the Bidder's position on the matter. HCA will evaluate the facts and may, at its sole discretion, reject the proposal on the grounds of the past experience. If no such termination for default has been experienced by the Bidder in the past five years, so indicate.

3.5. REFERENCES (MANDATORY)

Using Exhibit E, Business References, the Bidder and any subcontractor must submit a minimum of three (3) non-Bidder owned Business References for which the Bidder and any subcontractor has completed similar work within the last five (5) years. Complete, Exhibit E, Business References with the information for the references. DO NOT include current HCA staff as references.

Bidder and any subcontractor must grant permission to the HCA to independently contact the Business References at HCA's convenience. HCA reserve the right to obtain and consider information from other sources concerning a Bidder, such as Bidder's capability and performance under other contracts, the qualification of any subcontractor identified in the Proposal, Bidder's financial stability, past or pending litigation, and other publicly available information

Notify your Business References that HCA may be contacting them so they will be available for a reference check. By submitting a proposal in response to this RFP, the vendor and team members grant permission to HCA to contact these references and others, who from HCA's perspective, may have pertinent information. HCA may or may not, at HCA's discretion, contact references. HCA may evaluate references at HCA's discretion.

3.6. OMWBE CERTIFICATION (OPTIONAL AND NOT SCORED)

Include proof of certification issued by the Washington State Office of Minority and Women's Business Enterprises (OMWBE) if certified minority-owned firm and/or women-owned firm(s) will be participating on this contract. For information: http://www.omwbe.wa.gov.

3.7. EXECUTIVE ORDER 18-03 (SCORED)

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 20 points to any Bidder who certifies, pursuant to the certification attached as Exhibit I, Contractor Certification for Executive Order 18-03 – Workers' Rights, 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. If Bidder's firm does require its employees, as a condition of employment, to sign or agree to mandatory individual arbitration clauses or class or collective action waiver, the firm will receive zero (0) points for this section.

3.8. COST PROPOSAL (SCORED – MAXIMUM 300 POINTS)

The evaluation process is designed to award this procurement not necessarily to the Bidder of least cost, but rather to the Bidder whose proposal best meets the requirements of this RFP. However, Bidders are encouraged to submit proposals which are consistent with state government efforts to conserve state resources.

3.8.1. Identification of Costs (SCORED)

Identify all costs in U.S. dollars including expenses to be charged for performing the services necessary to accomplish the objectives of the contract. The Bidder is to submit a fully detailed budget including staff costs and any expenses necessary to accomplish the tasks and to produce the deliverables under the contract. Bidders are required to collect and pay Washington state sales and use taxes, as applicable.

The response shall include a narrative that reflects any cost assumptions and other relevant information that will assist in evaluating the Cost Proposal.

The Bidder must submit a detailed budget identifying expenses in support of the bid, **using Exhibit D, Cost Proposal.**

The Draft Statement of Work and/or Performance Work Statement outlined in Exhibit F, Draft Sample Contract, and the Deliverables Table in Exhibit H, are provided for assistance in development of the Bidder's Cost Proposal and should not be construed as a final representation of the work to be accomplished. A specific statement of work and payment schedule will be negotiated with the Apparent Successful Bidder based upon the submitted budget.

Line items listed in the Exhibit D, Cost Proposal are intended to be all-inclusive. Include any additional detail as appropriate.

Identify all costs in U.S. dollars including expenses to be charged for performing the services necessary to accomplish the objectives of the contract. Contractors are required to collect and pay Washington State sales tax, if applicable. HCA are not allowed to render an opinion as to whether certain taxes apply to products and services resulting from an anticipated contract. If in doubt, the Bidder should contact the Washington State Department of Revenue.

Minor modifications to deliverable requests will occur during the contract period(s). HCA will not incur additional costs or charges to the contract(s) unless the actual cost exceed ten percent (10%) of total costs.

3.8.2. Computation

The score for the cost proposal will be computed by dividing the lowest total cost bid received by the Bidder's total cost. Then the resultant number will be multiplied by the maximum possible points for the cost section.

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 ranking of the proposals. Evaluations will only be based upon information provided in the Bidder's Proposal.

All proposals received by the stated deadline, Section 2.2, *Estimated Schedule of Procurement Activities*, 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 will 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*. Proposals will be evaluated strictly in accordance with the requirements set forth in this RFP and any addenda issued.

HCA, at its sole discretion, may elect to select the top-scoring firms as finalists for an oral presentation.

4.2. EVALUATION WEIGHTING AND SCORING

The maximum number of written evaluation points available is 1,000 points. If Oral Presentations are required, an additional 250 points will be available. The Mandatory Requirements are evaluated on a pass/fail basis. The following weighting and points will be assigned to the proposal for evaluation purposes:

Mandatory Requirements (non-scored)	
RFP Compliance – Administrative Review	
Business References	
Mandatory Scored Requirements	
Technical Proposal – 50%	500 points
Management Proposal – 20%	200 points
Cost Proposal – 30%	300 points
Executive Order 18-03 Certification	20 points
TOTAL	**1,020 POINTS**
Oral Presentations (if required) –	250 points

Responses that pass all Mandatory requirements will be further evaluated and scored. Evaluators will evaluate and assign a score to each Scored (S) requirement using a point/weighted scoring system based on how well the Bidder's response matches the requirement. The Evaluators scores will then be averaged to make the Bidders final scores for each of the Technical and Management sections.

Evaluators will assign scores on a scale of zero (0) to ten (10) where the end and midpoints are defined as follows:

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

***A score of zero (0) on any Scored requirement may cause the entire response to be eliminated from further consideration, at HCA's sole discretion.*

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

HCA may after evaluating the written proposals elect to schedule oral presentations of the finalists. Should oral presentations become necessary, HCA will contact the top-scoring firm(s) from the written evaluation to schedule a date, time, and location. Commitments made by the Bidder at the oral interview, if any, will be considered binding.

HCA expects key personnel, identified in 3.3.2, including the proposed contract manager, project manager, and key clinical members, to participate in the oral presentations.

The scores from the written evaluation and the oral presentation combined together will determine the Apparent Successful Bidder.

4.4. SUBSTANTIALLY EQUIVALENT SCORES

Substantially equivalent scores are scores separated by two percent or less in total points. If multiple Proposals receive a Substantially Equivalent Score, HCA may leave the matter as scored, or select as the ASB the one Proposal that is deemed by HCA, in its sole discretion, to be in HCA's best interest relative to the overall purpose and objective as stated in Sections 1.1 and 1.2 of this RFP.

If applicable, HCA's best interest will be determined by HCA managers and executive officers, who have sole discretion over this determination. The basis for such determination will be communicated in writing to all Bidders with equivalent scores.

4.5. NOTIFICATION TO BIDDERS

HCA will notify the ASB 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.

4.6. 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., Pacific 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:

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

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

4.6.3. 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.

4.7. PROTEST PROCEDURE

A bid protest may be made only by Bidders who submitted a response to this RFP and who have participated in a debriefing conference. Upon completing the debriefing conference, the Bidder is allowed five business days to file a protest with the RFP Coordinator. Protests must be received by the RFP Coordinator no later than 4:30 p.m., Pacific Time, 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.

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

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

4.7.1.2. Errors in computing the score; or

4.7.1.3. 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.

4.7.2. The final determination of the protest will:

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

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

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

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

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

4.7.2.3.3. 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 AND ATTACHMENTS

Attached as Separate Documents

Exhibit A	Certification of Minimum Qualifications
Exhibit B	Letter of Submittal
Exhibit C	Certifications and Assurances
Exhibit D	Cost Proposal
Exhibit E	Business References
Exhibit F	Draft Sample Contract
Exhibit G	Diverse Business Inclusion Plan
Exhibit H	Deliverables Table
Exhibit I	Executive Order 18-03 – Workers' Rights

Attachment 1	2018 Technical Report
Attachment 2	2018 Comparative Analysis Report
Attachment 3	2018 Regional Analysis Report
Attachment 4	July 2019 Apple Health – Integrated Managed Care Model Contract
Attachment 5	July 2019 Apple Health – Integrated Foster Care Model Contract
Attachment 6	Apple Health Managed Care Service Area Matrix
Attachment 7	Apple Health Regional Service Areas
Attachment 8	OCS Design Review Checklist
Attachment 9	Engrossed Substitute House Bill 1109
Attachment 10	Washington Statewide Common Measures Set
Attachment 11	Wraparound with Intensive Services Program, Policy and Procedure Manual
Attachment 12	Wraparound with Intensive Services Quality Plan