

**STATE OF WASHINGTON
WASHINGTON STATE HEALTH CARE AUTHORITY
REQUEST FOR APPLICATION (RFA) NO. 14-031**

It is the responsibility of the potential Applicant(s) to carefully read, understand, and follow the instructions contained in this RFA document and all amendments to the RFA.

PROJECT TITLE: Puget Sound Accountable Care Program (ACP) option

EXECUTIVE SUMMARY: The Washington State Health Care Authority (HCA) is soliciting one or more clinically integrated health care organizations and/or network of partners to provide an Accountable Care Program (ACP) option, effective January 1, 2016. The ACP option will be offered to Public Employees Benefits Board (PEBB) program members in multiple contiguous Washington counties, with preference given to the five (5) county Puget Sound region. Successful Applicant(s) will have demonstrated the ability and capacity to meet HCA's requirements for the new ACP option, including entering into a binding agreement built on financial and quality performance incentives and disincentives, implementing effective care delivery models and aligning health system reimbursement and financial incentives.

APPLICATIONS DUE DATE: January 27, 2015, **no later than 2:00 p.m. PACIFIC TIME**

EXPECTED PERIOD OF CONTRACT: April 8, 2015 through December 31, 2020. ACP option begins January 1, 2016, with contractually obligated start-up activities commencing by April 8, 2015.

HCA reserves the right to not issue any contracts at all stemming from the RFA.

MINIMUM REQUIREMENTS FOR APPLYING: This RFA is open to those organizations that satisfy the following minimum requirements:

1. Must be licensed to do business in the State of Washington;
2. Must have submitted a Letter of Intent to Apply by the date and time specified in the RFA Schedule;
3. Must be an established clinically integrated health care organization and/or network with partners that offers primary, specialty and hospital care in multiple contiguous Washington counties, with preference given to the five (5) county Puget Sound region, and with capacity to serve at least 50,000 Public Employee Benefit Board (PEBB) program members; and
4. Must agree to enter into a binding agreement with HCA that guarantees a specific annualized performance trend for defined PEBB program populations.

Applicant(s) who do not meet and demonstrate these minimum requirements will be rejected as non-responsive and will not receive further consideration. Any Applicant(s) that is rejected as non-responsive will not be evaluated or scored.

RFA SCHEDULE

Activity	Due Dates	Time
RFA Release Date	December 19, 2014	
Letter of Intent to Apply	December 30, 2014	2:00 p.m., Pacific Time
Questions from Applicants deadline	December 30, 2014	2:00 p.m., Pacific Time
Answers to Applicants' Questions posted on website on two different dates	On January 2, 2015 & on January 7, 2015	
Complaints Deadline	January 20, 2015	2:00 p.m., Pacific Time
Applications Deadline from Applicants	January 27, 2015	2:00 p.m., Pacific Time
Evaluation Period/Finalist On-site Readiness Review	January 28, 2015 – February 13, 2015	
Projected Announcement of Apparently Successful Applicants (ASA)	February 17, 2015	
Debriefing request deadline	February 20, 2015	2:00 p.m., Pacific Time
Negotiations with ASA(s)	February 23, 2015- March 31, 2015	
Contract Start Date (on or before)	April 8, 2015	

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- Attachment A – Partner Information Request
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- Attachment E – Attestation of Minimum Requirements, Pre-Launch Milestones and Additional Attestations
- Attachment F – Letter of Submittal

1 DEFINITIONS

The following terms as used throughout this RFA shall have the meanings set forth below:

“Accountable Care Program” or **“(ACP)”** means a formal network of providers and health systems, collaborating to deliver Integrated Care and assuming financial and clinical accountability for a defined population.

“ACP Participants” means the population of members who belong to the ACP provider (attributed or designated) in a Plan Year.

“Addendum” or **“Amendment”** means a written clarification or revision to this RFA issued by the RFA Coordinator.

“Aggregate Allowed Amount” means the sum of the Allowed Amounts for all ACP Participants during a performance year. There will be a separate Aggregate Allowed Amount for the Designated Cohort and the Attributed Cohort.

“Aggregate Updated Base Costs” means the sum of all Updated Base Costs for the ACP Participants in either the Attributed Cohort or the Designated Cohort for a Performance Year.

“Allowed Amount” means the dollar amount approved as payment in full by HCA for the covered services furnished to an individual ACP Participant during a plan year, and, except as expressly stated otherwise in the contract, includes the dollar amounts allowed by employer for all medical, behavioral health and chemical dependency and pharmaceutical claims for Covered Services.

“Applicant” means the individual, company, or firm submitting an application in order to attain a contract with the Agency.

“Applications” means a written offer to perform a contract to provide goods or services to the State in application to an RFA or other acquisition process.

“Attributed ACP Participant” means a Member who is not a Designated ACP Participant (e.g., enrolled in an ACP) and who is Definitively Attributed to the ACP provider for a Performance Year in accordance with the attribution methodology.

“Attributed Cohort” or **“Cohort”** means the population of PEBB members who are Attributed ACP Participants.

“Binding Relationship” means an agreement has been consciously made, and certain actions are now either required or prohibited.

“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.

“Choosing Wisely” is an initiative of the American Board of Internal Medicine (ABIM) foundation to help providers and patients engage in conversations to reduce overuse of tests and procedures and supports patients in their efforts to make smart and effective care choices.

“Clinical Integration” means a health system that has demonstrated clinical leadership by taking accountability for delivering integrated clinical care delivery models for a defined population that are designed to produce quality, cost, efficiency and value.

“Confidential Information” means information that is exempt from disclosure to the public or other unauthorized persons under either chapter 42.56 RCW or other state or federal statutes. Confidential Information may include, but is not limited to, names, addresses, Social Security numbers, e-mail addresses, telephone numbers, financial profiles, credit and debit card information, driver’s license numbers, medical data, law enforcement records, source code or object code, security data, or any related payroll/labor data.

“Contractor” means that firm, provider, organization, individual or other entity performing services under this contract. It shall include any subcontractor retained by the prime contractor as permitted under the terms of this contract.

“Designated ACP Participant” means a Member who has chosen to enroll in the ACP Plan in accordance with the Plan for the Performance Year.

“Designated Cohort” means the population of Members who are Designated ACP Participants.

“Fee-for-Service” means a health care payment for unbundled and separate services; health care providers are paid for each service (for an office visit, test or procedure).

“Finalist(s)” means Applicant(s) that successful pass all three (3) evaluation phases and are asked to begin award negotiations.

“Financial Reconciliation” means the accounting process by which HCA compares the Aggregate Allowed Amount for a Performance Year to the Aggregate Updated Base Costs for the same Performance Year and calculates either Net Savings or Net Deficit separately for the Attributed Cohort and the Designated Cohort

“Health Care Authority” or **“(HCA)”** means the State of Washington Health Care Authority and its employees and authorized agents.

“HCA Contract Administrator” means that HCA employee designated to receive legal notices, and to administer, amend or terminate this Contract.

“HCA Contract Manager” means the agency 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.

“Integrated Care” means the delivery of a comprehensive continuum of physical, mental health and substance abuse services with accountability for and infrastructure to support financial and clinical outcomes across all care delivery partners for defined populations.

“Mandatory” or **“(M)”** means the Applicant must comply with the requirement, and the Application component will be evaluated on a pass/fail basis.

“Net Deficit Aggregate Updated Base Costs” shall mean the Aggregate Updated Base Costs for either the Attributed Cohort or the Designated Cohort for a Performance Year multiplied by the Net Deficit Guarantee Rate set forth in Table 1 for the same Performance Year.

“Net Savings” means the amount by which the Aggregate Allowed Amounts for a Performance Year is less than the Net Savings Aggregate Updated Base Costs, calculated separately for each Cohort.

“Net Savings Aggregate Updated Base Costs” shall mean the Aggregate Updated Base Costs for either the Attributed Cohort or Designated Cohort for a Performance Year multiplied by the Net Savings Guarantee Rate set forth in Table 1 for the same Performance Year

“Primary Care Provider” or **“(PCP)”** means a licensed health care practitioner who delivers routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury. This can include a general practice physician, family practitioner, internist, pediatrician, osteopath, naturopath, physician assistant, osteopathic physician assistant, and advanced registered nurse practitioner licensed under Title [18](#) RCW.

“Public Employees Benefits Board Program” or **“(PEBB) Program”** means the program that purchases and coordinates health insurance benefits for eligible public employees and retirees.

“Puget Sound Region” means the five (5) county area of Snohomish, Kitsap, King, Thurston and Pierce counties.

“Professional Services” means professional or technical expertise provided by a consultant to accomplish a specific study, project, task, or other work statement.

“Proprietary Information” means information owned by Applicant to which Applicant claims a protectable interest under law. Proprietary Information includes, but is not limited to, information protected by copyright, patent, trademark, or trade secret laws.

“Revised Code of Washington” or **“(RCW)”** means the laws of the state of Washington. All references in this Contract to RCW chapters or sections shall include any successor, amended, or replacement statute. Pertinent RCW chapters can be accessed at <http://www.leg.wa.gov/LawsAndAgencyRules/Pages/default.aspx>

“Request for Applications” or **“(RFA)”** means a Formal applications document in which a service or need is identified but no specific method to achieve it has been chosen. The purpose of an RFA is to permit the respondent to suggest various approaches to meet the need within financial parameters outlined in this RFA but to be finalized during negotiations with successful finalists.

“The Dr. Robert Bree Collaborative” or **“(Bree Collaborative)”** means the multi-stakeholder collaborative that was established in 2011 by the Washington State Legislature to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes and cost effectiveness of care in Washington State.

“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.

“Scored” or **“(S)”** means the Applicant must comply with the requirement and the Application component will be scored.

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

“Telemedicine” means to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

“Triple Aim” means (1) Improving the patient experience of care (including quality and satisfaction); (2) Improving the health of populations; and (3) Reducing the per capita cost of health care, as defined by the Institute for Healthcare Improvement.

“Washington Administrative Code” or **“(WAC)”** means the rules adopted by agencies to implement legislation and RCWs. All references in this Contract 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 Electronic Business Solutions” or **“(WEBS)”** is the State's vendor registration and bid notification system where Applicants can register to receive government bid notifications and where notices and information related to this RFA will be posted. Washington Electronic Business Solutions is located at: <http://www.des.wa.gov/services/ContractingPurchasing/Business/Pages/default.aspx>

Note: If you do not download bid documents, you will not receive any subsequent notifications regarding the RFA.

2 INTRODUCTION

2.1 Summary

The Washington State Health Care Authority (HCA) is soliciting one or more clinically integrated health care organizations and/or network of partners to provide an Accountable Care Program (ACP) option, effective January 1, 2016. The ACP option will be offered to Public Employees Benefits Board (PEBB) program members in multiple contiguous Washington counties, with preference given to the five (5) county Puget Sound region.

2.2 Purpose

The purpose of this Request for Application (RFA) is to evaluate health systems' readiness and capacity to deliver Integrated Care as outlined in the requirements of this RFA. Successful Applicant(s) will have the ability to: (1) deliver high-quality care; (2) have knowledge, experience and capacity to clinically integrate care (centered on a strong primary care foundation), (3) be accountable financially and clinically for a defined population (including hospital and specialty care), and (4) produce measurable improved health outcomes.

This solicitation is predicated on the clinically integrated health care organization and/or network of partners' ability to improve the health of PEBB members and willingness to guarantee that HCA's total per member per year (PMPY) costs will remain significantly below current PEBB trends for the duration of the contract. Successful Applicant(s) must also ensure that quality of care delivered to PEBB members markedly increases annually, based on standard measures of performance, described in further detail in this solicitation. Toward that end, HCA will require that successful Applicant(s) enter into a binding agreement built on financial and quality guarantees, achieved through a combination of effective care delivery models and aligned health system reimbursement and financial incentives.

2.3 Background

"Paying for Value" is a core strategy of the State Health Care Innovation Plan (Innovation Plan), also known as the Healthier Washington Initiative.¹ The Healthier Washington Initiative charts a bold course for transformative change in the way health care is delivered and paid for in Washington State. The Innovation Plan was embraced by the Washington State Legislature in 2014 through the passage of E2SHB 2572, requiring HCA "to increase the use of value based contracting, alternative quality contracting, and other payment incentives that promote quality, efficiency, cost savings, and health improvement, for Medicaid and public employee purchasing." Furthermore, the legislature anticipates this effort will "reduce extraneous medical costs, across all medical programs, when fully phased in by fiscal year 2017 to generate budget savings identified in the omnibus appropriations act."

¹ For Healthier Washington information, see: <http://www.hca.wa.gov/hw/Pages/default.aspx>.

As the largest purchaser of health care services in Washington State, HCA is changing how it purchases health care so payment is based on value, not volume. Through a multi-year, phased approach, HCA will drive accountable care and value-based purchasing strategies statewide in an effort to phase out traditional Fee-For-Service (FFS) payment models; align provider, payer and consumer incentives; and reward value, quality, effectiveness and efficiency. Washington aims to drive 80 percent of state-financed health care and 50 percent of the commercial market to value-based payment by 2019.

To accelerate market transformation, HCA in tandem with its own State-purchasing efforts will engage multiple payers, providers, and purchasers in aligning accountable care strategies, alternative payment models and basic delivery system requirements across Washington State through the Healthier Washington Initiative.²

ACP option under the PEBB program

The PEBB program provides medical benefits to over 350,000 state and other public employees and dependents including active employees, pre-Medicare retirees and Medicare retirees. The PEBB program is administered by HCA and is governed by the Public Employees Benefits Board.

Currently, PEBB members can choose from various health plan options through PEBB's self-funded business (Uniform Medical Plan (UMP), administered by Regence Blue Shield) or fully-insured business (Health Maintenance Organizations (HMO) Group Health Cooperative and Kaiser Permanente). Over 240,000 PEBB members are enrolled in UMP, and the remaining in an HMO. Moda Health is UMP's pharmacy benefits manager.

The ACP will be a health option offered to PEBB members under PEBB's self-insured business in multiple contiguous Washington counties, with preference given to the 5-county Puget Sound region. Approximately 163,000 active, non-Medicare PEBB members live in the Puget Sound region (county breakdown below):

- 71,000 in King County
- 41,000 in Thurston County
- 23,000 in Pierce County
- 22,000 in Snohomish County
- 5,800 in Kitsap County

Successful Applicant(s) will work with HCA's current claims administrator, Regence Blue Shield. Regence will continue to perform all present administrative services (e.g., managing provider network, administration of claims, data reporting, etc.).

Since HCA intends to expand ACP initiatives statewide by 2017, HCA is interested and will consider applications that offer an ACP option beyond the 5-county Puget Sound region for other Washington counties.

² For a description of proposed multi-purchaser and multi-payer strategies (Model Test 3 and 4), see Healthier Washington federal grant application: http://www.hca.wa.gov/hw/Documents/SIM_Grant_Application.pdf.

2.4 Expected Contract Term

The period of performance of any contract resulting from this RFA is tentatively scheduled for April 8, 2015 through December 31, 2020. Note: ACP option begins January 1, 2016, with contractually obligated start-up activities commencing by April 8, 2015.

HCA reserves the right to expand the scope of contract, e.g., geographic service area.

HCA reserves the right to not issue any contracts at all stemming from the RFA.

2.5 Financial Terms

Financial terms are dependent on Applicant(s) ability to manage costs within the parameters set, and will be finalized during negotiations with successful Applicant(s).

HCA will be making sufficient benefit enhancements to promote ACP option enrollment including some combination of lower monthly premium and lower point of care out of pocket expenses.

2.6 Americans with Disabilities Act

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

3 HCA REQUIREMENTS FOR SUCCESSFUL APPLICANT(S)

3.1 HCA's requirements of the ACP.

HCA's requirements of the ACP option are built on the Washington Health Alliance's Purchaser Guidelines to Evaluate Contracts for Accountable Care Organizations³ as outlined in HCA and King County's joint Request for Information (RFI), released in April 2014.

3.1.1 Organizational Structure, Partners and Commitment to Accountable Care.

HCA requires that the successful Applicant(s) currently has (alone or with partners) a comprehensive clinically integrated network in place that includes:

- 3.1.1.1 [Adequate geographical coverage](#) across multiple contiguous counties, with preference given to the five (5) county Puget Sound region demonstrated with geo-mapping for PEBB members;
- 3.1.1.2 Broad spectrum of services that assure high-quality delivery of all HCA's covered services and data and clinical systems that support the delivery of evidence based care;
- 3.1.1.3 Timely access to primary care and specialists visits, including the use of telephone consultations, virtual visits (including email), telemedicine and home monitoring; and
- 3.1.1.4 HCA requires successful Applicant(s) have a single, unified vision and leadership structure for their entity, with commitment of senior leaders, backed by the needed resources to implement the vision. In most instances, the vision driving a successful ACP option will differ substantially from the existing vision of the hospital or medical group.

3.2 Financial Approach and Guarantees

HCA will begin the process of performance incentives and disincentives with successful Applicant(s), starting in the first year of the contract. Performance incentives and disincentives will be tied to achieving specific financial, quality, patient experience and clinical outcomes targets. Successful Applicant(s) will share in savings if the targets are exceeded and agreed quality targets met, but will be penalized financially if targets are not met. HCA will require that successful Applicant(s)' trend to be significantly lower than current forecasted PEBB trend.

The financial requirements outlined in this RFA anticipate a five (5) year minimum agreement and will apply to two (2) Cohorts of ACP Participants:

1. Designated ACP Participants – PEBB members who have enrolled themselves and their dependents in the ACP option,

³ See www.wahealthalliance.org. For more information, please contact Susie Dade (sdade@wahealthalliance.org).

2. Attributed ACP Participants – PEBB members who have not elected the ACP option but who are using the ACP system based on overall utilization patterns under an agreed to attribution model.

On an annual basis, a Financial Reconciliation will be conducted for each Cohort to determine whether there are Net Deficits and/or Net Savings based on the financial requirements in Table 1 below. Table 1 illustrates the ACP’s responsibility for Net Deficits and opportunity to share in Net Savings relative to the 2015 Base Cost for each Performance Year.

Table 1

	ACP GUARANTEE		NET DEFICITS		NET SAVINGS	
	Designated Cohort	Attributed Cohort	Designated Cohort	Attributed Cohort	Designated Cohort	Attributed Cohort
2015	Base Cost PMPM	Base Cost PMPM	Base Cost established during 2015		Base Cost established during 2015	
2016	101%	102%	Net Deficit for each Cohort if Actual is greater than Base x ACP Guarantee		Net Savings for each Cohort if Actual is Base x ACP Guarantee	
2017	101%	102%				
2018	100%	101%				
2019	100%	101%				
2020	99%	100%				

While further details of the financial accountability and trend guarantee methods will be finalized during negotiations with successful Applicant(s), the following outlines the basic parameters of this method.

- 3.2.1 HCA will take both cost and quality into consideration when calculating the ACP guarantees.
- 3.2.2 The Financial Reconciliation will be performed separately for each Cohort and include a complete accounting of the Aggregate Allowed Amounts for all Covered Services furnished to the ACP Participants, including medical, pharmacy and behavioral health claims.
- 3.2.3 The Financial Reconciliation will be done on an incurred claims basis with 3 months run-out with no adjustment for claims incurred but not paid.
- 3.2.4 All financial calculations will be performed on a per-member-per-month (PMPM) basis.
- 3.2.5 Each ACP member’s 2015 PMPM Allowed Amounts will serve as his or her Base Cost from which increases or decreases in the Performance Year PMPM Allowed Amounts will be measured in the Financial Reconciliation.

- 3.2.6 The actual Performance Year PMPM Allowed Amount for each ACP Participant will be compared to his or her PMPM Base Costs updated as follows (Updated Base Costs):
 - 3.2.6.1 2015 Base Costs will be adjusted to equivalent Performance Year costs if there are changes to covered services.
 - 3.2.6.2 There will be separate adjustments for births and deaths.
- 3.2.7 Members enrolled during 2015 but not enrolled as of 1/1/16 will be excluded from Base Cost determination.
- 3.2.8 Surrogate Base Costs will be established for new entrants to the HCA self-funded plan during 2015, defined as those without 12 full months of 2015 enrollment:
 - 3.2.8.1 Their actual claims will be excluded from Base Cost claims.
 - 3.2.8.2 The Surrogate Base Cost will be calculated separately for each member in each Cohort, and will be equal to the average 2015 PMPM Allowed Amount for 2016 ACP Participants who were enrolled in an HCA self-insured plan in 2015, adjusted for age and gender.
- 3.2.9 ACP has the opportunity to share in Net Savings, up to fifty percent (50%), if quality targets are exceeded.
- 3.2.10 ACP will be responsible for one-hundred percent (100%) of Net Deficits in each year.
- 3.2.11 The Financial Guarantees in Table 1 will be factored into the Financial Reconciliation as follows. The Updated Base Costs for each Cohort (Attributed and Designated) will be multiplied by the Net Savings Guarantee Rate or the Net Deficit Guarantee Rate for the applicable Cohort and Performance Year and compared to the Performance Year Allowed Amounts to determine the Net Savings or Net Deficits for that Performance Year.

3.3 Alternative Payment Models

In addition to financial guarantees, new payment models are critical in order to successfully manage health care costs and transform care. HCA requires that successful Applicant(s) demonstrate movement away from FFS and have experience and knowledge in developing and implementing alternative payment models, including changes to provider compensation (e.g., care management fees, utilization bonuses, quality bonuses, shared savings/risk arrangements, bundles, warranties, total cost of care/global budget and other shifts in internal payment arrangements, etc.).

3.4 Measuring and Rewarding Quality, Performance and Outcomes

Financial incentives and disincentives and new payment methods will drive improvements in quality of care, patient experience and the health of PEBB members. As specified above, to share in Net Savings, successful Applicant(s) financial payment will be tied to performance on meeting or exceeding benchmark targets (e.g., the National Committee for Quality Assurance (NCQA) national 75th or 90th percentile) for a subset of evidence-based quality and patient experience metrics in the Washington statewide core measure set and additional health status and appropriateness metrics:

3.4.1 Chronic Conditions (NCQA Measures).

3.4.1.1 Blood pressure and A1C control for patients with diabetes.

3.4.1.2 Blood pressure control for patients with hypertension.

3.4.1.3 Prescribing of and adherence to statins for patients with Coronary Artery Disease (CAD).

3.4.2 Health Status (NCQA Measures).

3.4.2.1 PHQ9 depression assessment and follow up including remission rates.

3.4.2.2 Adult BMI screening and follow-up.

3.4.3 Preventive and Obstetric (NCQA Measures).

3.4.3.1 Colorectal cancer screening.

3.4.3.2 Cervical cancer screening.

3.4.3.3 NTSV C-section rate.

3.4.4 Member Experience (Clinician and Group- Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)).

3.4.5 Adherence to evidence-based medicine.

3.4.5.1 Adherence to appropriateness for surgery criteria in the Bree Collaborative Total Knee and Hip Replacement (THR/TKR) bundle.

3.4.5.2 Adherence to appropriateness of PCI.

3.4.5.3 Adherence to the Washington opiates prescribing guidelines for patients with non-malignant pain.

Successful Applicant(s) will be responsible for providing patient specific quality outcome data on a quarterly basis. Baseline and annual benchmark targets will be determined during negotiations.

In addition to collecting and reporting on metrics tied to Net Savings, successful Applicant(s) will be required to measure and report on additional metrics that monitor the rate and magnitude of quality improvement including the entire Washington statewide core measure set, additional quality, patient experience, outcome, productivity and utilization metrics as defined by the Bree Collaborative and Department of Labor and Industries (L&I), and other nationally-vetted metrics. Results will be expected to be shared with HCA on a semi-annual basis.

3.5 Coordinating and Standardizing Care: Improving Outcomes and Lowering Costs

HCA requires the successful Applicant(s) to:

- 3.5.1 Improve health and reduce the incidence of chronic conditions and major acute conditions through effective prevention and screening;
- 3.5.2 Effectively manage, integrate and ensure seamless care for chronic conditions, particularly for complex patients with physical and behavioral health conditions;
- 3.5.3 Use the lowest cost, highest quality care for acute, emergency and non-emergency conditions;
- 3.5.4 Implement HCA clinical policies; and
- 3.5.5 Implement HCA-endorsed Bree Collaborative recommendations and the Health Technology Assessment Program coverage decisions

Successful Applicant(s) must have the tools and demonstrate capacity to proactively monitor patient – within and outside their network – to ensure primary care, preventive services, and screenings are appropriate, evidence-based, and delivered in ways that are culturally and linguistically appropriate for the patient.

3.6 Health Information Technology to Improve Quality

HCA requires that successful Applicant(s) will have fully certified Electronic Health Record (EHR) systems as defined by the [Office of the National Coordinator](#). HCA further requires successful Applicant(s) to contribute clinical data from their EHR system to the state Health Information Exchange hosted by OneHealthPort, when a clinical data repository service is offered.

3.7 PEBB Member Engagement & Experience

HCA requires that successful Applicant(s) proactively engage PEBB members and encourage healthy behaviors, as well as help PEBB members identify which types of testing and treatments are appropriate. Successful tools will be culturally and linguistically appropriate for each PEBB member and ideally will include shared-decision making, an interactive member portal website which displays cost and quality information, videos, provider listings, information on how to access primary, specialty and behavioral health providers and selection of a primary care physician.

HCA requires that successful Applicant(s) measure and assess the impact and effectiveness of patient engagement activities (e.g., improved use of preventive services, reduction in unnecessary treatments or services, patient activation levels and self-management). Last, HCA will require PCPs to reach out proactively to welcome PEBB member and their families to their network/system.

3.8 Timely Access to Care

HCA requires successful Applicant(s) to provide appropriate, timely and convenient access to care for a defined PEBB population. (see **Table 2**)

Successful Applicant(s) also should offer and provide appropriate provider reimbursement for telephone consultations, virtual visits (including email), telemedicine and home monitoring.

HCA's required access standards for successful Applicant(s) are described in Table 2, below. Additionally, successful Applicant(s) will need to include access to sites that are open late (7 p.m.) and on weekends.

Table 2

Category	Criteria	Designated	Attributed	
		2016+	2016	2017+
PCP Visits for acute and urgent problems	Same or next day PCP visits with PEBB member's PCP, covering PCP, a new PCP (for those without an existing PCP relationship), or at an urgent care clinic.	95% of the time	95% of the time	95% of the time
PCP Visits for non-urgent and routine problems	Within ten (10) business days, with PEBB member's PCP, or for those without an existing PCP relationship, or a new PCP. The visit may be with a covering PCP if the PEBB member's PCP is unavailable due to protracted absence from the office.	95% of the time	95% of the time	95% of the time
Specialist Visits for acute and urgent problems	Within three (3) business days.	95% of the time	95% of the time	95% of the time
Specialist Visits for non-urgent and routine problems:	Within ten (10) business days. For PEBB members with an ongoing relationship with a specialist, the appointment will be with that specialist (if the condition is related to the original condition), or a covering practitioner in the same practice.	95% of the time	95% of the time	95% of the time

3.9 Required Administrative and Clinical Services

HCA requires that successful Applicant(s) will perform the required administrative and clinical services to successfully implement and launch the ACP option effective January 1, 2016 as identified in Table 3, below.

Table 3

Service	Summary of Pre-Launch Requirements	Summary of Annual Enrollment Requirements	Summary of Ongoing Requirements
HCA-dedicated customized website/member portal (available 24 hours)	<ul style="list-style-type: none"> Promotion of ACP option and ACP providers (including list and description of providers and clinics) Ability to be embedded in select HCA sites 	<ul style="list-style-type: none"> Provider search capability PEBB member services call number Link to select HCA sites 	<ul style="list-style-type: none"> User login Online welcome kit Registration for access to patient health record Appointment scheduling Email with ACP Providers/clinics Prescription refills Administrative support for members using site (i.e. password reset, navigation, site issues, etc.)
HCA-designated contact center (staffed with experienced customer service reps)	<ul style="list-style-type: none"> Educate contact center staff on the ACP option, outlining expectations for member experience 	<ul style="list-style-type: none"> Answer member questions about ACP providers and clinics Refer members to other experts (e.g., customer service support) 	<ul style="list-style-type: none"> Integrated with all ACP providers and clinics Extended hours of operation Support PEBB members with appointment scheduling (centralized or warm transfer) 24/7 nurse line Refer PEBB members to other providers as needed

3.10 Partnering with Purchasers on Strategies & Participation in Multi-Payer & Multi-Stakeholder Activities

To truly transform health care, purchasers, payers and delivery systems must partner to align provider payment strategies, delivery system design, benefit design and member education/support. HCA requires that successful Applicant(s) actively participate in multi-payer and multi-stakeholder activities, including replicating or extending HCA’s ACP model and requirements with other interested purchasers. Actively participating in multi-payer and multi-stakeholder activities is defined as incorporating recommendations produced by community collaboratives and quality improvement programs including Accountable Communities of Health, Health Technology Assessment Program, Dr. Robert Bree Collaborative and the Foundation for Health Care Quality programs (e.g., COAP, SCOAP, and OB-COAP).

4 RFA APPLICATION QUESTIONS

4.1 INSTRUCTIONS

4.1.1 Mandatory Application Overview

The Applicant must complete a response for each mandatory and scored section. Applications may be disqualified for not completing RFA sections. Each Mandatory item is noted with an (M) and scored on a Pass/Fail basis. Each Scored item is noted with a (S) and scored based on how Applicant's response meets compliance with the requirement.

In responding to each RFA requirement, Applicants must clearly state whether or not they meet the requirement by providing a detailed description of how they meet the requirement. Applications will be scored based on how well the Applicant meets HCA's requirements. Failure to meet an individual requirement will not be the sole basis for disqualification; however, failure to provide a response may be considered non-responsive and be the basis for disqualification of the application.

4.1.2 Scored Application Overview

Answers must be completed in a separate document unless otherwise noted. Answers must be submitted by restating the question number and text of the question in sequence, and writing the answer immediately after the question.

Page limits for each question are noted in the question. HCA highly values specificity over word count. In describing initiatives already underway, always include as much specificity as possible: dates, quantitative results, how you have assessed and implemented needed course corrections, capabilities yet to be developed, redefined roles and accountability, member involvement and next steps. Please refrain from including brochures, report and other materials as attachments to your application.

To the extent that your application is from more than one (1) clinically integrated organization and/or network of partners, we ask that you answer the questions as follows:

- 4.1.2.1 Provide one (1) integrated answer for your proposed ACP entity, including the Lead Applicant and partners (e.g., hospitals, medical groups and clinics and others).
- 4.1.2.2 Within each answer, include a separate response to each question for the Lead Applicant and each partner.⁴
- 4.1.2.3 Address on a scale of 0% to 100% progress made to date in both planning and penetration (percent of population to which initiative is currently available).

⁴ If partner is a medical group, providing a response for each medical group is sufficient; no need to include an answer for each clinic in each medical group.

- 4.1.2.4 If your answer is 'No' for a specific question, please indicate how you plan to address this going forward and your timeline.

4.2 QUESTIONS

4.2.1 (S) Organizational Structure, Partners and Commitment to Accountable Care (Max 20 points)

4.2.1.1 Complete Attachment A, Partner Information Request. (No page limit).

4.2.1.2 Complete Attachment B, Geoaccess Request. (No page limit).

4.2.1.3 Explain how you will gain the commitment of each partner, including various key leaders of medical groups, hospitals and others to implement integrated clinical care for a defined population. (Answer not to exceed 4 pages).

4.2.1.4 Please address how you will ensure commitment of top clinical and executive leadership and present a plan to: (Answer not to exceed 4 pages).

4.2.1.4.1 Merge the expertise, skills and interests in the governance structure that best supports managing the needs of a defined population.

4.2.1.4.2 Develop leadership and management structure that includes both clinical and managerial expertise to achieve top performance.

4.2.1.4.3 Demonstrate a detailed resource plan to successfully execute the strategy across all affiliated health systems.

4.2.1.4.4 Designate leaders to work specifically with HCA on the successful rollout and execution of the business plan and clinical care delivery plan.

4.2.1.4.5 Demonstrate rapid cycle infrastructure needed to measure and continuously improve on a quarterly basis of a defined population.

4.2.1.4.6 Demonstrate some means of cost, quality and member service transparency and systematic handling of errors and quality problems to improve care.

4.2.1.4.7 Demonstrate commitment to deliver care that adheres to the Cultural and Linguistically Appropriate Services (CLAS) standards issued by the United States Department of Health and Human Services Office of Minority Health.⁵

⁵ For more information on CLAS Standards, see <https://www.thinkculturalhealth.hhs.gov/content/clas.asp>.

- 4.2.1.5 Explain the criteria used when selecting your network partners. (Answer not to exceed 2 pages).
- 4.2.1.6 Please submit a copy of the Memorandum of Understanding (MOU) or relevant legal agreements from each of your major proposed partners (e.g., hospitals and medical groups). (No page limit).
- 4.2.2 (S) Financial Approach, Guarantees and Alternative Payment Models (Max 30 points)
 - 4.2.2.1 Complete Attachment C, Alternative Payment Model. (No page limit).
- 4.2.3 (S) Measuring & Reporting Quality, Performance and Outcomes (Max 20 points)
 - 4.2.3.1 Complete Attachment D, Quality Measures. For each area that is lower than national benchmarks or average, please also describe your plan for improving outcomes. Additionally, if available, please share any internal quality data (compared against national benchmarks). (No page limit).
 - 4.2.3.2 Provide sample formats of financial, utilization and clinical reports, along with any additional standard reports that you anticipate providing to managers and physicians in your proposed ACP entity. Describe frequency of reports and expectation of how they are used. (Answer not to exceed 5 pages).
- 4.2.4 (S) Demonstrate Plans or Proof of Programs that Standardize Care, Improve Outcomes and Lower Costs (Max 30 points)
 - 4.2.4.1 Episodic/Acute Care (Answers not to exceed 6 pages)
 - 4.2.4.1.1 **Total Hip and Knee Replacement “Bundle”**: Joint replacements are one of the most common surgical procedures in the PEBB population. The Dr. Robert Bree Collaborative (Bree Collaborative) has identified, and the HCA has endorsed, evidence-based care bundles for THR/TKR.⁶ Key elements of these bundles include four (4) clinical components: disability due to osteoarthritis despite conservative therapy, pre-operative, intra-operative and post-operative care.
 - 4.2.4.1.1.1 Describe the extent to which THR/TKR within and across proposed ACP partners conform to the four clinical components defined in the Bree Collaborative THR/TKR Bundle.

⁶ For a copy of the Bree Collaborative THR/TKR Bundle, see http://www.breecollaborative.org/wp-content/uploads/tkrthr_bundle.pdf.

4.2.4.1.1.2 Describe any variation with respect to the Bree Collaborative THR/TKR Bundle that exists within and across proposed ACP partners (hospitals and clinicians). How do you plan to integrate and standardize care across ACP partners and partner affiliations for patients undergoing THR/TKR?

4.2.4.1.1.3 Describe any ongoing quality improvement initiatives across proposed ACP partners with respect to improving the care and outcomes of patients undergoing THR/TKR. What QI model is being employed? What data is tracked and how is it fed back to clinicians and managers? What role do physician leaders play in this QI effort?

4.2.4.1.2 **Lumbar fusion “Bundle”**: Spinal surgeries are one of the most common surgical procedures in the PEBB population. The Bree Collaborative has identified, and the HCA has endorsed, an evidence-based care bundle for lumbar fusion.⁷ Key elements of these bundles include four clinical components: disability despite non-surgical therapy, fitness for surgery, spinal fusion procedure, and post-operative care and return to function.

4.2.4.1.2.1 Describe the extent to which lumbar fusions within and across proposed ACP partners conform to each key element of the Bree Collaborative Bundle.

4.2.4.1.2.2 Describe any variation that exists with respect to the Bree Collaborative lumbar fusion bundle within and across proposed ACP partners (hospitals and clinicians). How do you plan to integrate and standardize care across ACP partners and partner affiliations for patients undergoing lumbar fusions?

4.2.4.1.2.3 Which hospitals in your ACP participate in the Spine Surgery Clinical Outcomes Assessment Program (“Spine-SCOAP”)?

⁷ For a copy of the Bree Collaborative Lumbar Fusion Surgical Bundle, see <http://www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Bundle-Final-14-09.pdf>.

4.2.4.1.2.4 Describe any ongoing quality improvement initiatives across proposed ACP partners with respect to measuring and improving the care and outcomes of patients undergoing lumbar fusions. What QI model is being employed? What data is tracked and how is it fed back to clinicians and managers? What role do physician leaders play in this QI effort?

4.2.4.1.3 Obstetrical care: The PEBB population has a relatively high C-section rate. The Bree Collaborative has promulgated, and the HCA has endorsed, recommendations for obstetrical care.⁸

4.2.4.1.3.1 Describe the extent to which each hospital partner in the proposed ACP that provides OB care has implemented the hospital-specific recommendations of the Bree Collaborative (pages 10-12 of the Bree Collaborative Obstetrics Care Report and Recommendations).⁹

4.2.4.1.3.2 Describe any variation that exists within and across proposed ACP partners (hospitals and clinicians). How do you plan to integrate and standardize obstetrical care across systems and partner affiliations?

4.2.4.1.3.3 Which hospitals in your proposed ACP participate in the Obstetrical Clinical Outcomes Assessment Program (OB-COAP)?

4.2.4.1.3.4 Describe any ongoing quality improvement initiatives across proposed ACP partners with respect to improving obstetrical care and reducing primary and NTSV C-section rates. What QI model is being employed? What data is tracked and how is it fed back to clinicians and managers? What role do physician leaders play in this QI effort? What progress has been made?

⁸ For a copy of the Bree Collaborative Obstetrics Care Report and Recommendations, see http://www.breecollaborative.org/wp-content/uploads/bree_ob_report_final_080212.pdf.

⁹ For a copy of the Bree Collaborative Obstetrics Care Report and Recommendations, see <http://www.breecollaborative.org/topic-areas/obcare/>.

4.2.4.2 **Outpatient care:** Common and complex conditions (Answer not to exceed 10 pages)

4.2.4.2.1 Low back pain (both acute and chronic) is among the most common reasons that PEBB members seek outpatient care. The Bree Collaborative has identified best practices and created check lists for patient, providers, hospitals/clinics, health plans and purchasers for the management of low back pain (LBP).¹⁰

4.2.4.2.1.1 Describe the extent to which primary care clinics across proposed ACP partners have implemented the LBP recommendations of the Bree Collaborative.

4.2.4.2.1.2 How do proposed ACP partners standardize care for the management of LBP consistent with the Bree Collaborative recommendations?

4.2.4.2.1.3 Describe any ongoing quality improvement initiatives across proposed ACP partners with respect to improving the care of patients with LBP. What QI model is being employed? What data is tracked and how is it fed back to clinicians and managers? What role do physician leaders play in this QI effort?

4.2.4.2.2 **Depression, anxiety and substance use disorders** are prevalent conditions that are commonly seen in primary care settings.

4.2.4.2.2.1 Describe how depression, anxiety and substance use disorders are identified within the primary care clinics of proposed ACP partners. Is there a common workflow across clinics for screening for these illnesses?

4.2.4.2.2.2 Describe how depression, anxiety and substance use disorders are managed by the primary care clinics of proposed ACP partners. To what extent is behavioral health integrated into primary care settings? Describe any ongoing efforts to integrate behavioral health in primary care.

¹⁰ For a copy of the Bree Collaborative Spine/Low Back Pain Report and Recommendations and Check Lists, see <http://www.breecollaborative.org/topic-areas/spine/> and <http://www.breecollaborative.org/wp-content/uploads/LBP-Checklists.pdf>.

4.2.4.2.2.3 To what extent are the primary care clinics within proposed ACP partners able to track patients with depression, (PHQ9 screening and remissions), anxiety (GAD screening and remissions), substance use disorders (screening and remissions), and measure and report their outcomes?

4.2.4.2.2.4 Describe any ongoing quality improvement initiatives across proposed ACP partners with respect to improving the care of patients with depression, anxiety, and/or substance use disorder. What QI model is being employed? What data is tracked and how is it fed back to clinicians and managers? What role do physician leaders play in this QI effort?

4.2.4.3 Diabetes is prevalent in the PEBB population.

4.2.4.3.1 Using diabetes as a prototypical chronic disease, describe the extent to which primary care clinics across proposed ACP partners have implemented each of the following elements of the MacColl Institute Chronic Care Model, below.¹¹

1. Clinical Information Systems

- Diabetes registries to identify relevant subpopulations for proactive care.
- Monitor performance of practice teams and care system.
- Provide timely reminders for providers and patients

2. Delivery system design

- Define roles and distribute tasks among team members.
- Provide clinical case management services for complex patients.
- Give care that patients understand and that fits with their cultural background.

¹¹ For a diagram of the Chronic Care Model, see:
<http://www.improvingchroniccare.org/index.php?p=Chronic+Care+Model&s=124>

3. Self-management support

- Emphasize the patient's central role in managing their health.
- Use effective self-management support strategies that include assessment, goal setting, action planning, problem-solving and follow-up.

4. Decision support

- Embed evidence-based guidelines into daily clinical practice.
- Integrate specialist expertise and primary care.

5. The Community

- Encourage patients to participate in effective community programs.
- Form partnerships with community organizations to support and develop interventions that fill gaps in needed services.

4.2.4.3.2 Describe any ongoing quality improvement initiatives across proposed ACP partners with respect to improving the care of patients with diabetes. What QI model is being employed? What data is tracked and how is it fed back to clinicians and managers? What role do physician leaders play in this QI effort?

4.2.4.4 **The “5/50” complex chronic care population:** “High need – high cost” patients with multiple chronic conditions or advanced illness require complex, multi-faceted care.

4.2.4.4.1 Describe how each proposed ACP partner organizes and delivers complex care management for defined populations. Specifically, how do proposed ACP partners perform the following four essential activities of complex care management?

4.2.4.4.1.1 Identifying and engaging patients who are high risk for poor outcomes and unnecessary utilization;

- 4.2.4.4.1.2 Performing comprehensive assessments to identify problems that, if addressed through effective interventions, will improve care and reduce the need for expensive services;
 - 4.2.4.4.1.3 Working closely with patients and their caregivers as well as primary care, specialty, behavioral health and social service providers; and
 - 4.2.4.4.1.4 Rapidly and effectively responding to changes in patients' conditions to avoid use of unnecessary services, particularly emergency department visits or hospitalizations.
- 4.2.4.4.2 Describe any ongoing quality improvement initiatives across proposed ACP partners with respect to improving the care of patients with complex chronic illness. What QI model is being employed? What data is tracked and how is it fed back to clinicians and managers? What role do physician leaders play in this QI effort?
- 4.2.4.5 Cancer is a relatively common and costly condition in the PEBB population.
- 4.2.4.5.1 Describe how proposed ACP partners assure that oncology care is standardized and consistent with evidence-base guidelines across sites providing such care.
 - 4.2.4.5.2 To what extent are the providers within proposed ACP partners able to track patients with cancer, and measure and report outcomes? Does proposed ACP partners measure and report adherence to cancer related Choosing Wisely guidelines?
 - 4.2.4.5.3 How is palliative care and end of life decision-making integrated into the care of cancer patients?
 - 4.2.4.5.4 Describe any ongoing quality improvement initiatives across proposed ACP partners with respect to improving the care of patients in one or more specific cancers. What QI model is being employed? What role do physician leaders play in this QI effort?
- 4.2.4.6 Prevention: Preventive care is essential to improving population health and preventing costly diseases. (Answer not to exceed 2 pages).

4.2.4.6.1 Describe the population-based strategies that primary care clinics across proposed ACP partners currently utilize to assure timely provision of the following preventive services. For each service, describe whether and how registries are utilized, and strategies for outreach and engagement of families and patients.

4.2.4.6.1.1 Pediatric immunizations all ages;

4.2.4.6.1.2 Adolescent well-child visits;

4.2.4.6.1.3 Colorectal Cancer Screening;

4.2.4.6.1.4 Breast Cancer Screening; and

4.2.4.6.1.5 Cervical Cancer Screening.

4.2.4.6.2 Describe any ongoing quality improvement initiatives across proposed ACP partners with respect to improving preventive care. What QI model is being employed? What data is tracked and how is it fed back to clinicians and managers? What role do physician leaders play in this QI effort?

4.2.5 (S) Health Information Technology for Care Coordination/Integration (Answer not to exceed 4 pages) (Max 20 points)

4.2.5.1 Describe how you plan to use EHRs shared point-of-service data exchange systems and other clinical decision support tools (e.g., registries) to support care coordination and integration?

4.2.5.1.1 Where is your organization on the continuum of moving from traditional care, to the fully-Integrated Care needed to succeed as an ACP entity? Address actions you have taken to drive change, and contingency plans for accelerating the pace of change when needed, including:

4.2.5.1.1.1 Coordinating primary and specialty care; for example, ensuring the timely exchange of information between PCPs and specialists; enabling PCPs to virtually access specialists' expertise and avoid unnecessary specialty referrals; and assuring that specialty access is appropriate, timely and efficient.

4.2.5.1.1.2 Coordinating services delivered by subcontractors without a financial stake in ACP outcomes. Examples are: monitoring emergency room use, admissions, and readmission to reduce overuse.

4.2.5.1.2 What steps has your ACP taken to be able to achieve Stage 3 of Meaningful Use by January 1, 2017? Likewise, what steps has your ACP taken to be a full participant in the state Health Information Exchange and any future clinical data repository services?

4.2.6 (S) PEBB Member Engagement & Experience (Answer not to exceed 3 pages) (Max 20 points)

4.2.6.1 Describe how your proposed ACP entity will transform the member experience to attract and retain more membership. Describe virtual tools proposed ACP partners use with used with current patients and what you would provide to PEBB members (e.g, online appointment scheduling and access to personal health data, etc.).

4.2.6.2 Describe any efforts to date within your proposed ACP to incorporate shared decision making into patient – provider communication. How have you assessed the ability of various components of your organization to influence PEBB member and/or patient behavior? Describe further changes you will make to enhance PEBB member shared decision-making.

4.2.7 (S) Partnering with Purchasers on Strategies/Multi-Payer & Multi-Stakeholder Activities (Answers for this section not to exceed 2 pages) (Max 10 points)

4.2.7.1 Describe your experience in working with purchasers or involvement in multi-stakeholder collaboratives or activities.

4.2.7.2 Please describe how you would work with other purchasers interested in replicating or extending the ACP model with their members.

4.2.8 (S) Preliminary Work Plan (Answer not to exceed 3 pages) (Max 10 points)

Please provide a high-level work plan that addresses the key competencies described earlier in this section, plus legal and other operational steps you will need to address to be functional as an ACP by January 1, 2016.

4.2.9 (M) Attestation of Key Pre-Launch Milestones (Pass/Fail)

Using Attachment E, Attestation of Minimum Requirements, Pre-Launch Milestones and Additional Attestations, please attest to your ability to meet key 'Pre-Launch Key Milestones', and 'Additional Attestations'.

4.3 (S) ON-SITE READINESS REVIEW (Pass/Fail)

An on-site Readiness Review will be conducted with up to three (3) of the top scoring Applicants from the written portion of the Application and who meet and pass all minimum requirements in Section 5.4 of this RFA. Applicants must be available for an on-site Readiness Review at their place of business on the days specified in the RFA Schedule. The RFA Coordinator will notify the one (1) to three (3) identified finalists to schedule the exact time and location of the on-site Readiness Review, and will receive a “script” of the exact requirements that will be expected during the Readiness Review. Script will include an on-site readiness review at two (2) or more proposed ACP partner sites and meetings with clinical teams.

The purpose of the on-site Readiness Review will be two-fold: (1) to evaluate care delivery and care processes within the Finalist’s proposed ACP entity, and 2) to review financial statements and cash flow projections.

On-site visits will be organized similar to [The Joint Commission](#) “tracer” on-site visits, except that the Evaluators will use hypothetical patient scenario(s) to “trace” the various points of contact such a patient would experience within your ACP. For example, the Evaluators will review the patient’s file and interview staff that would be involved in the care of in the hypothetical patient, and review protocols, EHR capabilities and other materials that would be used to support the care of the patient.

4.4 (M) BUSINESS REFERENCES

The Applicant must submit up to three (3) non-Applicant owned Business References for which the Applicant has completed work within the last five (5) years. Complete, Exhibit C – Business References with the information for the references. Do not include current HCA staff as references.

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

Notify your Business References that HCA will be contacting them so they will be available for a reference check.

5 GENERAL INFORMATION FOR APPLICANTS

5.1 RFA Coordinator

The RFA Coordinator is the sole point of contact in HCA for this Application. Any other communication will be considered unofficial and non-binding on HCA. Applicants are to rely on written statements issued by the RFA Coordinators. Communication directed to parties other than the RFA Coordinators **may result in disqualification**. All communication between the Applicants and HCA upon receipt of this RFA shall be with the RFA Coordinator or designee, as follows:

RFA Coordinator
Email: contracts@hca.wa.gov

5.2 Communications

All Communications concerning this acquisition must be directed to the RFA Coordinator. Unauthorized contact regarding the RFA with other state employees may result in disqualification. Any oral communications will be considered unofficial and non-binding on HCA. Applicants shall reply only on written statements issued by the RFA Coordinator. Correspondence or Solicitation to any HCA or other State employees is prohibited in any form.

Base your Application on the material contained in the RFA and any subsequent amendments. Disregard any draft material you may have received and any oral representations by any party.

You may use email for any communications required in this RFA **except** your application.

HCA does not take responsibility for any problems in the e-mail, or Internet delivery services either within or outside HCA.

5.3 Application Schedule

All Applicants must adhere to the following schedule of activities. Applicants mailing Applications should allow normal mail delivery time to ensure timely receipt of their Application by the RFP Coordinator listed in this RFP. Late Applications will not be accepted, nor will time extensions be granted.

RFA SCHEDULE

Activity	Due Dates	Time
RFA Release Date	December 19, 2014	
Letter of Intent to Apply	December 30, 2014	2:00 p.m., Pacific Time
Questions from Applicants deadline	December 30, 2014	2:00 p.m., Pacific Time
Answers to Applicants' Questions posted on website on two different dates	On January 2, 2015 & on January 7, 2015	
Complaints Deadline	January 20, 2015	2:00 p.m., Pacific Time
Applications Deadline from Applicants	January 27, 2015	2:00 p.m., Pacific Time
Evaluation Period/Finalist On-site Readiness Review	January 28, 2015 – February 13, 2015	
Projected Announcement of Apparently Successful Applicants (ASA)	February 17, 2015	
Debriefing request deadline	February 20, 2015	2:00 p.m., Pacific Time
Negotiations with ASA(s)	February 23, 2015- March 31, 2015	
Contract Start Date (on or before)	April 8, 2015	

HCA reserves the right to adjust this schedule as it deems necessary, at its sole discretion.

The contents of this RFA and any Amendments will be posted on WEBS. See Section 5.7 for information on how to register in the WEBS system.

5.4 (M) Minimum Requirements

- 5.4.1 Must be licensed to do business in the State of Washington;
- 5.4.2 Must have submitted a Letter of Intent to Apply by the date and time specified in the RFA Schedule;
- 5.4.3 Must be an established clinically integrated health care organization and/or network with partners that offers primary, specialty and hospital care in multiple contiguous Washington counties, with preference given to the five (5) county Puget Sound region, and with capacity to serve at least 50,000 Public Employee Benefit Board (PEBB) program members; and
- 5.4.4 Must agree to enter into a binding agreement with HCA that guarantees a specific annualized performance trend for defined PEBB program populations.

5.5 (M) Letter of Intent to Apply

You must send HCA a Letter of Intent to Apply to be eligible to submit an Application. The Applicant must submit the Letter of Intent to Apply by email only. Submit the Letter of Intent to Apply to the RFA Coordinator no later than date and time stated in the RFA Schedule. Please reference the RFA 14-031 in the subject line and send to the RFA Coordinator at the email address listed in Section 5.1. By submitting the letter, the Applicant accepts the procedure, review criteria and the administrative instructions of this RFA.

Under no circumstances will Letters of Intent to Apply be accepted after the deadline. Submitting a Letter of Intent to Apply does not obligate you to submit an Application. Letters of Intent to Apply may be used as a pre-screening mechanism to determine whether minimum qualifications are met.

Information in your Letter of Intent to Apply should be placed in the same order as the following outline:

- 5.5.1 Lead Applicant's Name (Lead Organization Name and Proposed Partners);
- 5.5.2 Lead Applicant's authorized representative for this RFA (This representative shall also be named the authorized representative identified in the Applicant's Application);
- 5.5.3 Title of authorized representative;
- 5.5.4 Address;
- 5.5.5 Telephone number;
- 5.5.6 Email address;
- 5.5.7 Statement of intent to Apply; and
- 5.5.8 A detailed description documenting how the Lead Applicant and proposed partners meet ALL of the Minimum Requirements specified in Section 3.4 of the RFA.

Failure to submit a Letter of Intent to Apply which addresses all the elements above shall disqualify the Applicant from further participation in the RFA process.

HCA reserves the right to request clarification from the potential Applicant regarding their Letter of Intent to Apply response.

5.6 Applicants Questions and Answers

- 5.6.1 It is the responsibility of the potential Applicants to carefully read, understand and follow the instructions contained in this RFA document and all amendments to the RFA.
- 5.6.2 All questions regarding this RFA must be in writing (e-mail) and addressed to the RFA Coordinator. HCA will only answer questions received no later than dates and times specified in RFA Schedule. Questions received after the date and time stated in the schedule will not be accepted.
- 5.6.3 Individual questions will not be answered prior to the date scheduled for HCA to post answers to Applicants' questions unless the Applicant's question could determine whether that Applicant submits a Letter of Intent to Apply. Those questions and the application will become part of the official questions and answers (RFA Amendment).
- 5.6.4 Applicants' questions and HCA's official written answers will be posted on WEBS and on [HCA's website](#) by the dates in the RFA Schedule. WEBS will send out notices of the posting of the questions and answers only to those Applicants who have downloaded the RFA from WEBS. Applicants are responsible for the accuracy of their contact information in WEBS. If you do not download application documents, you will not receive any subsequent notifications regarding the RFA It is the responsibility of the Applicants who are not registered in WEBS to check the HCA website for any amendments to the RFA. The RFA Coordinator will not send individual notification to Applicants when applications to the questions are available.
- 5.6.5 In order to receive notifications of this opportunity, Applicants must be either registered in the following WEBS commodity codes: 948-07, 948-47, 948-48, 958-61, 953-52, 953-48, and 948-74, or check the [HCA's website](#) at their own discretion.

5.7 WEBS Registration

HCA is required to post all bid opportunities on WEBS, the state's electronic vendor registration and bid notification system. If not currently registered, Applicants interested in obtaining notification of state applying opportunities including those for HCA should register at

<http://des.wa.gov/services/ContractingPurchasing/Business/Pages/WEBSRegistration.aspx>.

There are step by step instructions to guide you through the process however, if you have difficulties, questions about the registration process may be directed to [WEBS Customer Service](#) or (360) 902-7400, 8:00 a.m. to 5:00 p.m., Monday – Friday.

The system is self-maintained and you are responsible for updating your registration information. You are required to use the WEBS vendor registration update functionality to update your registration information a minimum of once every calendar year. Only the account administrator can make changes or updates. Vendors have the ability to add as many additional contacts as necessary. Additional contacts may be branch locations as well as additional users who would like to receive notification of bid opportunities. In order to receive notifications **you must select “yes” for Bid notifications.**

Additional contacts do not have access to modify the vendor profile data but will have access to view and search for bid opportunities.

6 GENERAL PROVISIONS

6.1 Costs of RFA Preparation

HCA will not be liable for any costs incurred by the Applicant in preparation of an Application submitted in response to this RFA, in the conduct of a presentation, in facilitating site visits or any other activities related to applying to this RFA.

6.2 Alternative Applications

Each Applicant may submit only one Application if serving as the Lead Applicant. However, an Applicant can be included or listed as a subcontractor/partner in multiple Applications.

6.3 Ownership of Applications

All Applications and any accompanying documentation submitted in response to this RFA shall become the property of HCA. HCA will have the right to use ideas or adaptations of ideas that are presented in the Applications. Selection or rejection of the offer will not affect this right.

6.4 Insurance

Prior to contract execution (if a contract is awarded), selected Applicant(s) may be required to provide a Certificate(s) of Insurance executed by a duly authorized representative of each insurer showing compliance with the insurance requirements set forth in the Contract.

6.5 Recipient of Insufficient Competitive Applications

If HCA receives only one (1) Application as a result of this RFA, HCA reserves the right to either (a) select that Applicant, (b) select an organization that did not submit a bid but that HCA, in its sole discretion, concludes best meets the needs of HCA; or (c) not award any contract at all.

6.6 Non-Responsive /Waiver of Minor Irregularities

HCA will not be liable for any errors or omissions in Applicant's application. Applicants will not be allowed to alter their application documents after the Application due date identified in the RFA Schedule.

Read all instructions carefully. All Applications will be reviewed by the RFA Coordinator to determine compliance with administrative and mandatory requirements and instructions specified in this RFA. If you do not comply with any part of this RFA, HCA may, at its sole discretion, reject your application as non-responsive.

HCA reserves, in its sole discretion, the right to waive minor administrative irregularities contained in any RFA, including, but are not limited to, items that:

- Do not affect responsiveness;
- Are merely a matter of form or format;
- Do not change the relative standing or otherwise prejudice other offers;
- Do not change the meaning or scope of the RFA;
- Are trivial, negligible, or immaterial in nature;
- Do not reflect a material change in the work; or
- Do not constitute a substantial reservation against a requirement or provision.

6.7 Amendment to the RFA

HCA reserves the right to revise the RFA and to issue amendment(s) to the RFA. HCA may correct errors in the RFA document identified by HCA or an Applicant. Any changes or corrections will be made by one or more written amendment(s), dated, and attached to or incorporated in and made a part of this RFA document. In addition, the answers to questions that are submitted to the RFA Coordinator, together with other pertinent information, shall be provided as an amendment to the RFA. All changes must be authorized and issued in writing by the RFA Coordinator. If there is any conflict between amendments/addenda, or between an amendment and the RFA, whichever document was issued last in time shall be controlling.

The Applicant is instructed to disregard any oral representations it may have received. RFA evaluation will be based on the material contained in the RFA and any amendments to the RFA that have been issued.

It is incumbent upon each potential Applicant to carefully examine these requirements, terms and conditions. If any potential Applicant believes there are discrepancies, omissions or ambiguities in this RFA, the Applicant may submit a written request to the RFA Coordinator for an interpretation. Any inquiries, suggestions or requests concerning interpretation, clarification or additional information shall be made, in writing, (including email transmissions) to the RFA Coordinator, as specified in Section 5.1 of this RFA.

6.8 No Obligation to Buy

HCA reserves the right and without penalty to reject, in whole or in part, any or all applications, to award no contract as a result of this RFA, to advertise for a new RFA, to abandon the need for such services; and to cancel or reissue this RFA prior to execution of an award if it is in the best interest of HCA to do so, as determined by HCA in its sole discretion.

6.9 (M) Proprietary Information/Public Disclosure

HCA is subject to the Public Records Act (chapter 42.56 RCW). Applicant's Application can be disclosed through the process set forth in this subsection. Portions of Applicant's Application may be protected from disclosure through the process set forth in this subsection. However, Applicant cannot restrict its entire Application or entire sections of the Application from disclosure.

Any attempts to restrict disclosure through use of footers on every page and/or statements restricting disclosure will not be honored and may subject Applicant to disapplication.

If Applicant wants to protect any Proprietary Information that is included in its Application from disclosure, the information must be clearly identified by Applicant as Proprietary Information. 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. Applicant must identify sections or pages claimed as Proprietary in its Letter of Submittal (Section 7.3 Letter of Submittal).

HCA will maintain the confidentiality of all information marked Proprietary to the extent consistent with the Public Records Act. If a public disclosure request is made to view Applicant's Proprietary Information, HCA will notify Applicant of the request and of the date that the Proprietary Information will be released to the requester unless Applicant obtains a court order from a court of competent jurisdiction enjoining that disclosure. If Applicant fails to obtain the court order enjoining disclosure, HCA will release the Proprietary Information, on the date specified.

HCA's sole responsibility shall be limited to maintaining Applicant's identified Proprietary Information in a secure area and to notify Applicant of any request(s) for disclosure for so long as HCA retains Applicant's information in HCA records. Failure to so label such materials or failure to timely respond after notice of request for public disclosure has been given shall be deemed a waiver by Applicant of any claim that such materials are exempt from disclosure.

HCA will charge for copying and shipping any copies of materials requested as outlined in chapter 182-04 Washington Administrative Code (WAC). Address requests for copying or inspecting materials to the RFA Coordinator named in this RFA.

HCA will retain RFA records in accordance with Washington State and HCA Records Retention Schedules.

6.10 Acceptance Period

Applications providing less than one hundred twenty (120) calendar days for acceptance by HCA from the RFA due date will be considered non-responsive and will be rejected. Applications that do not address all areas requested by this RFA may be deemed non-responsive and may not be considered for a possible contract resulting from this RFA.

6.11 Authority to Bind HCA

The HCA Director and the Director's designees are the only persons who may legally commit HCA to the expenditures of funds under awards or amendments to the award resulting from this RFA. Successful Applicant(s) shall not incur, and HCA shall not pay, any costs incurred before an award or any subsequent amendment is fully executed.

6.12 Contract Terms

Either party may propose additional contract terms and conditions during negotiation of the final award. These terms and conditions will be within the scope of the RFA and will not affect the RFA evaluations

The Lead Applicant(s) of the Apparently Successful Applicant(s) will be HCA's sole point of contact and will bear sole responsibility for performance under any resulting award.

If the Apparently Successful Applicant(s) refuses to sign the final award within thirty (30) business days of delivery, HCA may cancel the selection and give the award to the next-highest-ranked Applicant(s).

6.13 Incorporation of RFA and Applications in Contract

This RFA and the Applicant(s)'s Application, including all promises, warranties, commitments, and representations made in the successful Application, shall be binding and incorporated by reference in HCA's contract with the Applicant.

6.14 Most Favorable Terms

HCA reserves the right to make an award without further discussion of the Applications submitted. Therefore, applications should be submitted initially on the most favorable terms that the Applicant can offer. At its discretion, HCA reserves the right to request best and final offers from the RFA finalists. Applicants must be prepared to accept this RFA for incorporation into an award resulting from this RFA. The contract may incorporate some of the Applicant's entire Application. It is understood that the application will become a part of the official file on this matter without obligation to HCA.

6.15 Withdrawal of Applications

The Applicants may withdraw an Application that has been submitted at any time up to the RFA due date and time in the RFA Schedule. A written request signed by an authorized representative of the Applicant must be submitted to the RFA Coordinator by email. After withdrawing a previously submitted Application, the Applicant may submit another application at any time up to the RFA due date and time as listed in the RFA Schedule.

6.16 Applications Clarifications

HCA will make the sole determination of clarity and completeness in the Applications to any of the provisions in this RFA. HCA reserves the right to require clarification, additional information and materials in any form relative to any or all of the provisions or conditions of this RFA.

6.17 Non-Endorsement

No informational pamphlets, notices, press releases, research reports and/or similar public notices concerning this project, may be released by any Apparently Successful Applicant(s), without obtaining prior written approval from HCA.

6.18 Waivers

HCA reserves the right, at its sole discretion, to waive specific terms and conditions contained in this RFA. It shall be understood by Applicants that the Application is predicated upon acceptance of all terms and conditions contained in this RFA, unless the Applicant has obtained such a waiver in writing from HCA prior to submission of the Application. Such a waiver, if granted, will be granted to all Applicants.

6.19 Conditional Sales Contract

The State may not enter into a conditional sales contract, unless the contract can be cancelled for non-allocation of funds by the legislature, with no penalty to the State.

6.20 Worker's Compensation Coverage

The Finalist(s) 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. Neither the State of Washington nor HCA will be held responsible in any way, for claims filed by the Finalist(s) or their employees for service(s) performed under the terms of the award that results from this RFA.

6.21 Minority and Women Owned and Veteran Owned Business Enterprises

In accordance with the legislative findings and policies set forth in chapter 39.19 RCW, and RCW 43.60A.200 and 39.22.240, the State of Washington encourages participation by veteran-owned business enterprises and Minority- & Women-Owned Business Enterprises (MWBE), either self-identified or certified by, respectively, the Department of Veterans Affairs or the Office of Minority & Women's Business Enterprises (OMWBE). While the State does not give preferential treatment, it does seek equitable representation from the veterans, minority and women's business communities.

Participation by veteran-owned and MWBE contractors may be either on a direct basis in application to this RFA or as a subcontractor to a contractor. However, no preference will be given in the evaluation of applications, no minimum level of MWBE or veteran-owned business participation shall be required, and applications will not be evaluated, rejected or considered non-responsive on that basis.

Applicants may contact the Office of Minority & Women's Business Enterprises (OMWBE) at <http://www.omwbe.wa.gov/index.shtml> and/or the Department of Veterans Affairs at <http://www.dva.wa.gov/BusinessRegistry/default.aspx> to obtain information on certified firms for potential sub-contracting arrangements or for information on how to become certified.

6.22 Right to Withdraw Selected Finalist(s) Award

HCA reserves the right to withdraw awarding Finalist(s) if prior to executing the contract a receiver is appointed to take possession of the ASA's assets, the ASA makes a general assignment for the benefit of creditors, or the ASA becomes insolvent or takes or suffers action under the federal Bankruptcy Act. In such event, HCA may, in its sole judgment, issue a letter of award to the ASA ranked second as a result of the Proposal evaluation.

7 APPLICATION CONTENT AND SUBMISSION

7.1 (M) Submission and Delivery of Application

Applicants are required to submit their applications in both USB thumb drive or CD and hard copy format. Applicants must submit one (1) hard copy with **original** signatures and six (6) identical **copies** of their application. Submit one (1) electronic copy of all required information on a USB stick or CD-RW/CD-ROM in Microsoft Office 2003 or later and/or Adobe PDF. Ensure the USB or diskette is labeled with the date, RFA title, RFA number, and Applicant's name and packaged with the original copy of the application

The RFA Coordinator must receive the Application at the address no later than the date and time specified in RFA Schedule.

Overnight or hand delivery of Applications:

RFA Coordinator
14-031 – Puget Sound Accountable Care Program
3819 Pacific Avenue S.E., Suite A
Lacey, WA 98503

Applications must be received by the RFA Coordinator at the address specified above no later than the date and time specified in the RFA Procurement Schedule.

Applicants are hereby advised that the U.S. Postal Service does not make deliveries to our physical location. Applications may be delivered by hand or courier/overnight service to our warehouse/mailroom location.

If hand delivering the Applications, Applicant must actually hand the Application to an individual located at our warehouse/mailroom at address listed above. Staff at the warehouse will provide you with a receipt that provides you with a date and time the Application was received.

Applicants mailing their application should allow normal mail delivery time to ensure timely receipt of their application by the RFA Coordinator. Applicants assume the risk for the method of delivery chosen. Applicants are encouraged to submit their applications at least one day early to ensure against unforeseen delivery issues such as weather or traffic problems. HCA assumes no responsibility for delays caused by the U.S. Postal Service, or other delivery systems regarding any documents relating to this RFA.

Extensions will not be granted. Applications received after the specified deadline will be deemed as non-responsive and will not be accepted, reviewed, or evaluated. Emailed Applications will not be accepted and will be disqualified.

All Applications and any accompanying documentation will not be returned.

7.2 (M) Application Format

The Application should be prepared simply and economically, providing straightforward and concise description of the Applicant's ability to meet HCA's ACP requirements.

The Application must be prepared using 11 or 12-size font Arial or Times New Roman and printed on single or double sided 8.5" x 11" inch paper using separators for the major sections of the applications with each copy bound either by binder clips or in 3-ring binders. **Do not use spiral binding.**

The Application must contain information applying to all Mandatory Requirements in each of the major requirements and must include all of the Exhibits completely filled out and signed by an authorized Applicant representative.

The major sections of the RFA to respond to include:

- Attachment F – Letter of Submittal
- Exhibit A – Certifications and Assurances
- Exhibit B – Business References
- Section 4.2 – RFA Questions
- Attachment A – Partner Information Request
- Attachment B – Geoaccess Request
- Attachment C – Alternative Payment Models
- Attachment D – Quality Measures
- Attachment E – Attestation of Minimum Requirements, Pre-Launch Milestones & Additional Attestations

Do not respond by referring to other sections of your Application. Do not refer to websites or other sources in your RFA. The evaluators will only evaluate materials provided in the Application that are responsive to the requirements.

The number in parentheses after each question or requirement represents the maximum number of points that may be awarded for the Applicant's Application to that question or requirement.

Applications must be only based on the material contained in this RFA. Applicants are to disregard any previous draft material and any oral representations they may have received.

It is the Applicant's responsibility to ensure all of the pages are included in all of the copies and all pages are numbered. Reviewers will not have access to pages that were included in the original, but not in their copies.

7.3 (M) Letter of Submittal

The Letter of Submittal will be submitted using **Attachment F**, Letter of Submittal. Applicants must complete all sections of **Attachment F**. Signing **Attachment F** indicates the Applicant accepts the terms and conditions of the RFA. Failure to address all of the elements identified in **Attachment F** may result in disapplication.

Carefully read **Attachment F** as there are additional pages that you must attach to **Attachment F**, depending on your applications to the questions.

8 EVALUATION

The evaluation process is designed to produce a list of up to three (3) Finalists. The top three (3) Applicant(s) may not necessarily be the Applicant(s) of least cost, but rather to the Applicant(s) with the best combination of attributes and demonstrated ability to meet HCA's ACP requirements based upon the evaluation criteria.

Evaluations will only be based upon information provided in the Applicant's Application, and the On-Site Readiness Review. In those cases where it is unclear to what extent a requirement has been addressed, the RFA Coordinator may, at their discretion, contact the Applicant to clarify specific points in an Application. Applicants should take every precaution to assure that all answers are clear, complete and directly address the specific requirement. Applications will be evaluated strictly in accordance with the requirements set forth in this RFA and any issued amendment.

8.1 Evaluation Procedures

- All Applications received by the stated deadline will be reviewed by the RFA Coordinator to ensure that the Applications contain all of the required information requested in the RFA. Only responsive Applications that meet the requirements will be forwarded to the Evaluators for further review. Any Applicant who does not meet the stated application or any Application that does not contain all of the required information will be rejected as non-responsive.
- The evaluations will be conducted in three (3) phases as explained below.
- Responsive Applications will be reviewed and scored by Evaluators, to be designated by HCA, using a point/weighted scoring system in Phase two (2). Applications will be evaluated strictly in accordance with the requirements set forth in this RFA and any addenda that are issued.
- The Applicant(s) that have met the following requirements and passed all Phases will be invited to begin contract negotiations.

8.1.1 Phases:

8.1.1.1 Phase one (1) – Minimum Requirements

Applicants will be reviewed to ensure they meet all Minimum Requirements. Applicants that have met all Minimum Requirements described in Section 5.2, and Attachment E, Attestation of Minimum Requirements, Pre-Launch Milestones and Additional Attestations, of this RFA will be forwarded to the Evaluation Team in Phase two (2).

8.1.1.2 Phase two (2) – Written Application Questions

All Applications that pass Phase one (1) will be reviewed and scored by HCA appointed Evaluators using a point/weighted scoring system. Up to three (3) of the top scoring Applicants from Phase two (2) will advance to the Phase three (3). The scores from Phase two (2) will not carry forward into Phase three (3).

8.1.1.3 Phase three (3) – On-Site Readiness Review

Up to three (3) scoring Applicants from Phase two (2) will advance to Phase three (3) which involves an on-site Readiness Review that involves evaluating care delivery and care processes within the Finalist Applicant’s proposed ACP entity, and 2) to review financial statements and cash flow projections.

Only Applicants that successfully complete Phase three (3) based on the criteria in Section 4.3 will be offered the opportunity to begin Contract Negotiations. HCA reserves the right to select Applicants from Phase three (3) on a pass/fail basis.

8.2 Evaluation Scoring

The maximum number of evaluation points available is 160 points. The Mandatory Requirements are evaluated on a pass/fail basis. The following weighted points will be assigned to the Application for evaluation purposes.

Specific Criteria for RFA Evaluation:

Evaluation Criteria	Maximum Weighted Points
RFA Compliance	Pass/Fail
Mandatory Management Review <ul style="list-style-type: none">• Letter of Intent to Propose – Section 5.5• Letter of Submittal – Section 7.3	Pass/Fail
RFA Questions – Section 4.2	160
Readiness Review – Section 4.3	Pass/Fail
Business References – Section 4.4	N/A
Total	160 Points

8.3 References

HCA reserves the right to obtain and consider information from other sources concerning an Applicant, such as Applicant’s capability and performance under other contracts, the application of any subcontractor identified in the Applications, Applicant’s financial stability, past or pending litigation and other publicly available information.

8.4 Pass/Fail Evaluations

The RFA Compliance and Mandatory Management Review sections of the Applicant’s Applications will be scored on a Pass/Fail basis. Applications receiving a failing score from the RFA Compliance and Mandatory Management Review will be viewed as not meeting the minimum mandatory requirements and will be eliminated from further consideration. Only applications passing all Mandatory requirements will be further evaluated and moved forward to the Evaluators.

8.5 Scored Requirements:

Applications that pass all Mandatory requirements will be further evaluated and scored. Evaluators will evaluate and assign a score to each Scored (S) requirement based on how well the Applicant’s Application matches the requirement.

Score	Description	Discussion
0	No value	The Response has omitted any discussion of this requirement or the information provided is of no value.
1	Poor	The Response has not fully established the capability to perform the requirement, has marginally described its ability, or has simply restated the requirement.
3	Good	The Response indicates an above-average capability and has provided a complete description of the capability or alternative.
5	Excellent	The Response has provided an innovative, detailed demonstration of the capability or established, by references and presentation of information or material, far superior capability in this area.

A score of zero (0) on any Mandatory Scored requirement may cause the entire application to be eliminated from further consideration.

8.6 Pass/Fail Assessment – On-Site Readiness Review

Up to three (3) of the top scoring Applicants from Phase (2) will move on to the Phase three (3), on-site Readiness Review. The on-Site Readiness Review will be assessed on a pass/fail basis based on the criteria (to be disclosure when an On-site Readiness Review is scheduled). Only Applicants receiving a “pass” designation on all Requirements will be asked to participate in Finalist(s) negotiations, but a “pass” designation does not guarantee the offer of an award.

8.7 Contract Award

Up to three (3) Applicants who have passed all three (3) Phases will be considered the Apparently Successful Applicant(s) (ASA) and begin contract negotiations. Upon determining the ASA(s), the RFA Coordinator will provide notification as such by the date identified in RFA Schedule.

8.8 Notification of Unsuccessful Applicants

Applicants, whose Applications have not been selected will be notified via email by the RFA Coordinator.

8.9 Debriefing of Unsuccessful Applicants

Applicants who submitted an Application and were not selected will be given the opportunity for a debriefing conference. The RFA Coordinator must receive the request for a debriefing conference within three (3) business days after the notification of unsuccessful Applicant email is sent. The debriefing shall be held within three (3) business days of the request.

Discussion will be limited to a critique of the requesting Applicant's Application including the factors considered in the evaluation of the requesting Applicant's Application and Applicant's performance with regard to the application requirements. Comparisons between Applications or evaluations of the other Applications 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.

9 RESOLUTION OF PROTESTS

9.1 Protests

Applicants protesting this Application shall follow the procedures described in section 8.3 below. Protests that do not follow these procedures shall not be considered. This protest procedure constitutes the sole administrative remedy available to Applicant under this application.

HCA shall not accept any protest before the announcement of the ASA(s). This procedure is available to Applicants who submitted an Application to this RFA document and who have participated in a debriefing conference. HCA must receive a protest within five (5) business days of the debriefing.

9.2 Application Records Disclosure

An Applicant may request copies of Application and evaluation documents or may inspect Application and evaluation documents in order to make a decision about the efficacy of making a protest. Such a request must be in writing and sent to the RFA Coordinator. HCA will respond as follows within five (5) Business Days of receipt of the request.

- a) The requested documents will either be sent to or made available to the requesting Applicant, except for any portions of the documents that have been identified as Proprietary Information. HCA will follow the process set forth in Section 6.9 Proprietary Information/Public Disclosure before disclosing any portions of Applications that have been identified as Proprietary Information.
- b) If more time is needed, HCA will inform the requestor of the date the requested documents will be available.

9.3 Grounds for Protest

A protest may be made based on these grounds only:

- A matter of bias, discrimination, or conflict of interest on the part of an evaluator;
- Errors in computing the scores; or
- Non-compliance with procedures established in this RFA document or HCA protest process or DES requirements.

Protests not based on these grounds will not be considered. Protests will be rejected as without merit if they address issues such as: 1) An evaluator's professional judgment on the quality of an Application, or 2) HCA's assessment of its own needs or requirements.

9.4 Protest Form and Content

A Protest must state all of the facts and arguments upon which the Protest is based, and the grounds for the Protest. It must be in writing and signed by a person authorized to bind the Applicant to a contractual relationship. At a minimum, the Protest must include:

- The name of the protesting Applicant, mailing address and phone number, and the name of the individual responsible for submission of the Protest;

- The RFA number and title;
- A detailed and complete statement of the specific action(s) by HCA under protest;
- The grounds for the Protest;
- Description of the relief or corrective action requested.

Applicants may attach to their Protest any documentation they have to offer in support.

9.5 Submitting a Protest

Protests must be in writing, must be signed by the Applicant and must be received by the HCA Contract Administrator at the address or email below within five (5) Business Days after the debriefing conference. Protests may be submitted by email.

All protests shall be emailed to Laura Wood, HCA Contract Administrator as follows:

Email: contracts@hca.wa.gov

The subject Line must contain the RFX Title and RFX number. Example: RFA#12-123, Save the Children

Upon HCA's receipt of a protest, a review and investigation will be conducted by a neutral party that had no involvement in the evaluation and award process. The reviewer will conduct an objective review of the Protest, based on the contents of the written Protest and the RFA and any amendments, the Applications, all documents showing evaluation and scoring of the Applications record and any other pertinent information and issue a decision within ten (10) Business Days of receipt of the protest, unless additional time is needed. If additional time is needed, the protesting Applicant will be notified of the delay.

In the event a protest may affect the interest of another Applicant that submitted an Application, such Applicant will be given an opportunity to submit its views and any relevant information on the protest to the Contract Administrator.

HCA will make a final determination of the protest and will:

- Find the protest lacking in merit and uphold HCA's action.
- Find only technical or harmless errors in HCA's acquisition process and determine HCA to be in substantial compliance and reject the protest.
- Find merit in the protest and provide HCA options which may include:
 - that HCA correct the errors and re-evaluate all Applications
 - that HCA reissue the RFA document and begin a new process
 - other courses of action as appropriate

If the reviewer determines that the protest is without merit, HCA will enter into an award with the ASA(s). If the protest is determined to have merit, one of the alternatives noted in the preceding paragraph will be taken.